2021 Proceedings of the
National Association of Insurance Commissioners

2021 Summer National Meeting
August 14 – 17, 2021

Held at the
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Columbus, Ohio
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NAIC Executive Office
444 North Capitol Street, NW
Suite 700
Washington, DC 20001
202.471.3990

NAIC Central Office
1100 Walnut Street
Suite 1500
Kansas City, MO 64106
816.842.3600

NAIC Capital Markets
& Investment Analysis Office
One New York Plaza, Suite 4210
New York, NY 10004
212.398.9000
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CERTIFICATE OF INCORPORATION OF
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
a Nonstock Corporation

I. Name

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

II. Duration

The period of duration of the NAIC is perpetual.

III. Registered Office and Agent

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

IV. Authority to Issue Stock

The NAIC shall have no authority to issue capital stock.

V. Incorporators

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

VI. Purpose

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

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

VII. Restrictions

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

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

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

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

IX. Activities

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

X. Powers

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

XI. Immunity

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

XII. Exculpation and Indemnification

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

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

XIII. Dissolution

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

XIV. Bylaws

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

XV. Amendments

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

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

/signature/
Catherine J. Weatherford, Incorporator

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

ARTICLE I Name, Organization and Location

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

ARTICLE II Membership

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

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

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

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

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

ARTICLE III Officers

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

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

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

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

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

ARTICLE IV Executive Committee

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) NAIC OFFICES

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

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

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

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

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

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

The Internal Administration (EX1) Subcommittee shall:

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

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

4. Audit Committee

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

ARTICLE V Zones

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

ARTICLE VI Standing Committees and Task Forces

1. General

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

2. Specific Duties

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

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

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

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

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

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

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

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

3. Task Forces

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

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

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

1. Regular Meetings.

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

2. Special Meetings.

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

3. Waiver of Notice; Postponement.

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

4. Quorum.

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

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

ARTICLE VIII Elections

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

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

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

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

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

7. The Chair shall announce the opening of nominations for offices in the following order:
   (a) President. Provided, however, where the President does not run for re-election, the President-Elect shall become
       President at the conclusion of the President’s term of office. In those cases where the President runs for re-election
       or where a vacancy exists because the President–Elect fails or is otherwise unable to assume the Presidency, this
       office will be subject to an election.
   (b) President-Elect.
   (c) Vice President.
   (d) Secretary-Treasurer.

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

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

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

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

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

**ARTICLE IX Proxies; Waiver of Notice**

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

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

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

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

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

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

ARTICLE XI Amendments

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Plenary

Executive Committee

(EX1) Subcommittee

Internal Administration

Information Systems Task Force

(A) Committee

Life Insurance and Annuities

Life Actuarial Task Force

(B) Committee

Health Insurance and Managed Care

Health Actuarial Task Force

Regulatory Framework Task Force

Senior Issues Task Force

(C) Committee

Property and Casualty Insurance

Casualty Actuarial and Statistical Task Force

Surplus Lines Task Force

Title Insurance Task Force

Workers’ Compensation Task Force

(D) Committee

Market Regulation and Consumer Affairs

Antifraud Task Force

Market Information Systems Task Force

Producer Licensing Task Force

(E) Committee

Financial Condition

Accounting Practices and Procedures Task Force

Capital Adequacy Task Force

Examination Oversight Task Force

Financial Stability Task Force

Receivership and Insolvency Task Force

Reinsurance Task Force

Risk Retention Group Task Force

Valuation of Securities Task Force

(F) Committee

Financial Regulation Standards and Accreditation

(G) Committee

International Insurance Relations

NAIC/Consumer Liaison Committee

NAIC/American Indian and Alaska Native Liaison Committee

Updated January 25, 2021
### APPOINTED and DISBANDED GROUPS

#### APPOINTED SINCE JANUARY 2021

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

<table>
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<tr>
<th>Group</th>
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<tbody>
<tr>
<td>Financial Stability (E) Task Force (f.k.a. Financial Stability (EX) Task Force)</td>
<td>01/08/2021</td>
<td>Tim Nauheimer</td>
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<tr>
<td>Liquidity Assessment (E) Subgroup (f.k.a. Liquidity Assessment (EX) Subgroup)</td>
<td>01/08/2021</td>
<td>Tim Nauheimer</td>
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<td>Mutual Recognition of Jurisdictions (E) Working Group (f.k.a. Qualified Jurisdiction (E) Working Group)</td>
<td>03/08/2021</td>
<td>Dan Schelp</td>
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#### DISBANDED SINCE JANUARY 2021

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

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

*Updated June 17, 2021*
# 2021 Members by Zone

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

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

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

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

*Updated June 2, 2021*
## 2021 EXECUTIVE (EX) COMMITTEE

<table>
<thead>
<tr>
<th>Name</th>
<th>State</th>
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<tbody>
<tr>
<td>David Altmaier</td>
<td>Florida</td>
</tr>
<tr>
<td>Dean L. Cameron</td>
<td>Idaho</td>
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<tr>
<td>Chlora Lindley-Myers</td>
<td>Missouri</td>
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<tr>
<td>Andrew N. Mais</td>
<td>Connecticut</td>
</tr>
</tbody>
</table>

Most Recent Past President
Raymond G. Farmer
South Carolina

### Northeast Zone

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Jessica K. Altman</td>
<td>Pennsylvania</td>
</tr>
<tr>
<td>Gary D. Anderson</td>
<td>Massachusetts</td>
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<td>Kathleen A. Birrane</td>
<td>Maryland</td>
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### Southeast Zone

<table>
<thead>
<tr>
<th>Name</th>
<th>State</th>
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</thead>
<tbody>
<tr>
<td>Jim L. Ridling</td>
<td>Alabama</td>
</tr>
<tr>
<td>Mike Chaney</td>
<td>Mississippi</td>
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<tr>
<td>James J. Donelon</td>
<td>Louisiana</td>
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### Midwest Zone

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<tbody>
<tr>
<td>Larry D. Deiter</td>
<td>South Dakota</td>
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<tr>
<td>Glen Mulready</td>
<td>Oklahoma</td>
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<tr>
<td>Doug Ommen</td>
<td>Iowa</td>
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### Western Zone

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Lori K. Wing-Heier</td>
<td>Alaska</td>
</tr>
<tr>
<td>Michael Conway</td>
<td>Colorado</td>
</tr>
<tr>
<td>Andrew R. Stolfi</td>
<td>Oregon</td>
</tr>
</tbody>
</table>

NAIC Support Staff: Andrew J. Beal/Kay Noonan

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

Ricardo Lara, Co-Chair
California
Raymond G. Farmer, Co-Chair
South Carolina
Colin M. Hayashida, Co-Vice Chair
Hawaii
James J. Donelon, Co-Vice Chair
Louisiana
Kathleen A. Birrane, Co-Vice Chair
Maryland
Mark Afable, Co-Vice Chair
Wisconsin
Andrew R. Stolfi, Co-Vice Chair
Oregon
Jim L. Ridling
Alabama
Lori K. Wing-Heier
Alaska
Michael Conway
Colorado
Andrew N. Mais
Connecticut
Trinidad Navarro
Delaware
Karima M. Woods
District of Columbia
David Altmaier
Florida
Amy L. Beard
Indiana
Eric A. Cioppa
Maine
Gary D. Anderson
Massachusetts
Anita G. Fox
Michigan
Grace Arnold
Minnesota
Eric Dunning
Nebraska
Barbara D. Richardson
Nevada
Marlene Caride
New Jersey
Russell Toal
New Mexico
Linda A. Lacewell
New York
Jon Godfread
North Dakota
Judith L. French
Ohio
Jessica K. Altman
Pennsylvania
Elizabeth Kelleher Dwyer
Rhode Island
Michael S. Pieciak
Vermont
Scott A. White
Virginia
Mike Kreidler
Washington
James A. Dodrill
West Virginia
Jeff Rude
Wyoming

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

David Altmaier, Chair  Florida  
Dean L. Cameron, Vice Chair  Idaho  
Ricardo Lara  California  
Andrew N. Mais  Connecticut  
John F. King  Georgia  
Sharon P. Clark  Kentucky  
Gary D. Anderson  Massachusetts  
Anita G. Fox  Michigan  
Chlora Lindley-Myers  Missouri  
Jon Godfread  North Dakota  
Glen Mulready  Oklahoma  
Jessica K. Altman  Pennsylvania  
Raymond G. Farmer  South Carolina  
Mike Kreidler  Washington  
Jeff Rude  Wyoming  

NAIC Support Staff: Ethan Sonnichsen/Brian R. Webb  

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

Jon Godfread, Chair  North Dakota  
Elizabeth Kelleher Dwyer, Vice Chair  Rhode Island  
Jim L. Ridling  Alabama  
Lori K. Wing-Heier  Alaska  
Peni Itula Sapini Teo  American Samoa  
Evan G. Daniels  Arizona  
Alan McClain  Arkansas  
Ricardo Lara  California  
Michael Conway  Colorado  
Andrew N. Mais  Connecticut  
Trinidad Navarro  Delaware  
Karima M. Woods  District of Columbia  
David Altmaier  Florida  
Colin M. Hayashida  Hawaii  
Dean L. Cameron  Idaho  
Dana Popish Severinghaus  Illinois  
Amy L. Beard  Indiana  
Doug Ommen  Iowa  
Vicki Schmidt  Kansas  
Sharon P. Clark  Kentucky  
James J. Donelon  Louisiana  
Eric A. Cioppa  Maine  
Kathleen A. Birrane  Maryland  
Gary D. Anderson  Massachusetts  
Anita G. Fox  Michigan  
Grace Arnold  Minnesota  
Mike Chaney  Mississippi  
Chlora Lindley-Myers  Missouri  
Troy Downing  Montana  
Edward M. Deleon Guerrero  N. Mariana Islands  
Eric Dunning  Nebraska  
Barbara D. Richardson  Nevada  
Chris Nicolopoulos  New Hampshire  
Russell Toal  New Jersey  
Mike Causey  New Mexico  
Judith L. French  North Carolina  
Glen Mulready  Ohio  
Andrew R. Stolfi  Oklahoma  
Jessica K. Altman  Oregon  
Raymond G. Farmer  Pennsylvania  
Larry D. Deiter  South Carolina  
Carter Lawrence  South Dakota  
Doug Slape  Tennessee  
Jonathan T. Pike  Texas  
Michael S. Pieciak  Utah  
Scott A. White  Vermont  
Mike Kreidler  Virginia  
James A. Dodrill  Washington  
Mark Afable  West Virginia  

NAIC Support Staff: Scott Morris/Denise Matthews  

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INNOVATION AND TECHNOLOGY (EX) TASK FORCE (Continued)

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

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

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

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

E-Commerce (EX) Working Group
of the Innovation and Technology (EX) Task Force

Kathleen A. Birrane/Robert Baron, Chair Maryland
Jully Pae California
Andrew N. Mais/George Bradner Connecticut
Dana Sheppard District of Columbia
Heather Droge Kansas
Tom Travis Louisiana
Cynthia Amann Missouri
Martin Swanson Nebraska
Chris Aufenthie North Dakota
Judith L. French/Lori Barron Ohio
John Lacek Pennsylvania
Elizabeth Kelleher Dwyer/Matt Gendron Rhode Island
Bryce Carlen Washington

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<td>Mark Afable</td>
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## PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE (Continued)

**Transparency and Readability of Consumer Information (C) Working Group**

*of the Property and Casualty Insurance (C) Committee*

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<thead>
<tr>
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<th>State</th>
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<td>Joy Hatchette, Chair</td>
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<td>Jeff Rude</td>
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# Financial Analysis (E) Working Group

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<td>Judy Weaver</td>
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| Updated: 6/2/2021

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## NAIC Member Tenure List

**ALABAMA—Appointed, at the Pleasure of the Governor; 6-Year Term**

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<th>State/Member Title</th>
<th>Member Name</th>
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| **ALASKA—Appointed, at the Pleasure of the Commissioner of Commerce, Community, and Economic Development** | | | | | |
| Insurance Director | Lori K. Wing-Heier | 2/25/2014 | incumbent | |
| Acting Insurance Director | Marty Hester | 12/20/2013 | 2/25/2014 | 0 | 2 |
| Insurance Director | Bret S. Kolb | 5/30/2012 | 11/30/2013 | 1 | 6 |
| Acting Insurance Director | Stan Ridgeway | 1/1/2003 | 3/3/2003 | 0 | 2 |
| Insurance Director | Robert A. ‘Bob’ Lohr | 8/11/1999 | 1/1/2003 | 3 | 5 |
| Insurance Director | John Ference | 7/1/1999 | 8/11/1999 | 0 | 1 |
| Insurance Director | Marianne K. Burke | 3/1/1995 | 7/1/1999 | 4 | 4 |
| Acting Insurance Director | Thelma Walker | 1/1/1995 | 3/1/1995 | 0 | 2 |
| Insurance Director | David J. Walsh | 2/15/1990 | 1/1/1995 | 4 | 11 |
| Acting Insurance Director | Dick Monkman | 2/1/1990 | 2/15/1990 | 0 | 1 |
| Acting Insurance Director | James Jordan | 9/1/1989 | 2/19/1990 | 0 | 5 |
| Insurance Director | John George | 11/1/1984 | 4/1/1988 | 3 | 5 |
| Acting Insurance Director | John George | 7/1/1984 | 11/1/1984 | 0 | 4 |
| Insurance Director | Kenneth C. Moore | 2/28/1979 | 7/1/1984 | 5 | 5 |
| Insurance Director | Richard L. ‘Dick’ Block | 12/7/1975 | 2/1/1979 | 3 | 2 |
| Insurance Director | William W. ‘Bill’ Fritz | 1/1/1967 | 6/14/1971 | 4 | 5 |
| Director of Insurance | Joseph B. Loonam | 6/18/1962 | 3/1/1964 | 1 | 9 |
| Director of Insurance | William M. Scott | 5/30/1960 | 5/29/1962 | 2 | 0 |
| Insurance Commissioner | Ross P. Duncan | 11/1/1955 | 12/22/1959 | 4 | 1 |
| Auditor of Territory | Frank A. Boyle (Died Dec. 15, 1950) | 4/1/1933 | 12/4/1950 | 17 | 8 |
| Auditor of Territory | Cash Cole | 12/16/1929 | 4/1/1933 | 3 | 4 |
| Secretary of Territory | Karl Theile | 7/22/1921 | 12/16/1929 | 8 | 5 |
| Secretary of Territory | Robert J. Sommers | 9/25/1919 | 7/22/1921 | 1 | 10 |
| Secretary of Territory | Charles E. ‘Chas’ Davidson (Died Aug. 8, 1919) | 10/18/1913 | 8/8/1919 | 5 | 10 |
| Surveyor-General/Secretary | William L. Distin | 8/7/1897 | 10/18/1913 | 16 | 2 |

| **AMERICAN SAMOA—Appointed, at the Pleasure of the Governor** | | | | | |
| Insurance Commissioner | Peni ‘Ben’ Itula Sapini Teo | 1/3/2021 | incumbent | |
| Acting Insurance Commissioner | Elizabeth S. Perri | 10/23/2019 | 1/3/2021 | 1 | 3 |
| Insurance Commissioner | Peteru M. “Peter” Fuimaono | 2/12/2019 | 10/23/2019 | 0 | 8 |
### NAIC MEMBER TENURE LIST

#### AMERICAN SAMOA—Continued

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<tr>
<th>State/Member Title</th>
<th>Member Name</th>
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<th>End Date</th>
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#### ARIZONA—Appointed, at the Will of the Governor; 6-Year Term

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<td>Evan G. Daniels</td>
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### NAIC MEMBER TENURE LIST

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<td>Isaac Corddard</td>
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### ARKANSAS—Appointed, at the Pleasure of the Governor; 4-Year Term

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**NAIC MEMBER TENURE LIST**

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### NAIC MEMBER TENURE LIST

#### CALIFORNIA—Continued

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

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### NAIC MEMBER TENURE LIST

#### DELAWARE—Elected; 4-Year Term

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<td>Trinidad Navarro (Elected Nov. 8, 2016; Re-elected Nov. 3, 2020)</td>
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<td>1/18/1875</td>
<td>4/21/1879</td>
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#### DISTRICT OF COLUMBIA—Appointed, at the Pleasure of the Mayor; Confirmed by the Council of District Columbia

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<th>BEG. DATE</th>
<th>END DATE</th>
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<td>Commissioner, Dept. of Insurance, Securities &amp; Banking (DISB)</td>
<td>Karima M. Woods</td>
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**NAIC MEMBER TENURE LIST**

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

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<th>MEMBER NAME</th>
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## NAIC MEMBER TENURE LIST

### FLORIDA—Continued

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<th>Mos. Served</th>
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<td>State Treasurer/Ins. Commissioner</td>
<td>William V. Knott</td>
<td>9/28/1928</td>
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<td>John C. Luning</td>
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<td>Henry A. L’Engle</td>
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<td>Charles H. Foster</td>
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<td>Simon B. Conover</td>
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### FLORIDA (Department of Financial Services)—Elected; 4-Year Term

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<tr>
<td>Jimmy T. Patronis, Jr.</td>
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<td>1/4/2011</td>
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<tr>
<td>Adelaide Alexander ‘Alex’ Sink</td>
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<td>C. Thomas ‘Tom’ Gallagher</td>
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### GEORGIA—Elected; 4-Year Term

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<td>John F. King</td>
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<td>Madison Bell</td>
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## NAIC MEMBER TENURE LIST

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<th>STATE/MEMBER TITLE</th>
<th>MEMBER NAME</th>
<th>BEG. DATE</th>
<th>END DATE</th>
<th>YRS. SERVED</th>
<th>MOS. SERVED</th>
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<tr>
<td>GUAM—Appointed, at the Pleasure of the Governor</td>
<td>Michelle B. Santos</td>
<td>12/7/2020</td>
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<tr>
<td>Cmsr. of Banking and Insurance</td>
<td>Dafne M. Shimizu</td>
<td>1/7/2019</td>
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<td>Director of Rev. &amp; Taxation/Acting Cmsr. of Banking &amp; Insurance</td>
<td>John P. Camacho</td>
<td>2/5/2018</td>
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<td>1/3/2011</td>
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<td>10/29/2008</td>
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<td>Director of Rev. &amp; Taxation/Acting Cmsr. of Banking &amp; Insurance</td>
<td>Artemio B. ‘Art’ Ilagan</td>
<td>1/1/2008</td>
<td>10/29/2008</td>
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<td>6/26/2007</td>
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<td>George V. Cruz</td>
<td>9/28/2001</td>
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<tr>
<td>Director of Revenue and Taxation/Insurance Commissioner</td>
<td>Joaquin G. Blaz</td>
<td>1/1/1988</td>
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<td>Acting Director of Revenue and Taxation/Acting Insurance Cmsr.</td>
<td>J.C. Carr Bettis</td>
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<td>Director of Revenue and Taxation/Insurance Commissioner</td>
<td>David J. ‘Dave’ Santos</td>
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<td>Jose R. Rivera</td>
<td>1/2/1981</td>
<td>1/3/1983</td>
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<td>Director of Revenue and Taxation/Insurance Commissioner</td>
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<td>Segundo C. Aguon</td>
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<td>Robert A. Smith</td>
<td>1/1/1964</td>
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<td>George W. Ingling (Died March 26, 1979)</td>
<td>3/6/1961</td>
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| HAWAII—Appointed, at the Pleasure of the Governor | Colin M. Hayashida | 1/1/2019 | incumbent | 11 | 0 |
| Insurance Commissioner | Gordon I. Ito | 12/1/2010 | 12/31/2018 | 8 | 0 |
| Insurance Commissioner | Gordon I. Ito | 7/20/2010 | 12/1/2010 | 0 | 5 |
| Insurance Commissioner | J. P. Schmidt | 2/3/2003 | 7/1/2010 | 7 | 5 |
### NAIC MEMBER TENURE LIST

#### HAWAII—Continued

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<th>State/Member Title</th>
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<th>End Date</th>
<th>Yrs. Served</th>
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<td>Rey Graulty</td>
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<td>Lawrence M. Reifurth</td>
<td>3/1/1994</td>
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<td>Robin Campaniano</td>
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<td>Susan Kee-Young Park</td>
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#### IDAHO—Appointed; Four Years, Subject to Earlier Removal by the Governor

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### NAIC MEMBER TENURE LIST

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

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<td>Interim Acting Director of Insurance</td>
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### NAIC Member Tenure List

#### Illinois — Continued

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

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<tr>
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### NAIC MEMBER TENURE LIST

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

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## NAIC MEMBER TENURE LIST

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

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## NAIC Member Tenure List

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<td>Guy R. Whitten</td>
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### NAIC Member Tenure List

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<th>Begin Date</th>
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<th>Years Served</th>
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<td><strong>Maine—Continued</strong></td>
<td>Joshua Nye</td>
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<td>Albert W. Paine</td>
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<td><strong>Maryland—Appointed, at the Pleasure of the Governor; 4-Year Term</strong></td>
<td>Kathleen A. Birrane</td>
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<tr>
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<td>Therese M. Goldsmith</td>
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<td>Elizabeth 'Beth' Sammis</td>
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<td>R. Steven 'Steve' Orr</td>
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<td>Newton I. Steers, Jr.</td>
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<td>Lawrence E. Ensor</td>
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© 2021 National Association of Insurance Commissioners
## NAIC Member Tenure List

### NAIC Member Tenure List

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<tr>
<th>State/Member Title</th>
<th>Member Name</th>
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<td>Chief Clerk of the Treasury and Superintendent of Insurance</td>
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<td><strong>MASSACHUSETTS—Appointed, at the Discretion of the Governor</strong></td>
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<td>Daniel R. Judson</td>
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<td>Linda L. Ruthardt</td>
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<td>Kay Doughty</td>
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<td>John K. Tarbox (Died May 28, 1887)</td>
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<td>Acting Director, DIFS</td>
<td>Judith A. ‘Judy’ Weaver</td>
<td>12/28/2018</td>
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### NAIC Member Tenure List

**Michigan—Continued**

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

#### Michigan—Continued

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<th>State/Member Title</th>
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<th>Mos. Served</th>
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<tr>
<td>Commissioner of Commerce</td>
<td>Samuel H. Row</td>
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#### Minnesota—Appointed, at the Pleasure of the Governor; Confirmed by the Senate

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<td>Commissioner of Commerce</td>
<td>Grace Arnold</td>
<td>4/15/2021</td>
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<tr>
<td>Temporary Cmr. of Commerce</td>
<td>Grace Arnold</td>
<td>9/11/2020</td>
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<td>Steve Kelley</td>
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<td>Jessica Looman</td>
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## NAIC MEMBER TENURE LIST

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<td>Christopher H. Smith</td>
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### MISSISSIPPI—Elected; 4-Year Term

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<tr>
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### MISSOURI—Appointed, at the Pleasure of the Governor; Confirmed by the Senate

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<th>State/Member Title</th>
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<th>Beg. Date</th>
<th>End Date</th>
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### NAIC Member Tenure List

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<tr>
<th>State/Member Title</th>
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<th>Beg. Date</th>
<th>End Date</th>
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### Montana—Elected: 4-Year Term

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<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tr>
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<td>Troy Downing (Elected Nov. 3, 2020)</td>
<td>1/4/2021</td>
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<tr>
<td>Cmsr. of Securities and Insurance / State Auditor</td>
<td>Matthew M. &quot;Matt&quot; Rosendale (Elected Nov. 8, 2016)</td>
<td>1/2/2017</td>
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### NAIC Member Tenure List

#### Montana—Continued

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<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<td>Monica J. Lindeen (Elected Nov. 4, 2008; Re-elected Nov. 6, 2012)</td>
<td>1/5/2009</td>
<td>1/2/2017</td>
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<tr>
<td>Cmsr. of Securities and Insurance / State Auditor</td>
<td>John Morrison (Elected Nov. 7, 2000; Re-elected Nov. 2, 2004)</td>
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<td>1/5/2009</td>
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#### Nebraska—Appointed, at the Pleasure of the Governor

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<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tbody>
<tr>
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<td>Eric Dunning</td>
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<tr>
<td>Director of Insurance</td>
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### NEVADA—Appointed, at the Pleasure of the Director of the Department of Business and Industry

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# NAIC Member Tenure List

## Nevada—Continued

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## New Hampshire—Appointed, 5-Year Term; Nominated by the Governor; Approved by the Executive Council

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<td>Christopher R. 'Chris' Nicolopoulos</td>
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## New Jersey—Appointed, at the Pleasure of the Governor

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<th>End Date</th>
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<th>Mos. Served</th>
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## NAIC MEMBER TENURE LIST

### NEW JERSEY—Continued

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<th>Member Name</th>
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### NAIC Member Tenure List

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<th>State/Member Title</th>
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<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
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### NEW MEXICO—Appointed, by the Insurance Nominating Committee; 4-Year Term

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### NAIC MEMBER TENURE LIST

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<th>Yrs. Served</th>
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<td>Linda A. Lacewell</td>
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<td>Benjamin R. Schenck</td>
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<td>Jesse S. Phillips</td>
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### NAIC MEMBER TENURE LIST

#### NEW YORK—Continued

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<td>Orlow W. Chapman</td>
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#### NORTH CAROLINA—Elected; 4-Year Term

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<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tr>
<td>Commissioner of Insurance</td>
<td>Mike Causey</td>
<td>1/1/2017</td>
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<tr>
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<tr>
<td>Commissioner of Insurance</td>
<td>G. Wayne Goodwin</td>
<td>1/10/2009</td>
<td>1/1/2017</td>
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<td>Commissioner of Insurance</td>
<td>James E. 'Jim' Long</td>
<td>1/5/1985</td>
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<td>Commissioner of Insurance</td>
<td>John Randolph Ingram</td>
<td>1/10/1973</td>
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<td>Edwin S. Lanier</td>
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<td>Charles F. Gold</td>
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<td>William P. 'Bill' Hodges</td>
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<td>Daniel C. 'Dan' Boney</td>
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<td>Stacey W. Wade</td>
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<td>Cyrus Thompson</td>
<td>1/1/1897</td>
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<td>C. M. Cooke</td>
<td>8/1/1895</td>
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<td>William H. Finch)</td>
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#### NORTH DAKOTA—Elected; 4-Year Term

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<td>Commissioner of Insurance</td>
<td>Jon Godfred</td>
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<td>Commissioner of Insurance</td>
<td>Adam Hamm</td>
<td>10/9/2007</td>
<td>1/3/2017</td>
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<tr>
<td>Acting Commissioner of Insurance</td>
<td>Rebecca Ternes</td>
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<td>James A. 'Jim' Poolman</td>
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<td>Glenn Pomeroy</td>
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## NAIC MEMBER TENURE LIST

### NORTH DAKOTA—Continued

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

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<td>Edward M. Deleon Guerrero</td>
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<td>incumbent</td>
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<tr>
<td>Acting Secretary of Commerce</td>
<td>Edward M. Deleon Guerrero</td>
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<td>7/8/2021</td>
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<td>Mark O. Rabauliman</td>
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<td>Mark O. Rabauliman</td>
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<td>9/9/2014</td>
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<td>Michael J. Ada</td>
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<td>Michael J. Ada</td>
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### OHIO—Appointed, at the Pleasure of the Governor; Confirmed by the Senate

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<th>End Date</th>
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<th>Mos. Served</th>
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<tr>
<td>Director of Insurance</td>
<td>Judith L. ‘Judi’ French</td>
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(Died Jan. 27, 1969)
### NAIC MEMBER TENURE LIST

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### OKLAHOMA—Elected; 4-Year Term

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<td>Glen Mulready</td>
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<td>(Elected Nov. 6, 2018)</td>
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## NAIC MEMBER TENURE LIST

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### NAIC MEMBER TENURE LIST

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## NAIC MEMBER TENURE LIST

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### PUERTO RICO—Appointed, Indefinite

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### NAIC Member Tenure List

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### SOUTH CAROLINA—Appointed, at the Will of the Governor

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### NAIC MEMBER TENURE LIST

#### SOUTH CAROLINA—Continued

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

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### NAIC MEMBER TENURE LIST

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

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## NAIC Member Tenure List

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### Texas—Appointed; 2-Year Term

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<td>John E. Hollingsworth</td>
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### NAIC MEMBER TENURE LIST

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<td>E. Virgil Norton</td>
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<td>Lewis M. Terry</td>
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<td>James T. Hammond</td>
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<td>Arthur L. Thomas</td>
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**VERMONT—Appointed, Biannually by the Governor with Senate Consent**

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<td>Commissioner, Department of Financial Regulation (DFR)</td>
<td>Michael S. ‘Mike’ Pieciak</td>
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<td>Commissioner, DFR</td>
<td>Susan L. Donegan</td>
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### NAIC MEMBER TENURE LIST

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<td>Stephen W. ‘Steve’ Kimbell</td>
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<td>Paulette J. Thabault</td>
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<td>Jeffery P. Johnson</td>
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## NAIC Member Tenure List

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<th>End Date</th>
<th>Yrs. Served</th>
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<td>Lt. Governor/Ins. Commissioner</td>
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<tr>
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<td>1/1/2018</td>
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## NAIC MEMBER TENURE LIST

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<td>Mike Kreidler (Elected Nov. 7, 2000; Re-elected Nov. 2, 2004; Re-elected Nov. 4, 2008; Re-elected Nov. 6, 2012; Re-elected Nov. 8, 2016; Re-Elected Nov. 3, 2020)</td>
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## NAIC Member Tenure List

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

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## NAIC MEMBER TENURE LIST

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<th>Yrs. Served</th>
<th>Mos. Served</th>
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</thead>
<tbody>
<tr>
<td>Insurance Commissioner</td>
<td>Kenneth Erickson</td>
<td>2/1/1990</td>
<td>10/1/1991</td>
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<tr>
<td>Acting Insurance Commissioner</td>
<td>Ralph Thomas</td>
<td>12/1/1989</td>
<td>2/1/1990</td>
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<td>Insurance Commissioner</td>
<td>Gordon W. Taylor, Jr.</td>
<td>7/1/1986</td>
<td>12/1/1989</td>
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<td>Acting Insurance Commissioner</td>
<td>Monroe D. Lauer</td>
<td>3/1/1986</td>
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<td>Insurance Commissioner</td>
<td>John T. Langdon</td>
<td>1/1/1975</td>
<td>6/1/1984</td>
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<td>Insurance Commissioner</td>
<td>Ben S. Murphy</td>
<td>1/1/1971</td>
<td>1/1/1975</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Vincent J. Horn, Jr.</td>
<td>6/1/1970</td>
<td>1/1/1971</td>
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<td>Insurance Commissioner</td>
<td>Mark Duncan</td>
<td>6/1/1963</td>
<td>6/1/1967</td>
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<td>Insurance Commissioner</td>
<td>Gilbert A.D. Hart</td>
<td>5/1/1960</td>
<td>6/1/1963</td>
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<td>Insurance Commissioner</td>
<td>Robert Adams</td>
<td>3/1/1959</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Ford S. Taft</td>
<td>3/1/1951</td>
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<td>Insurance Commissioner</td>
<td>Rodney Barrus</td>
<td>3/18/1945</td>
<td>3/1/1951</td>
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<td>Insurance Commissioner</td>
<td>Alex MacDonald</td>
<td>2/1/1939</td>
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<td>Insurance Commissioner</td>
<td>Arthur J. Ham</td>
<td>3/1/1935</td>
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<td>Insurance Commissioner</td>
<td>Theodore Thulemeyer</td>
<td>2/13/1929</td>
<td>3/1/1935</td>
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<td>Insurance Commissioner</td>
<td>Lyle E. Jay</td>
<td>6/6/1927</td>
<td>2/13/1929</td>
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<td>Insurance Commissioner</td>
<td>John M. Fairfield (Died May 21, 1927)</td>
<td>3/1/1927</td>
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<td>Insurance Commissioner</td>
<td>Donald M. Forsyth</td>
<td>11/8/1920</td>
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<td>Robert B. Forsyth</td>
<td>1/2/1911</td>
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<td>LeRoy Grant</td>
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<td>12/1/1911</td>
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<td>1/7/1895</td>
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<td>Charles W. Burdick</td>
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<td>Mortimer N. Grant</td>
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<td>Territorial Auditor</td>
<td>Mortimer N. Grant</td>
<td>3/8/1888</td>
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<td>Territorial Auditor</td>
<td>Jesse Knight</td>
<td>4/1/1882</td>
<td>3/31/1884</td>
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<td>Territorial Auditor</td>
<td>John H. Nason</td>
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<td>3/31/1882</td>
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<td>Territorial Auditor</td>
<td>James France</td>
<td>12/13/1877</td>
<td>1/4/1880</td>
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*Updated: 12/3/2021*
The following is a record of officers and list of national meeting locations at which the NAIC has met since its organization.

<table>
<thead>
<tr>
<th>Mtg</th>
<th>Date</th>
<th>Meeting Site</th>
<th>President</th>
<th>Vice-President</th>
<th>Secretary / Secretary-Treasurer</th>
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<tr>
<td>1</td>
<td>5/24–6/2/1871</td>
<td>New York, NY</td>
<td>George W. Miller, NY</td>
<td>Llewelyn Breese, WI</td>
<td>Henry S. Olcott, NY</td>
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<td>10/18–30/1871</td>
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<td>Henry S. Olcott, NY</td>
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<td>10/–1872</td>
<td>New York, NY</td>
<td>George W. Miller, NY</td>
<td>John W. Foard, CA</td>
<td>Henry S. Olcott, NY</td>
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<td>9/17–20/1873</td>
<td>Boston, MA</td>
<td>Llewelyn Breese, WI</td>
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<td>Orlow W. Chapman, NY</td>
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<td>St. Paul, MN</td>
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<td>8/27/1878</td>
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<td>Julius L. Clarke, MA</td>
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<td>Julius L. Clarke, MA</td>
<td>John A. McCall Jr., NY</td>
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<td>Charles P. Swigert, IL</td>
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<td>John J. Brinkerhoff, IL</td>
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<td>Mackinac Island, MI</td>
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<td>9/22–23/1896</td>
<td>Philadelphia, PA</td>
<td>James R. Waddill, MO3</td>
<td>Stephen W. Carr, ME3</td>
<td>Frederick L. &quot;Fred&quot; Cutting, MA</td>
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<td>Old Point Comfort, VA</td>
<td>Stephen W. Carr, ME4</td>
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<td>William A. Fricke, WI</td>
<td>John J. Brinkerhoff, IL</td>
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<td>Edward T. Oreau, MO7</td>
<td>Milo D. Campbell, MI</td>
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<td>William H. Hart, IN8</td>
<td>Edwin L. Scofield, CT</td>
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<td>John J. Brinkerhoff, IL</td>
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<td>Harry R. Cunningham, MT</td>
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<td>Harry R. Cunningham, MT</td>
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<td>Frank H. Hardison, MA</td>
<td>Fitz Hugh McMaster, SC10</td>
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<td>Frank H. Hardison, MA</td>
<td>1st James R. Young, NC</td>
<td>Fitz Hugh McMaster, SC</td>
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<td>James R. Young, NC</td>
<td>2nd Willard Done, UT11</td>
<td>Fitz Hugh McMaster, SC</td>
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<td>Fitz Hugh McMaster, SC</td>
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<td>Burton Mansfield, CT</td>
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<td>Fitz Hugh McMaster, SC</td>
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<td>2nd W. C. Taylor, ND</td>
<td>Fitz Hugh McMaster, SC</td>
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<td>Michael J. Cleary, Wt12</td>
<td>2nd Emory H. English, IA</td>
<td>Fitz Hugh McMaster, SC</td>
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<td>Joseph L. Button, VA13</td>
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<td>2nd Frank H. Ellsworth, MI</td>
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<td>Meeting Site</td>
<td>President</td>
<td>Vice-President</td>
<td>Secretary / Secretary-Treasurer</td>
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<td>Alfred L. Harty, MO15</td>
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<td>Joseph L. Button, VA</td>
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<td>Swampscott, MA</td>
<td>Thomas B. Donaldson, PA</td>
<td>1st Platt Whitman, WI15</td>
<td>Joseph L. Button, VA</td>
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<td>Minneapolis, MN</td>
<td>Herbert D. Fishback, WA16</td>
<td>1st. H. O. Fishback, WA</td>
<td>Joseph L. Button, VA</td>
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<td>Herbert O. Fishback, WA</td>
<td>1st John C. Luning, FL16</td>
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<td>San Antonio, TX</td>
<td>John C. Luning, FL</td>
<td>1st Samuel W. McCulloch, PA</td>
<td>Joseph L. Button, VA</td>
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<td>Los Angeles, CA</td>
<td>Harry L. Conn, OH17</td>
<td>1st T. M. Henry, MA</td>
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<td>9/1927</td>
<td>Cincinnati, OH</td>
<td>Albert S. Caldwell, TN18</td>
<td>1st Charles R. Detrick, CA</td>
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<td>Rapid City, SD</td>
<td>Albert S. Caldwell, TN</td>
<td>1st Charles R. Detrick, CA</td>
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<td>Toronto, Canada</td>
<td>Howard P. Dunham, CT19</td>
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<td>Hartford, CT</td>
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<td>Joseph L. Button, VA</td>
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<td>9/1931</td>
<td>Portland, OR</td>
<td>Jess G. Read, OK21</td>
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<td>Albert S. Caldwell, TN</td>
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<td>Vice-President</td>
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<td>Vice-President</td>
<td>Secretary / Secretary-Treasurer</td>
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<td>Earl R. Pomeroy, ND</td>
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<td>Indianapolis, IN</td>
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<td>9/1991</td>
<td>Pittsburgh, PA</td>
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<td>Houston, TX</td>
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<td>Seattle, WA</td>
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<td>Steven T. Foster, VA</td>
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<td>Washington, DC</td>
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<td>David J. Walsh, AK</td>
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<td>Cincinnati, OH</td>
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<td>Meeting Site</td>
<td>President</td>
<td>Vice-President</td>
<td>Secretary / Secretary-Treasurer</td>
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<td>Joel Ario, OR</td>
<td>Alessandro A. ‘Al’ Iuppa, ME</td>
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<td>President-Member</td>
<td>President-Elect</td>
<td>Vice President</td>
<td>Secretary-Treasurer</td>
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<td>R. A. Sevigny, NH</td>
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<td>Alessandro A. 'Al' Iuppa, ME</td>
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<td>Walter A. Bell, AL</td>
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<td>Roger A. Sevigny, NH</td>
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<td>Walter A. Bell, AL</td>
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<td>Roger A. Sevigny, NH</td>
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<td>9/29–10/2/2007</td>
<td>Washington, DC</td>
<td>Walter A. Bell, AL</td>
<td>Sandra K. 'Sandy' Praeger, KS</td>
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<td>12/2–4/2007</td>
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<td>Sandra K. 'Sandy' Praeger, KS</td>
<td>Roger A. Sevigny, NH</td>
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<td>9/22–24/2008</td>
<td>National Harbor, MD</td>
<td>Sandra K. 'Sandy' Praeger, KS</td>
<td>Roger A. Sevigny, NH</td>
<td>Jane L. Cline, WV</td>
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<td>12/5–8/2008</td>
<td>Grapevine, TX</td>
<td>Sandra K. 'Sandy' Praeger, KS</td>
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<td>3/15–18/2009</td>
<td>San Diego, CA</td>
<td>Roger A. Sevigny, NH</td>
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<td>Minneapolis, MN</td>
<td>Roger A. Sevigny, NH</td>
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<td>Orlando, FL</td>
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<td>3/26–29/2011</td>
<td>Austin, TX</td>
<td>Susan E. Voss, IA</td>
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<td>Kevin M. McCarty, FL</td>
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<td>National Harbor, MD</td>
<td>Kevin M. McCarty, FL</td>
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<td>Adam Ham, ND</td>
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<tr>
<td>8/24–27/2013</td>
<td>Indianapolis, IN</td>
<td>James Donelan, LA</td>
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<td>Adam Ham, ND</td>
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<td>Michael F. Consedine, PA</td>
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<td>8/15–18/2015</td>
<td>Chicago, IL</td>
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<td>Sharon P. Clark, KY</td>
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<td>12/10–13/2016</td>
<td>Miami, FL</td>
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<td>John M. Huff, MO</td>
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<td>Theodore K. Ted' Nickel, WI</td>
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<td>6/4–9/2019</td>
<td>Orlando, FL</td>
<td>Eric A. Cioppa, ME</td>
<td>Raymond G. Farmer, SC</td>
<td>David Altmaier, FL</td>
<td>Dean L. Cameron, ID</td>
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<td>New York, NY</td>
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<td>Chloris Lindley-McCoy, MO</td>
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<td>Raymond G. Farmer, SC</td>
<td>David Altmaier, FL</td>
<td>Dean L. Cameron, ID</td>
<td>Chloris Lindley-McCoy, MO</td>
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<tr>
<td>4/7–14/2021</td>
<td>Virtual meeting</td>
<td>David Altmaier, FL</td>
<td>Dean L. Cameron, ID</td>
<td>Chloris Lindley-McCoy, MO</td>
<td>Andrew N. Mais, CT</td>
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<td>8/13–17/2021</td>
<td>Columbus, OH</td>
<td>David Altmaier, FL</td>
<td>Dean L. Cameron, ID</td>
<td>Chloris Lindley-McCoy, MO</td>
<td>Andrew N. Mais, CT</td>
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</table>

1. Sept. 23, 1886: John K. Tarbox (MA) was elected President for the 1887 Convention; Samuel H. Cross (RI) was elected Vice-President; and Robert B. Brinkerhoff (Ohio chief clerk) was elected Secretary. Commissioner Tarbox died May 28, 1887. Auditor Cross was out of office effective June 1, 1887. Mr. Brinkerhoff was out of office effective June 3, 1887. Oliver Pillsbury (NH) was chosen to preside over the 1887 Convention. It is unknown who act as Vice-President. Jacob A. McEwen (Ohio chief clerk) was chosen to act as Secretary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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


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

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

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

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

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

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

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

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

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

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

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


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

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

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

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

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

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

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

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

Updated: 8/13/2021
NAIC MODEL LAWS, REGULATIONS AND GUIDELINES

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

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CALL TO ORDER

The 232nd session of the National Association of Insurance Commissioners (NAIC) will now come to order. Good morning, my name is David Altmaier, I’m Florida’s Commissioner and President of the NAIC. I am honored to open the NAIC Summer National Meeting.

INTRODUCTION OF HEAD TABLE

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

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

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

New Member Video

Now, I would also like to recognize our newest members in this short video. [New Member Video Plays.]

Introduction of Ohio Commissioner

It is my pleasure to introduce the Director of the Ohio Department of Insurance (DOI), Judith L. French.

Director French was appointed by Governor Mike DeWine in February of this year. Prior to becoming the Director of Insurance, she served as a justice of the Ohio Supreme Court, the tenth woman to serve in that role in Ohio’s history. Director French, welcome and thank you for serving as our host.

Ohio Director of Insurance Speech

Thank you, President Altmaier, for the introduction and your leadership during these challenging times.

Good afternoon and welcome to the 2021 NAIC Summer National Meeting. For those who were in Austin, TX in December 2019, who could have imagined that the journey back together would be so long and tumultuous, but here we are, back together again! The NAIC last held a national meeting in Ohio in 1992. Twenty-nine years ago! It’s long overdue, and it’s great to have all of you here. I appreciate every effort you made to join us.

As one of the newer commissioners in the NAIC ranks, I would be remiss if I didn’t thank my predecessor at the Ohio DOI for making this possible. During the meeting in Denver in 2017, then-Commissioner Jillian Froment (OH), who I know many of you worked with over the last decade, successfully made the pitch to bring a national meeting to Columbus, OH, and a lot of work has gone into getting us here. Thank you to everyone who worked tirelessly to make this meeting possible.

I know your time here will be brief, but I hope you get a chance to enjoy a little of what Columbus and Ohio have to offer. Growing up in Ohio, I often heard the term “rust belt,” and it still makes me cringe. As you move around the city, you will see signs of recovery in downtown Columbus, but you’re not going to see much rust. Ohio, and Columbus in particular, is on the
rise, and our insurance industry is a significant part of our growth and strength. More than 100,000 Ohioans work in the insurance industry, and just like those in your home states, we are grateful for them.

I have traveled across the Buckeye state many times, and I often marvel at the common threads that hold all Ohioans together. Oh, we have our differences—the accents, the traditions, and the team colors we wear. Cincinnati, Cleveland, and Columbus (not to mention Toledo, Youngstown, and Athens) are all very different places, but the pride and determination of their people is an unwavering constant.

We are a collaborative state, one with generations of problem solvers, innovators, and leaders. We are proud of what we do and work hard doing it. We take great pride in our aviation history, being home to the Wright brothers, John Glenn, and Neil Armstrong. But we are also home to Thomas Edison, eight U.S. Presidents, Jack Nicklaus, Jesse Owens, Steven Spielberg, Annie Oakley, Halle Berry, and too many more Ohioans to name.

These American icons rose to legendary heights because they chose to work together to solve problems, think outside the box, and face challenges head-on, and that is precisely what we do at the NAIC.

In my brief time serving as commissioner, it’s clear how hard this group works to tackle important issues facing consumers and the market, and that’s what I want to emphasize today. Sure, we have our differences, and our states are not all the same. We have different political views and often different approaches to solving the same problem. But it’s our collective focus on the consumers we serve and the industry that protects those consumers that leads to the best outcomes.

None of us could have imagined the events that unfolded during the past 17 months, but together we worked to provide stability in the market as the world shut down; and we did it without sacrificing essential consumer protections—the protections that are there for families in moments of tremendous loss and need.

I don’t know if many young children consider their future and think, I want to be an insurance executive, but what a surprise when they realize they can touch every human life in ways that are supportive, meaningful, and uplifting, just by working in the insurance industry.

Neil Armstrong once observed, “we all like to be recognized not for one piece of fireworks, but for the ledger of our daily work.” For you, that ledger may include a decision about how to provide long-term care (LTC) at a reasonable cost for thousands of individuals in your state, the launch of a new product that will change the face of insurance for decades to come, or the implementation of a new and innovative work plan that keeps your employees safe and the public served. Whatever it is, I can assure you that you are making a difference by working in this important industry, and your work matters.

It’s my honor to be one of you and my honor to serve as your host. I look forward to our collaborative conversations over the next few days. Bonus points if you can work in a reference to Archie Griffin. Thanks, everyone. Enjoy Columbus.

PRESIDENTIAL ADDRESS

David Altmaier, NAIC President

Thank you for your comments, Director French, and thank you again for being such a gracious host. We are looking forward to our time here in Ohio.

Welcome to the NAIC’s 232nd national meeting in our 150-year history. I have missed the live exchange at our national meetings, and I am happy to be together once more. Our strong working relationships have without a doubt helped us navigate the last 19 months, and I am excited to have the opportunity to meet face-to-face with those of you who were able to join us here in Columbus, OH, and I look forward to hearing the comments of those who are attending virtually.

The hybrid approach to this national meeting is a testament to the innovation and adaptability of our states, territories, and the NAIC. It feels good to have this opportunity to meet face-to-face and be back to this new version of normal, and we are indebted to the efforts of so many to get to this point.

Throughout our history, the commissioners and the NAIC have come together to find solutions to the many challenges facing the insurance industry and the world. The organization has weathered two world wars, financial crises, countless natural disasters, pandemics, and ever-changing laws over the past 150 years. Each of these challenges has provided us with valuable lessons and caused us to rethink our old ways of doing things, which in turn has made the NAIC stronger and more resilient.
COVID-19

The COVID-19 pandemic is only the most recent example of state insurance regulators coming together to tackle big, unanticipated issues.

The pandemic has created a host of new challenges for our regulatory system. As a result, the NAIC continues to test and implement new processes and technologies to better focus our efforts on supporting our members in their mission to protect consumers and maintain strong insurance markets.

To ensure the insurance sector could provide the critical services consumers needed throughout the pandemic, many states expanded the use of virtual platforms to provide health care, offered flexible work arrangements, and enabled agents to be licensed online.

The pandemic challenged insurer’s business models, processes, and practices. Insurance companies automated processes to speed up the delivery of services. Auto insurers reviewed the impact of decreased driving on rating models and how COVID-19 could affect underwriting and rate considerations going forward.

These are just some of the highlights of the COVID-19-related issues NAIC members are examining. We are looking at the lessons we have learned so far, the benefits to consumers, and the potential unintended consequences to determine what modifications to existing laws and practices should be considered. NAIC members are committed to ensuring that consumers remain protected as we transition to whatever comes next.

The COVID-19 vaccine has been a gamechanger; however, we are also aware that the pandemic and its impact on the insurance sector continues to evolve. We remain vigilant and steadfast in our work with federal agencies to ensure access to testing, treatment, and vaccinations, along with our commitment to combat misinformation surrounding insurance coverage.

The U.S. industry demonstrated its strong solvency position and overall resilience through its positive operating performance for 2020, and they are poised to continue building even stronger solvency positions in 2021. The sector’s strength is due, in part, to the strong solvency and governance requirements that we instituted following the last financial crisis.

Your state insurance regulators and the NAIC remain committed to ensuring that insurance companies can meet consumer demands and cover their obligations, and insurance agents have the knowledge and integrity to adequately advise consumers about coverages and policies.

The pandemic highlighted both business insurance coverage gaps and the improper marketing of health insurance. The NAIC continues to work with the U.S. Congress (Congress) to provide information and insights around business interruption insurance, promote resilience and mitigation, foster stable and competitive insurance markets, and ensure fair treatment of policyholders.

The Antifraud (D) Task Force and the Improper Marketing of Health Insurance (D) Working Group combined forces to coordinate with state insurance regulators on a state and federal level to provide guidance and monitoring of the inappropriate marketing of health plans.

Cybersecurity

Cybersecurity is one of the most important topics for the insurance sector and businesses today. It is paramount that insurers and insurance producers find ways to protect the highly sensitive consumer financial and health information collected as part of the underwriting and claims processes. For the last four years, state insurance regulators have been committed to finding ways to tackle this growing risk.

Director Farmer serves on the U.S. Department of the Treasury's (Treasury Department’s) Financial Banking and Information Infrastructure Committee (FBIIC), where he represents state commissioners in working with federal regulators to address cyber threats in the U.S.

NAIC membership adopted several Cybersecurity Working Group recommendations and the Insurance Data Security Model Law (#668), which requires insurers and other entities licensed by state insurance departments to develop, implement, and maintain an information security program; investigate any cybersecurity events; and notify the state insurance commissioner of such events. Model #668 has been adopted by 18 states, with several other states adopting similar laws.
The NAIC membership also adopted a Cybersecurity Insurance and Identity Theft Coverage Supplement for the property/casualty (P/C) annual financial statement to collect information about cybersecurity insurance markets.

I would strongly encourage states that have not passed the models to consider doing so. It is not hard to envision scenarios where, for example, several large P/C carriers are subject to a ransomware attack following a large natural disaster, disabling their ability to pay claims. This type of scenario poses not just an existential threat to the solvency of those companies and our state-based insurance system, but to the industry as a whole. This is a threat that we cannot ignore.

**Consumer Data Privacy**

Beyond cyber breaches, regulatory concerns about the use of consumer data by a variety of commercial, financial, and technology companies remain a priority for the NAIC. State insurance regulators encourage innovation but continue to scrutinize the underwriting, pricing and claims algorithms, and risk models associated with smart tools to ensure policyholders are being treated fairly and information is sufficiently protected.

The NAIC developed and adopted artificial intelligence (AI) principles last year. We utilize those principles to evaluate the use of consumer data in innovative technologies feeding into algorithms and models involving AI and machine learning (ML).

The NAIC’s Innovation and Technology (EX) Task Force continues to provide forums and resource materials around new developments within the insurance sector. The Task Force and the AI principles offer guardrails around how these advances could affect consumer protection, privacy, insurer oversight, marketplace dynamics, and the state-based insurance regulatory framework.

Given the critical importance of these technology-related issues and their impact on insurance markets and consumers, we are taking the significant step of creating a new standing committee focused on innovation, AI, and cybersecurity by the end of this year. This will be the first new letter committee—the “H” Committee—formed by NAIC members in a couple of decades. The new committee will help us better address a wide range of evolving and challenging issues in these important areas.

The new committee will be charged with monitoring developments and coordinating the NAIC’s work in the areas of innovation, AI, and cybersecurity that are affecting the insurance sector. The new committee will also develop regulatory models and guidance, as appropriate, to ensure our state-based system continues to keep pace with the rapidly evolving insurance sector.

There will be additional discussion about the formation of this new committee during the Task Force meeting, and we look forward to engaging stakeholders as the process moves forward.

**Diversity, Equity, & Inclusion/Race and Insurance**

As part of our ongoing commitment to ensure historically under-represented groups are not adversely affected within the insurance industry, we more clearly articulated the charges of the Special (EX) Committee on Race and Insurance and added new charges to existing committees.

The charges outline our commitment to take meaningful action in the months and years to come to ensure all consumers are treated fairly and equitably when it comes to both accessibility and affordability of insurance products. This is not a new mission for us. Since the 1960s, the NAIC and state insurance regulators have worked to fight overt and proxy discrimination, be it discriminatory underwriting and rating criteria or redlining. As insurers increase their use of data, modeling, and other tools we must ensure unfair discrimination is not imbedded in these new business approaches. Similarly, we are committed to working with our state and federal legislative partners to advocate for greater accessibility to the insurance marketplace for people of color and other underrepresented groups.

Last year, when we launched the Special Committee, we committed to a diverse, inclusive, and member-led discussion on how to enhance consumer protections on race and insurance; looking inward and outward; and focused on outcomes. Our charges and the work we have done thus far provides us a course to follow. As we have said many times before, we will not fix these problems in a year, but we are committed to the journey no matter how long it takes.

Our long history has shown us that one of the greatest strengths of our state-based system is to adapt when confronted with fundamental challenges. We know additional progress is needed and we invite all stakeholders, industry, consumers, state legislators, federal government, and others to work with us to deliver on this commitment to consumers.
Long-Term Care Insurance

State insurance regulators continue to grapple with long-term care insurance (LTCI). This includes issues surrounding a shrinking market, the threat of insolvencies, and the impact of large rate increases on our most vulnerable residents.

Significant work has been completed to design a Long-Term Care Insurance Multi-State Actuarial Rate Review Framework (MSA Framework) to address rate increase requests from insurers, but much more work is in store. This approach is designed to result in more actuarially appropriate increases being granted by affected states in a timely manner and improve future rate parity across the states for all policyholders.

A detailed framework, documenting the operating features and actuarial considerations of the MSA process is currently available for public review and feedback. Our Long-Term Care Insurance (EX) Task Force, led by Commissioner Scott A. White (VA) and Commissioner Mike Conway (CO), is monitoring the progress on this work and has the challenging task of balancing the financial aspects of the coverages and promises made to policyholders. This work will likely spill over into next year as the committee works through technical and operational aspects of the process, but I am pleased with its progress to date.

In addition to our efforts to help stabilize rate increases, we are also focused on the appropriateness of reduced benefit options (RBOs) provided by insurers, further examination of the adequacy of policy and claim reserves of LTC writers, facilitating innovative ideas in LTC, and engaging with the Treasury Department Federal Interagency Task Force on Long-Term Care Insurance matters.

Climate Risk and Resiliency

We continue to face increasingly severe weather patterns across much of the U.S., with catastrophic losses in many markets. The NAIC and state insurance regulators continue to work with counterparts both domestically and internationally on the critical work of addressing climate and resiliency issues facing insurance consumers and insurance markets.

The Climate Disclosure Workstream of the Climate and Resiliency (EX) Task Force allowed states to report on the Task Force on Climate-Related Financial Disclosures (TCFD) or the Climate Risk Exposure Survey, more than doubling the number of jurisdictions participating in its survey. This year, Delaware; Maine; Maryland; Massachusetts; Oregon; Pennsylvania; Rhode Island; Vermont; and Washington, DC were added to the list of those participating in the survey, increasing the percentage of the market represented from 70% to 78%.

The NAIC and its Center for Insurance Policy and Research (CIPR) maintains a central web-based repository for agencies, academics, and other interested parties studying risks, resiliency building codes, and the impact on insurance on naic.org. The CIPR also has coordinated risk and resiliency assessments, disclosures, and workshops with the Federal Emergency Management Agency (FEMA) and the Insurance Institute for Business & Home Safety (IBHS) to help ensure the states have the information necessary to foster stable insurance markets for its citizens.

On a related note, I would also like to highlight the CIPR special session on Tuesday morning from 8:30 – 10:30 a.m., entitled “Casualty Catastrophe Risk in the Time of Social Inflation: Landscape, Modeling, and Action.” This session will explore the casualty catastrophe emerging risk landscape, tools available to understand it, and actions industry and state insurance regulators can take to address these risks.

The NAIC’s Communications department developed tools, educational material, and social media messaging to educate consumers about their risks, coverage options, and mitigation techniques associated with severe weather.

At the national level, we remain committed to engaging with FEMA and other federal partners on climate risk issues, advocating for state mitigation grant tax parity, advocating for the reauthorization of the National Flood Insurance Program (NFIP), and increasing the private flood market.

International

While my remarks so far have focused mainly on domestic priorities and activities, these same issues are increasingly the focus of international work. Supervisors from around the globe came together to share experiences and help one another in the face of COVID-19. This renewed spirit of collaboration carries forward as we look at challenges, risks, and opportunities from issues like climate; diversity, equity, & inclusion (DE&I); innovation and data; and cybersecurity. As organizations like the
International Association of Insurance Supervisors (IAIS), the Sustainable Insurance Forum (SIF), the Organisation for Economic Co-Operation and Development (OECD), and the Financial Stability Board (FSB) address these issues, we will continue to and learn from international efforts.

As we welcome this pivot to address emerging issues, we also remain committed to the implementation of reforms, such as the IAIS’s holistic framework for systemic risk and the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame). We appreciate the ongoing contributions to these workstreams from both of our relevant group-wide supervisors and insurance groups, which is important as work progresses on the process to assess the comparability of the Aggregation Method to the insurance capital standard (ICS).

While our passports may have gone unused during the pandemic, we have found virtual ways to foster the relationships and exchanges with our international counterparts. We continue to hold virtual bilateral meetings with key jurisdictions.

After having to cancel our 2020 International Forum, we were pleased to hold this year’s forum virtually, which focused on a variety of important topics in October. We look forward to hosting the event in person in Washington, DC in 2022.

We have also been pleased with the level of participation in our virtual International Fellows program. In fact, starting in 2022, the Spring session will be virtual to continue broader availability, and the Fall session will be the traditional six-week in-person session to continue an in-depth experience and exchange of ideas.

**State Ahead**

In addition to focusing on the big issue facing the insurance industry, the NAIC continues its efforts to enhance the products and services we offer to state insurance regulators and the industry.

Implementation of State Ahead, the NAIC’s strategic blueprint for the future, continues on pace. Some highlights of this initiative include enhanced tools for state insurance departments, improved modeling resources, and cloud migration. In the fall, the membership will work together to forecast what the insurance sector may look like several years into the future and start to build our State Ahead 2.0 plan.

The State Ahead plan brings together the tools, talent, and technology needed to help state insurance regulators ensure the U.S.’s preeminence as the largest single insurance market, not just for today, but for the generations of state insurance regulators to follow.

Today’s top priorities may be COVID-19, natural catastrophe and climate risks, DE&I, the impact of AI and big data, ensuring consumer data privacy, and addressing issues in the LTC market; but rest assured, our 100 or so committees, task forces, and subgroups are actively engaged in ensuring the many insurance issues facing consumers and the industry are being reviewed and properly addressed.

If our 150-year history has taught us anything, it is that we must keep our eyes on both today’s risks and the emerging risks of tomorrow. Although we do not know exactly what the future will hold, our experience has shown us we are well-suited to successfully handle anything that comes our way.

While none of us knows what the future holds, we are committed to asking the necessary and tough questions. It’s our responsibility to future generations to ensure we take a long view on issues. I’m proud of the resilience we have all displayed during the past several months. Our thoughts, decisions, and actions will provide valuable insight for those we represent now and for those who will follow in our footsteps.

Over the next several days, we will have an opportunity to hear from you. We look forward to the unique perspective each one of you bring, as we know the best decisions come when we look at issues from as many different angles as possible.

We appreciate your participation and insights. I encourage you to engage as much as possible in the coming days. And I look forward to working and connecting with each of you.

**ADJOURNMENT**

I officially conclude this opening session of the 232nd meeting of the NAIC.

David Altmaier, NAIC President

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Synopsis of the NAIC Committee, Subcommittee and Task Force Meetings
2021 Summer National Meeting
August 14–17, 2021

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

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

EXECUTIVE (EX) COMMITTEE AND PLENARY (Joint Session)
August 17, 2021
1. Adopted the report of the Executive (EX) Committee. See the Committee listing for details.
2. Adopted by consent the committee, subcommittee and task force minutes of the 2021 Spring National Meeting.
3. Adopted amendments to the 2021 charges.
4. Received the report of the Life Insurance and Annuities (A) Committee. See the Committee listing for details.
5. Received the report of the Health Insurance and Managed Care (B) Committee. See the Committee listing for details.
6. Received the report of the Property and Casualty Insurance (C) Committee. See the Committee listing for details.
7. Received the report of the Market Regulation and Consumer Affairs (D) Committee. See the Committee listing for details.
8. Received the report of the Financial Condition (E) Committee. See the Committee listing for details.
9. Received the report of the Financial Regulation Standards and Accreditation (F) Committee. See the Committee listing for details.
12. Failed to adopt the [State] Pharmacy Benefit Manager Licensure and Regulation Model Act.
15. Adopted amendments to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450).
17. Received a status report on state implementation of NAIC-adopted model laws and regulations.

EXECUTIVE (EX) COMMITTEE
August 15, 2021
1. Adopted the report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, which met Aug. 13 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) and paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings. During this meeting, the Committee and Subcommittee took the following action:
   A. Adopted its July 13, June 29, May 20, and Spring National Meeting minutes, which included the following action:
      i. Received a mid-year financial update and overview of the preliminary 2022 budget.
      ii. Approved the State Based Systems (SBS) Kansas Implementation 2021 Fiscal.
      iii. Approved a commercial mortgage-backed securities (CMBS) and residential mortgage-backed securities (RMBS) financial modeling vendor.
      iv. Approved a contribution to the NAIC Defined Benefit Pension Plan portfolio.
v. Approved the Solvency Workpaper Software Modernization Project – Implementation Preparation Phase Fiscal.
vi. Approved the System for Electronic Rate and Form Filing (SERFF) Modernization – Mobilization and Pilot Phase Fiscal.
vii. Approved the SBS State Implementation 2021 Fiscal.
viii. Approved the Property/ Casualty (P/C) Rate Model Review Staffing Resources Fiscal.

B. Adopted the report of the Audit Committee, which met Aug. 10 and took the following action:
i. Received an overview of the June 30 financial statements.
ii. Reconfirmed RSM for the 2021 financial audit.
iii. Received an update on the 2021 Service Organization Control (SOC) 2 for transaction processing in the cloud review.
iv. Received an update on Zone financials and the 2022 budget calendar.
v. Reaffirmed its 2022 proposed charter.

C. Adopted the report of the Internal Administration (EX1) Subcommittee, which met Aug. 13, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. During this meeting, the Subcommittee took the following action:
i. Received the June 30 Long-Term Investment Portfolio and Defined Benefit Pension Plan Portfolio reports.
iii. Adopted its 2022 proposed charges.

E. Approved the request for an amicus brief in Gunn v. Continental Casualty Co.

2. Adopted the report of the Executive (EX) Committee, which met July 13, June 29, and May 20 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. During these meetings, the Committee took the following action:
A. Discussed appointing a new standing “H” committee to focus on innovation, technology, and cybersecurity.
B. Received a mid-year financial update and an overview of the preliminary 2022 budget.
C. Adopted the Audit Committee report, including the 2020/2021 SOC reports.
D. Adopted the Internal Administration (EX1) Subcommittee’s May 13 minutes.
E. Approved a Fiscal for the Solvency Workpaper Software Modernization Project – Implementation Preparation Phase.

3. Adopted the report of the Climate and Resiliency (EX) Task Force. See the Task Force listing for details.
5. Adopted the report of the Innovation and Technology (EX) Task Force. See the Task Force listing for details.
6. Adopted the report of the Long-Term Care Insurance (EX) Task Force. See the Task Force listing for details.
7. Adopted the report of the Special (EX) Committee on Race and Insurance. See the Special Committee listing for details.
8. Received a status report on the NAIC State Ahead strategic plan implementation.
9. Received a status report on model law development efforts for amendments to: the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171); the Annuity Disclosure Model Regulation (#245); the Insurance Holding Company System Regulatory Act (#440); the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450); the Life Insurance Disclosure Model Regulation (#580); the Nonadmitted Insurance Model Act (#870); and new models, including the Pet Insurance Model Law and the [State] Pharmacy Benefit Manager Licensure and Regulation Model Act.

10. Heard reports from the National Insurance Producer Registry (NIPR) and the Interstate Insurance Product Regulation Commission (Compact).

Climate and Resiliency (EX) Task Force
August 15, 2021
1. Adopted its Spring National Meeting minutes.
2. Received updates from its five Workstreams: Pre-Disaster Mitigation; Climate Risk Disclosure; Solvency; Innovation; and Technology.
3. Heard a presentation from the California Department of Insurance (CDI) regarding its Climate Insurance Working Group report, “Protecting Communities, Preserving Nature and Building Resiliency.”
4. Heard a presentation from the Reinsurance Association of America (RAA) regarding its mapping and analysis tool using Federal Emergency Management Agency (FEMA) Natural Risk Index data.
Government Relations (EX) Leadership Council
The Government Relations (EX) Leadership Council did not meet at the Summer National Meeting.

Innovation and Technology (EX) Task Force
August 14, 2021
1. Adopted its Spring National Meeting minutes.
2. Adopted the report of the Big Data and Artificial Intelligence (EX) Working Group, including its July 9 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its March 29 minutes.
   B. Discussed a draft survey to conduct analysis on private passenger automobile (PPA) insurers’ use and governance of big data as used in an artificial intelligence (AI) and machine learning (ML) system. The survey is being conducted under the examination authority of Connecticut, Illinois, Iowa, Louisiana, Nevada, North Dakota, Pennsylvania, Rhode Island, and Wisconsin.
3. Adopted the report of the Speed to Market (EX) Working Group, including its June 30 and June 29 minutes. During these meetings, the Working Group took the following action:
   A. Adopted its March 10 minutes.
   B. Received an update from the Interstate Insurance Product Regulation Commission (Compact).
   C. Discussed the results of the Product Requirements Locator (PRL) survey.
   D. Received an update on the System for Electronic Rate and Form Filing (SERFF).
   E. Discussed the annual review of the product coding matrix (PCM) and uniform transmittal document (UTD).
   F. Discussed and considered the suggestions received for updates to the PCM and UTD. Three suggestions were received and discussed. None of the three suggested changes were adopted.
4. Adopted the report of the E-Commerce (EX) Working Group, including its June 30 minutes. During this meeting, the Working Group took the following action:
   A. Discussed the establishment of this newly appointed Working Group.
   B. Discussed its 2021 charges and work plan.
5. Heard an update on NAIC cybersecurity workstreams and priorities.
6. Discussed consumer data ownership issues and potential guidance. The Task Force agreed it would be appropriate to refer this to the Market Regulation and Consumer Affairs (D) Committee to consider giving the Privacy Protections (D) Working Group the charge to address this issue.
7. Heard updates from other NAIC committees and working groups on related activities, including the Special (EX) Committee on Race and Insurance, the Accelerated Underwriting (A) Working Group, the Property and Casualty Insurance (C) Committee, and the Privacy Protections (D) Working Group.
8. Received reports on the NAIC model review process and international initiatives relative to AI and big data.
9. Discussed the appointment of a new standing “H” committee that would take on the current Task Force’s charges and expand to include some cybersecurity issues.

Long-Term Care Insurance (EX) Task Force
August 13, 2021
1. Adopted its July 6 minutes, which included the following action:
   A. Adopted it Spring National Meeting minutes.
   B. Received the report of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup, which met June 22 and took the following action:
      i. Heard comments from state insurance regulators and interested parties on the operational section of the long-term care insurance (LTCI) multistate actuarial (MSA) rate review framework draft.
   C. Received the report of the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup, which met May 4 and took the following action:
      i. Heard presentations on current innovative long-term care (LTC) wellness pilot programs.
      ii. Exposed a draft “Reduced Benefit Options (RBO) Consumer Notices Checklist” for a 30-day public comment period ending July 21.
2. Received the report of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup, which met Aug. 13 and took the following action:
   A. Discussed the status of revisions to the operational section of the LTCI MSA rate review framework. The drafting group continues to work through issues identified in the comments received. A second draft is expected to be released for comment in September.
   B. Heard comments on the actuarial section of the LTCI MSA rate review framework. Comments were received from: Vermont; Washington; the American Academy of Actuaries (Academy); joint comments from the American Council of Life Insurers (ACLI) and America’s Health Insurance Plans (AHIP); and Financial Medics LLC. The drafting group will begin work addressing the issues identified in the comments received. A second draft is expected to be exposed for public comment in September.

3. Received the report of the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup, which met July 28 and July 22. During these meetings, the Subgroup took the following action:
   A. Began making revisions to the draft “RBO Consumer Notices Checklist” based on comments received during the exposure period.
   B. Exposed a document titled, “Issues Related to LTC Wellness Benefits” for a 45-day public comment period ending Sept. 5.

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

5. Released a public report on the LTCI special data call, which was prepared by the consultant LTCG Actuarial Consulting Group, for informational purposes only.

6. Discussed the LTCI MSA rate review framework timeline and next steps.

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

*August 15, 2021*

1. Adopted its July 21, July 1 and Spring National Meeting minutes, which included the following action:
   A. Adopted its 2021/2022 proposed charges.
   B. Heard comments from interested parties.

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


4. Heard a presentation from the Center for Economic Justice (CEJ) on testing for racial bias in insurance.

5. Heard a presentation from the American Council of Life Insurers (ACLI) on its racial equity initiative.

6. Heard a presentation from Root on fairness in auto insurance.

7. Heard a presentation from the American Property Casualty Insurance Association (APCIA) on its efforts related to diversity and inclusion in insurance.

**INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE**

See the Executive (EX) Committee listing for details.
Information Systems (EX1) Task Force

July 27, 2021 (in lieu of the Summer National Meeting)

1. Adopted its Spring National Meeting minutes.
2. Adopted its 2022 proposed charges, which remain unchanged from 2021.
3. Received an information technology (IT) operational report on the NAIC’s IT activities, including: product highlights; innovation and technology; service and support; data collection metrics; team; project portfolio summary; and technology adoption and system usage. The report provides updates for upcoming improvements, impacts to new state technology offerings from the NAIC, and general updates on the activities of the NAIC technology team.
4. Received a project portfolio update, including project status reports for 23 active technical projects and a summary of a recently completed project.
5. Adjourned into regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings.

LIFE INSURANCE AND ANNUITIES (A) COMMITTEE

August 16, 2021

1. Adopted its July 19 minutes, which included the following action:
   A. Adopted its June 30 minutes, which included the following action:
      i. Appointed the Index-Linked Variable Annuity (A) Subgroup.
   B. Adopted its Spring National Meeting Minutes.
   C. Adopted a frequently asked questions (FAQ) guidance document to assist the states as they move forward with adopting the revisions to the Suitability in Annuity Transactions Model Regulation (#275).
2. Adopted the report of the Accelerated Underwriting (A) Working Group, including its July 29 minutes. During this meeting, the Working Group took the following action:
   A. Exposed the July 8 draft of the accelerated underwriting educational report for a 21-day public comment period ending July 30.
3. Adopted the report of the Life Actuarial (A) Task Force. See the Task Force listing for details.
4. Discussed the next steps for the Life Insurance Illustration Issues (A) Working Group. The Committee asked Richard Wicka (WI) to develop a chair report for its review at the Fall National Meeting. The chair report will detail the work of the Working Group and include a summary of comments that have been received and incorporated into the work product over the years. The Committee will review the report and provide guidance to the Working Group on next steps at the Fall National Meeting.
5. Heard an update from Workstream Four of the Special (EX) Committee on Race and Insurance. The Workstream intends to convene regular meetings starting in September to achieve its goals.

Life Actuarial (A) Task Force

August 12, 2021

1. Adopted its July 1, June 24, June 17, June 10, May 27, May 20, May 13, May 6, April 29, and April 22 minutes, which included the following action:
   A. Adopted its Spring National Meeting minutes.
   B. Adopted amendment proposal 2019-33, which clarifies the definition of individually underwritten life insurance and the applicability of principle-based reserving (PBR) requirements for group contracts with individual risk selection issued under insurance certificates.
   C. Adopted amendment proposal 2020-10, which allows the use of a prudent level of mortality improvement beyond the valuation date.
   D. Adopted amendment proposal 2021-03, which updates the reference to required minimum distribution age.
   E. Adopted amendment proposal 2021-05, which changes the term in VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation, from “model investment strategy” to “modeled company investment strategy” and clarifies the comparison to the alternative investment strategy.
   F. Adopted amendment proposal 2021-06, which allows for third-party submission of experience data.
   G. Adopted amendment proposal 2021-07, which clarifies the universal life with secondary guarantees (ULSG) net premium reserve (NPR) calculation requirements.
H. Adopted amendment proposal 2021-09, which updates the materiality language in Section 3.E.1 of VM-31 to be consistent with VM-21, Requirements for Principle-Based Reserves for Variable Annuities.

2. Adopted the report of the Index-Linked Variable Annuity (A) Subgroup, including its July 15 minutes. During this meeting, the Subgroup took the following action:
   A. Discussed preparing a document listing potential options for index-linked variable annuity (ILVA) interim value guidance, along with the pros and cons of each. The goal is then to identify the optimal approach and develop into a recommendation to the Life Actuarial (A) Task Force.

3. Adopted the report of the Longevity Risk (E/A) Subgroup, which has not met since the Spring National Meeting. A drafting group has been formed to contemplate reserve requirements related to pension risk transfer (PRT) and longevity reinsurance (LR) transactions that are more specific to the PRT reserves and are not solely related to the longevity component.

4. Adopted the report of the Guaranteed Issue (GI) Life Valuation (A) Subgroup, which has not met since the Spring National Meeting. The Subgroup may meet prior to the Fall National Meeting depending on availability of its members or their concerns. Otherwise, this Subgroup is in a dormant/monitoring mode given that there have been no new known studies of GI life mortality that could prove useful in formulating a new prescriptive requirement for the reserves for GI Life products.

5. Adopted the report of the Experience Reporting (A) Subgroup, which has not met since the Spring National Meeting. Upcoming projects include monitoring the plans for collecting life insurance mortality and policyholder behavior data using the NAIC as the statistical agent, starting to develop mandatory reporting of variable annuity data, and continuing to work on evaluating actuarial aspects of accelerated underwriting.

6. Adopted the report of the Indexed Universal Life (IUL) Illustration (A) Subgroup, which has not met since the Spring National Meeting. Research is being conducted on market developments following the adoption of Actuarial Guideline XLIX-A, The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest Sold On or After November 25, 2020 (AG 49-A). It is expected that a Subgroup call will be scheduled to present findings related to the research prior to the Fall National Meeting.

7. Adopted the report of the Valuation Manual (VM)-22 (A) Subgroup, including its July 21, July 7, June 30, June 16, May 26, May 12, May 5, April 28, and April 21 minutes. During these meetings, the Subgroup took the following action:
   A. Exposed VM-22 exposure priorities for a 90-day public comment period ending Oct. 19.
   B. Exposed alternative definitions for reserve categories.
   C. Discussed the American Academy of Actuaries’ (Academy) Annuity Reserves and Capital Working Group (ARCWG) fixed annuity reserving framework proposal.
   D. Discussed the VM-22 field test.
   E. Heard an update from the Pension Risk Transfer (PRT) Drafting Group, which was formed to review the appropriateness of the mortality tables currently used for PRT mortality.
   F. Discussed the language in Section 5.A of VM-20, Requirements for Principle-Based Reserves for Life Products.
   G. Discussed options for addressing aggregation in VM-22, Statutory Maximum Valuation Interest Rate for Income Annuities.
   H. Discussed materiality standards for VM-22 and VM-21, Requirements for Principle-Based Reserves for Variable Annuities.
   I. Discussed the fixed annuity principle-based reserving (PBR) deviations from the VM-21 document.
   J. Tabled a motion to retain the VM-20 integrated risk management language.

8. Heard an update from the joint committee of the American Academy of Actuaries (Academy) and Society of Actuaries (SOA) on the use of future mortality improvement beyond the valuation date.

9. Heard an update on the development of the economic scenario generator (ESG).

10. Exposed the SOA 2022 Generally Recognized Expense Table (GRET).

11. Heard an update on the transition from the London Interbank Offered Rate (LIBOR)

12. Heard an update on experience reporting data collection.

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

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

August 16, 2021

1. Adopted its June 22 and Spring National Meeting minutes, which included the following action:
   A. Adopted the [State] Pharmacy Benefit Manager Licensure and Regulation Model Act.

2. Adopted the report of the Consumer Information (B) Subgroup, including its July 1 minutes. During this meeting, the Subgroup took the following action:
   A. Adopted its May 25 and April 1 minutes, which included the following action:
      i. Discussed a plan to complete several short consumer guides on the claims process.
   B. Discussed draft claims process-related guides; specifically, appeals process; medical necessity; explanation of benefits (EOBs); claims filing; and billing codes and claims. The Subgroup agreed to consider and make edits to the guides over the next few weeks. Following completion of the edits, the Subgroup anticipates conducting an e-vote to consider adoption of the guides.

3. Adopted the report of the Health Innovations (B) Working Group, including its July 27 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its March 26 minutes.
   B. Discussed its approach to fulfilling charges received from the Special (EX) Committee on Race and Insurance.
   C. Heard presentations on hospital price transparency requirements from the federal Centers for Medicare and Medicaid Services (CMS) Center on Medicare and on insurer price transparency requirements from the CMS Center for Consumer Information and Insurance Oversight (CCIIO).
   D. Heard a presentation from FAIR Health on its research and resources related to health care price transparency.
   E. Heard a presentation from Consumers’ Checkbook on ways to make health care price information relevant and understandable for consumers.

4. Adopted the report of the Health Actuarial (B) Task Force. See the Task Force listing for details.

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

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

7. Heard a presentation from the federal Center for Consumer Information and Insurance Oversight (CCIIO) regarding the Biden administration’s federal legislative and administrative initiatives and priorities. The presentation included a discussion of the administration’s plans on working with the states with respect to the implementation and enforcement of the provider provisions of the federal No Surprises Act (NSA).

8. Heard from a representative of the American Hospital Association (AHA), a representative of the American Medical Association (AMA), and a representative of the Federation of State Medical Boards (FSMBs) regarding the implementation and enforcement of the NSA’s provider requirements.

9. Heard an update from Workstream Five of the Special (EX) Committee on Race and Insurance. The Workstream met July 8 and June 10. During these meetings, the Workstream discussed data-collection issues and provider networks, provider directories, and cultural competency. Based on its discussions on data collection, the Workstream exposed a draft best practices document for a public comment period ending Aug. 19. The Workstream plans to discuss any comments received on the draft document during its Aug. 26 meeting. The Workstream anticipates developing a similar best practices document on provider networks, provider directories, and cultural competency.

Health Actuarial (B) Task Force

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

Regulatory Framework (B) Task Force

July 28, 2021 (in lieu of the Summer National Meeting)

1. Adopted its June 15 and March 25 minutes, which included the following action:
   A. Adopted a new 2021 charge for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup to develop a white paper on issues related to the state regulation of certain pharmacy benefit manager (PBM) business practices and the effect, if any, of the recent U.S. Supreme Court decision in Rutledge v. the Pharmaceutical Care Management Association on these current and emerging state laws and regulations regulating such business practices. The white paper will also examine the role PBMs, pharmacy services administrative organizations (PSAOs), and other prescription drug supply chain entities play in the provision of prescription drug benefits.
2. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its July 12 and June 7 minutes. During these meetings, the Subgroup took the following action:
   A. Established a new public comment period ending July 2 to receive comments on Section 1 through Section 7 of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171).
   B. Began discussion of the comments received on Section 1 through Section 7 of Model #171 received by the July 2 public comment deadline. The Subgroup anticipates meeting approximately every two weeks to continue its discussions of the comments received.
3. Adopted the report of the Employee Retirement Income Security Act (ERISA) (B) Working Group, which met July 30 and took the following action:
   A. Discussed Rutledge v. Pharmaceutical Care Management Association and agreed to:
      ii. Ask for state insurance regulator volunteers to develop a draft “preemption road map” to assist state insurance regulators in assessing the potential impact of the Rutledge case on state laws for use by the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup in its white paper.
   B. Received an introduction to Ali Khawar, the acting assistant secretary for the Employee Benefits Security Administration (EBSA) at the U.S. Department of Labor (DOL).
   C. Adjourned into regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings.
4. Adopted the report of the Mental Health Parity and Addiction Equity Act (MH/PAEA) (B) Working Group, which met July 20 in regulator-to-regulator session, pursuant to paragraph 2 (pending investigations which may involve either the NAIC or any member in any capacity), paragraph 3 (specific companies, entities or individuals), and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings. The Working Group also met April 21 and took the following action:
   A. Received an update from the DOL and the federal Centers for Medicare & Medicaid Services (CMS) on their work related to the recently enacted federal Consolidated Appropriations Act of 2021 (CAA), which amended the MH/PAEA to provide important new protections. In anticipation of new 2021 charges from the Special (EX) Committee on Race and Insurance, the Working Group also discussed equity and diversity in the mental health/substance use disorder (MH/SUD) treatment context. The Working Group plans to meet Aug. 5 to hear a provider perspective on mental health parity.
5. Adopted the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, which has not met since October 2020 because it completed its work. The Subgroup plans to resume meeting after the Summer National Meeting to work on a new 2021 charge to develop a white paper on issues related to the state regulation of certain PBM business practices. The white paper will also examine the role PBMs, PSAOs, and other prescription drug supply chain entities play in the provision of prescription drug benefits.
6. Heard an update from the Center on Health Insurance Reforms (CHIR) regarding its work related to federal Affordable Care Act (ACA) implementation; recently enacted federal laws, such as the federal No Surprises Act (NSA) and the federal American Rescue Plan Act (ARPA); and other issues of interest to state insurance regulators. The update included a discussion of the CHIR’s recent publications, including a 50-state survey of state employee benefit plans and efforts to restrain health care costs and state actions to expand telemedicine access during COVID-19 and future policy considerations. The CHIR is researching and expects to release issue briefs or blogs on standardized plans, limited plan sales, state “Easy Enrollment” programs, efforts by select state-based marketplaces (SBMs) to improve health equity, and small group health insurance market trends. The CHIR presentation also highlighted some of the CHIR’s future work related to NSA implementation and technical assistance available to the states and its ongoing work related to network adequacy. The CHIR will also be looking more closely at health care cost containment through initiatives such as federal and state public option programs and the role of ERISA and its impact on state efforts to address cost containment with respect to employer plans.
7. Heard a presentation on the NSA’s interim final rules and implications for the states. The presentation provided an overview of the NSA’s scope, including what types of plans it covers and where its protections apply. The NSA’s interim final rules were issued July 1 with an effective date of Sept. 13. The interim final rules include provisions focused on both patients and regulated entities. The patient-focused provisions outline how patients can calculate cost-sharing, include notice-and-consent waivers provisions, and establish a consolidated complaints process. The regulated entities-focused provisions outline how to calculate the qualifying payment amount and include disclosure requirements and provisions related to communications between insurers and providers. The interim final rules confirm that state departments of insurance (DOIs) are the primary enforcers of provisions that apply to insurers and fully insured health products. The U.S.
Department of Health and Human Services (HHS) will enforce the NSA’s requirements in states that fail to substantially
enforce the law. The DOL will enforce the NSA’s provisions for self-funded group health plans. The same enforcement
framework is established with respect to providers, including air ambulances. As noted in the presentation, the NSA is
silent on which state agency is to enforce the NSA’s provider provisions. The presentation also highlighted key
considerations for the states, particularly that state laws can be more protective of consumers if the state law does not
“prevent the application of federal law.” It is anticipated that the federal government will issue additional NSA rules in
2021, including federal rules on the independent dispute resolution process (interim final rule) and enforcement and air
ambulance data reporting (proposed rule). The presentation noted that additional federal rulemaking will occur over
time on other NSA requirements, such as accurate provider directories, gag clauses, and PBM reporting requirements.
However, these rules will not be promulgated prior to the NSA’s 2022 effective date.

Senior Issues (B) Task Force
July 29, 2021 (in lieu of the Summer National Meeting)
1. Adopted its June 8 minutes, which included the following action:
   A. Adopted its Feb. 23, 2021, and Oct. 20, 2020, minutes, which included the following action:
      i. Discussed its 2021 agenda.
   B. Heard a presentation on bundling Medicare supplement and short-term care insurance.
2. Adopted the report of the Long-Term Care Insurance Model Update (B) Subgroup, including its July 15 minutes. During
   this meeting, the Subgroup took the following action:
   A. Adopted its May 27 minutes, which included the following action:
      i. Adopted its May 6 minutes, which included the following action:
         a. Adopted its April 22 minutes, which included the following action:
            1) Discussed its charge. The Subgroup was appointed to determine whether the Long-Term Care Insurance
               Model Act (#640) and the Long-Term Care Insurance Model Regulation (#641) need to be updated to
               remain flexible and compatible with the LTCI marketplace.
            b. Discussed comments received on Section 1 through Section 7 of Model #640.
            ii. Discussed comments received on Section 8 through Section 14 of Model #640.
      B. Heard presentations on the current long-term care insurance (LTCI) marketplace, including what products are being
         seen, filed, and produced.

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE
August 16, 2021
1. Adopted its Spring National Meeting minutes.
2. Adopted the report of the Casualty Actuarial and Statistical (C) Task Force. See the Task Force listing for details.
3. Adopted the report of the Surplus Lines (C) Task Force. See the Task Force listing for details.
4. Adopted the report of the Title Insurance (C) Task Force. See the Task Force listing for details.
5. Adopted the report of the Workers’ Compensation (C) Task Force. See the Task Force listing for details.
6. Adopted the report of the Cannabis Insurance (C) Working Group, including its July 27 and July 19 minutes. During these
   meetings, the Working Group took the following action:
   A. Held a two-day fact-finding hearing on insurance for cannabis-related business.
      i. During Session 1: Setting the Stage, the Working Group:
         a. Heard a presentation from Wilson Elser on the impact of the geographical expansion of states legalizing
            cannabis on discussions at the federal level.
         b. Heard a presentation from the Cannabis Regulators Association (CANNRA) on the cannabis regulatory and
            licensing landscape.
         c. Heard a presentation from Golden Bear Insurance and Cannasure on the insurance needs of the
            cannabis market.
      ii. During Session 2: Insurance Product Availability, the Working Group:
         a. Heard a presentation from the Insurance Services Office (ISO) and the American Association of Insurance
            Services (AAIS) on commercial cannabis product options.
         b. Heard from a panel of experts that included James River, Golden Bear Insurance, Cannasure, and Amwins
            about admitted and nonadmitted coverage availability across the cannabis business sectors.
iii. During Session 3: Barriers to Coverage Availability and Affordability, the Working Group:
   a. Heard a presentation from East Carolina University on balancing actual and perceived risks in the cannabis space.
   b. Heard from a panel of experts that included Wilson Elser, GJ Sullivan Co. Reinsurance, Golden Bear Insurance, and the ISO on uncovering obstacles to insurers offering coverage in the cannabis-related business space.
   c. Heard from a panel of experts that included Cannasure, Amwins, James River, Golden Bear Insurance, and Wilson Elser on insurance coverage challenges for cannabis-related businesses.

iv. During Session 4: Moving Forward, the Working Group:
   a. Heard from a panel of experts that included Cannasure, Golden Bear Insurance, Amwins, James River, and East Carolina University on emerging trends and how state insurance regulators can support growth of the cannabis insurance market.

7. Adopted the report of the Catastrophe Insurance (C) Working Group, including its July 22 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its June 21 and Spring National Meeting minutes, which included the following action:
      i. Discussed the Catastrophe Computer Modeling Handbook.
   B. Heard an update regarding federal legislation and the National Flood Insurance Program (NFIP) reauthorization.
   C. Discussed the status of the Handbook and drafting group formation. The drafting group will begin meeting in August.
   D. Heard a presentation from Mississippi regarding roofing repair and the Mississippi Windstorm Underwriting Association (MWUA) roof upgrade program.
   E. Discussed items to help insurers with expedited claims process. The American Property Casualty Insurance Association (APCIA) discussed its Catastrophe Actions Toolkit. The Working Group will continue this discussion.

8. Adopted the report of the Pet Insurance (C) Working Group, including its Aug. 13 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its Aug. 4 minutes, which included the following action:
      i. Adopted its July 29 minutes, which included the following action:
         a. Discussed Section 3, Section 4 and Section 7 of the draft Pet Insurance Model Act.
         b. Discussed issues with classifying pet insurance as a property/casualty (P/C) product.
      ii. Discussed comments received on Section 7 of the draft Pet Insurance Model Act.
      iii. Discussed the use of wellness products in pet insurance.
   B) Discussed language on waiting periods and free-look periods in the draft Pet Insurance Model Act.
   2) Discussed language on waiting periods, free-look periods, and wellness plans in the draft Pet Insurance Model Act.
   b. Discussed language related to wellness plans in the draft Pet Insurance Model Act.
   ii. Adopted a definition of “wellness program” to include in Section 3 of the draft Pet Insurance Model Act.
   iii. Adopted the entire Pet Insurance Model Act as drafted.

9. Adopted the report of the Terrorism Insurance Implementation (C) Working Group, which has not met since the Spring National Meeting. State insurance regulators decided to pause the State Supplement portion of the state regulator terrorism risk insurance data call for fall. The Working Group plans to meet soon to discuss workers’ compensation and other data received in the data call earlier this year.
10. Adopted the report of the Transparency and Readability of Consumer Information (C) Working Group, including its July 20 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its May 13 and Spring National Meeting minutes, which included the following action:
      i. Heard reports from the three drafting groups formed to draft the various sections of a consumer disclosure regarding significant premium increases on property/casualty (P/C) insurance products.
      ii. Heard a presentation from VisibleThread regarding its language analysis platform.
   B. Received an update from the Thresholds and Communications Standards Drafting Group. This drafting group is nearing the completion of this project. The Working Group members offered suggestions to update the document.
   C. Received an update from the Rate Checklist Drafting Group. This drafting group is nearing the completion of this project.
   D. Received an update from the Consumer Education Drafting Group. This drafting group continues to meet regularly to complete the consumer education documents and has divided the topics into three smaller groups that meet regularly.
12. Adopted updates to the Title Insurance Consumer Shopping Tool Template.
13. Heard a presentation from the Association of Bermuda Insurers and Reinsurers (ABIR) and the Insurance Development Forum on ways to close the insurance protection gap.
14. Heard a report on the cyberinsurance market, including results from the Cybersecurity and Identity Theft Insurance Coverage Supplement.
15. Heard a report on the private flood insurance market, including results from the Private Flood Insurance Supplement.
16. Heard an update on the Special (EX) Committee on Race and Insurance, including the fact that Workstream Three, focused on property/casualty (P/C) insurance issues, will take the new charges and formulate a work plan.
17. Heard that the Committee would hold a future meeting to hear from interested parties to discuss auto insurance refunds related to reduced driving from the COVID-19 pandemic.

Casualty Actuarial and Statistical (C) Task Force
August 10, 2021 (in lieu of the Summer National Meeting)

1. Adopted its July 13, June 8, May 11, and March 9 minutes, which included the following action:
   A. Adopted responses to referrals from the Blanks (E) Working Group.
   B. Adopted a request for NAIC staff to gather information about statistical reports.
   C. Exposed referrals from the from the Blanks (E) Working Group for a 30-day public comment period ending July 7.
   D. Discussed the Casualty Actuarial Society (CAS) decision to reinstate the “Statement of Principles Regarding Property and Casualty Insurance Ratemaking” as it relates to U.S. regulated ratemaking.
2. Adopted the report of the Actuarial Opinion (C) Working Group, including its July 22 and July 1 minutes. During this meeting, the Working Group took the following action:
   A. Discussed proposed revisions to the Statement of Actuarial Opinion.
   B. Discussed adding language regarding Schedule P reconciliation.
   C. Discussed proposed language regarding review of actuarial qualification documentation.
   D. Discussed reviews of the 2020 Statement of Actuarial Opinion.
   E. Discussed issues with Schedule P reconciliation.
3. Adopted the report of the Statistical Data (C) Working Group, which has not met recently.
4. Appointed Sandra Darby (ME) as chair of the Statistical Data (C) Working Group.
5. Discussed the second exposure draft of the American Academy of Actuaries’ (Academy’s) U.S Qualification Standards. The Task Force will meet in regulator-to-regulator session to consider adoption of a comment letter via e-vote before the Academy’s Aug. 20 comment deadline.
6. Received a report on Project #2019-49 Retroactive Reinsurance Exception. A proposal will be presented for consideration at the Fall National Meeting.
7. Discussed referral 2021-11BWG from the Blanks (E) Working Group. The Task Force charged the Statistical Data (C) Working Group to gather information about whether the timeline can be sped up on receipt of premium and exposure information from outside partners. The Working Group should report back to the Task Force before Oct. 12.
8. Received a report on NAIC rate model reviews.
9. Heard reports from professional actuarial associations.
Surplus Lines (C) Task Force
August 5, 2021 (in lieu of the Summer National Meeting)

1. Adopted its Nov. 18, 2020, minutes.
2. Adopted the 2022 proposed charges of the Task Force and the Surplus Lines (C) Working Group, which remained unchanged from 2021.
3. Adopted the report of the Surplus Lines (C) Working Group, including its July 7 minutes. During this meeting, the Working Group took the following action:
   A. Reported that it met June 21 and March 2 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings.
   B. Exposed proposed modifications to the Trust Agreement for Alien Excess or Surplus Lines Insurers for a 30-day public comment period ending Aug. 6.
   C. Exposed proposed modifications to the Quarterly Listing of Alien Insurers for a 30-day public comment period ending Aug. 6
4. Discussed and formed a drafting group to amend the Nonadmitted Insurance Model Act (#870).
5. Heard a presentation regarding the potential of surety bonds as a funding device for surplus lines.

Title Insurance (C) Task Force
July 13, 2021 (in lieu of the Summer National Meeting)

1. Adopted its June 7 minutes, which included the following action:
   A. Exposed revisions to the Title Insurance Consumer Shopping Tool Template for a public comment period ending July 5.
2. Adopted revisions to the Title Insurance Consumer Shopping Tool template. Revisions included adding questions and answers about title insurance-related fraud topics, including closing protection letters (CPLs) and wire fraud.
3. Heard a presentation from the Federal Bureau of Investigation (FBI) on business email compromise schemes and other cybercrimes.
4. Heard from state insurance regulators about title insurance fraud trends in their respective states. Trends included fraudulent settlement transactions, wire fraud complaints, cybercrime and defalcations.

Workers’ Compensation (C) Task Force
July 21, 2021 (in lieu of the Summer National Meeting)

1. Adopted its March 15 minutes.
2. Heard a presentation from the National Council on Compensation Insurance (NCCI) on the classification of telecommuters and the potential implications of an increase in telecommuting on workers’ compensation. Current information indicates remote work will not have a big impact

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE
August 16, 2021

1. Adopted its July 27 minutes, which included the following action:
   A. Adopted its Spring National Meeting minutes.
   B. Adopted revised charges for the Antifraud (D) Task Force.
   C. Adopted the short-term, limited-duration (STLD) Market Conduct Annual Statement (MCAS) data call and definitions.
   D. Adopted the travel insurance MCAS data call and definitions.
   E. Adopted digital claims data in the private passenger auto and homeowners data call and definitions.
   F. Heard presentations from a state insurance regulator, an NAIC funded consumer representative, and an industry trade representative on the benefits and challenges of collecting market conduct data annually on a transactional level.
2. Heard a presentation from an NAIC funded consumer representative on claim optimization and the potential of using artificial intelligence (AI) to evaluate the willingness of insureds or claimants to accept values less than the fair and equitable amount. The presenter encouraged state insurance regulators to determine the extent of use of predictive analytics in claim settlements and require insurers to report on the algorithmic models used in claim handling.
3. Adopted the Regulatory Information Retrieval System (RIRS) proposed coding structure changes.

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

5. Adopted the report of the Market Information Systems (D) Task Force. See the Task Force listing for details.

6. Adopted the report of the Producer Licensing (D) Task Force. See the Task Force listing for details.

7. Adopted the report of the Market Conduct Annual Statement Blanks (D) Working Group, including its July 28 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its June 30 minutes, which included the following action:
      i. Adopted its May 26 and May 25 minutes, which included the following action:
         a. Adopted its April 28 minutes, which included the following action:
            1) Adopted its March 23 minutes.
            2) Agreed to collect non-claims lawsuit data in the private passenger auto (PPA) and homeowners (HO) Market Conduct Annual Statement (MCAS) blanks.
         b. Adopted the travel MCAS data call and definitions.
         c. Adopted the short-term limited-duration (STLD) MCAS data call and definitions.
         d. Discussed the addition of digital claims data elements to the HO and PPA MCAS data call and definitions.
         e. Discussed the draft edits to the life MCAS data call and definitions to include reporting for accelerated underwriting.
      f. Adopted revisions to the definition of “lawsuit.”
      ii. Agreed to wait for the Accelerated Underwriting (A) Working Group to adopt its definition of “accelerated underwriting” before proceeding with the MCAS definition of “accelerated underwriting.”
      iii. Adopted the digital claims data elements and definitions for the PPA and HO MCAS data call and definitions.
      iv. Agreed to postpone the collection of non-claims lawsuit data until the 2023 data year reported in 2024.
   B. Heard an update on the addition of accelerated underwriting data elements in the Life and Annuity MCAS data call and definitions. The subject-matter expert (SME) drafting group continues to wait for the Accelerated Underwriting (A) Working Group to adopt a definition of “accelerated underwriting.”
   C. Heard an update on the “other health” MCAS data call and definitions. The drafting group plans to resume meeting to begin drafting the remainder of the other health products.
   D. Agreed to form an SME group to draft a proposal for incorporating non-claims-related lawsuits in the PPA and HO MCAS blanks and revise the definition of “lawsuit,” as necessary. The group will also consider the best way to collect digital claims vendor information in the interrogatories for the PPA and HO MCAS blanks.

8. Adopted the report of the Market Conduct Examination Guidelines (D) Working Group, including its June 10 minutes. During this meeting, the Working Group took the following action:
   A. Reviewed its 2021 charges.
   B. Discussed and prioritized its potential tasks for 2021.
   C. Identified models adopted in 2020 and asked for state insurance regulator volunteers to begin a review of the models and report at the next Working Group meeting, if applicable revisions to corresponding sections of the Market Regulation Handbook are warranted.
   D. Discussed new title insurance standardized data requests (SDRs) to address in force policies and claims for inclusion in the reference documents of the Market Regulation Handbook.

9. Adopted the report of the Market Analysis Procedures (D) Working Group, including its July 1 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its March 19 minutes, which included the following action:
      i. Adopted revisions to the Market Conduct Annual Statement (MCAS) Best Practices Guide.
      ii. Adopted a requirement that companies identify their MCAS attesters by line of business and jurisdiction.
      iii. Adopted revisions to the Market Regulation Handbook training opportunities for market regulation analysts.
   B. Discussed market analysis training needs for state insurance regulators.
   C. Opened discussions on the next line of business to be included in the MCAS.
   D. Discussed initial aggregate analysis of MCAS data with an April 30 due date. This discussion will continue once the validation of the data is completed.
   E. Discussed MCAS reporting by jurisdiction of residency or jurisdiction of issuance. The Working Group will make no recommendations to change the current instructions in the data calls and definitions for the various MCAS blanks. It was agreed that additional training on reporting requirements will be helpful for market analysts.
10. Adopted the report of the Privacy Protections (D) Working Group, including its July 12 minutes. During this meeting, the Working Group took the following action:
   A. During the July 12 meeting, the Working Group:
      i. Adopted its June 14 minutes, which included the following action:
         a. Adopted its May 10 minutes, which included the following action:
            1) Adopted its March 29 minutes.
            2) Discussed the draft of the initial privacy policy statement.
            3) Requested comments in the form of parameters and examples on the initial privacy policy statement by June 7.
         b. Discussed comments received from health insurers received on the six consumer privacy rights identified by the 2021 NAIC member-adopted strategy for consumer data privacy protections to be discussed by the Working Group as part of its gap analysis in its 2019 work plan.
   B. Received comments from the American Council of Life Insurers (ACLI) about the six consumer privacy rights.
   C. Heard a presentation from NAIC consumer representatives on the consumer perspective of data privacy and consumer privacy rights.
   D. Requested comments in the form of parameters and examples on the revised draft of the privacy policy statement by July 29.

Antifraud (D) Task Force
July 26, 2021 (in lieu of the Summer National Meeting)
1. Adopted its May 25 minutes, which included the following action:
   A. Adopted its March 24 minutes.
2. Received an update from the Antifraud Education Enhancement (D) Working Group. The Working Group held a webinar on Feb. 11 from CARCO regarding the mobile capabilities it can provide state insurance departments to assist with fighting insurance fraud. The Working Group also conducted investigator safety training on June 2. The Working Group advised Task Force members to send any suggested training/webinar topics they would like to have provided.
3. Received an update from the Antifraud Technology (D) Working Group. The Working Group noted that the revision of the Antifraud Plan Guideline (#1690) was the first step in its charge to “review and provide recommendations for the development of an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions.” The Working Group formed a subject-matter expert (SME) group to create a template for industry to use when creating their Antifraud Plan. The SME Group will meet every week through October in order to finalize this project.
4. Received an update on the NAIC Online Fraud Reporting System (OFRS) redesign project. The NAIC is continuing its work on the redesign of the OFRS. The Task Force was informed that beta testing is currently taking place, and the NAIC will be opening up the testing to industry in an effort to finalize this testing period.
5. Heard reports on antifraud activity from NAIC staff and the following organizations: the National Insurance Crime Bureau (NICB) and the Coalition Against Insurance Fraud (CAIF).

Market Information Systems (D) Task Force
July 28, 2021 (in lieu of the Summer National Meeting)
1. Adopted its March 22 minutes.
2. Adopted the report of the Market Information Systems Research and Development (D) Working Group, which met July 21, July 15, and June 16 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings. During these meetings, the Working Group took the following action:
   A. Heard presentations from NAIC staff regarding the testing of the use of artificial intelligence (AI) to construct predictive models of insolvency risk and the Center for Economic Justice (CEJ) regarding how AI can be used in market analysis. The Working Group agreed to form a subject-matter expert (SME) group to develop recommendations for incorporating AI into the NAIC MIS.
   B. Reviewed outstanding USER forms.
   C. Reviewed comments received on the RIRS Coding Changes Proposal.
   D. Reviewed the progress of the implementation of the MIS data analysis recommendations.
3. Adopted the RIRS Coding Changes Proposal.
4. Heard a report on the outstanding USER forms.

**Producer Licensing (D) Task Force**

*August 4, 2021 (in lieu of the Summer National Meeting)*

1. Adopted its March 26 minutes.
2. Heard an update on the state implementation of online examinations.
3. Discussed a referral from the Special (EX) Committee on Race and Insurance.
5. Discussed procedures for amending uniform applications.
6. Received reports from the Producer Licensing Uniformity (D) Working Group and the Uniform Education (D) Working Group. Both groups are currently without a chair and have not met since the Spring National Meeting.

**FINANCIAL CONDITION (E) COMMITTEE**

*August 14, 2021*

1. Adopted its July 8 and Spring National Meeting minutes, which included the following action:
   A. Adopted changes to the *Insurance Holding Company System Regulatory Act (#440)* and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)* that are intended to make explicit, rather than implicit, the regulatory authority that a commissioner should have relative to the continuation of essential services of an insurance company from an affiliate during a receivership.
   B. Updated life risk-based capital (RBC) bond factors effective for the 2021 reporting period.
3. Adopted the report of the Capital Adequacy (E) Task Force. See the Task Force listing for details.
4. Adopted the report of the Examination Oversight (E) Task Force. See the Task Force listing for details.
5. Adopted the report of the Financial Stability (E) Task Force. See the Task Force listing for details.
6. Adopted the report of the Receivership and Insolvency (E) Task Force. See the Task Force listing for details.
7. Adopted the report of the Reinsurance (E) Task Force. See the Task Force listing for details.
9. Adopted the report of the Valuation of Securities (E) Task Force. See the Task Force listing for details.
10. Adopted the report of the Financial Analysis (E) Working Group, which met July 14, June 16, May 18–19, and April 19 in regulator-to-regulator sessions, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss letter responses and financial results.
11. Adopted the report of the Group Capital Calculation (E) Working Group, including its July 26 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its May 27, May 17, April 27, and March 10 minutes, which included the following action:
      i. Adopted a revised template for use in the 2021 group capital calculation (GCC) trial implementation, including changes to gather data on a stress scenario.
      ii. Adopted clarifying edits to the GCC instructions that will be used for the 2021 GCC trial implementation.
      iii. Exposed proposed GCC-related changes to the *Financial Analysis Handbook*.
   B. Exposed draft maintenance documents for a 60-day public comment period ending Sept. 24.
   C. Exposed a draft referral to the Capital Adequacy (E) Task Force for a 90-day public comment period ending Oct. 25.
12. Adopted the report of the Group Solvency Issues (E) Working Group, including its Aug. 4 minutes. During this meeting, the Working Group took the following action:
    A. Discussed comments received on the exposure of proposed revisions to the *Financial Analysis Handbook* to incorporate elements of the International Association of Insurance Supervisors’ (IAIS) Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) deemed appropriate for the U.S. system of insurance regulation. The Working Group discussed comments received from each of the following organizations: Iowa Insurance Division (IID); American Council of Life Insurers (ACLI); America’s Health Insurance Plans (AHIP); American Property Casualty Insurance Association (APCIA); and Blue Cross and Blue Shield Association (BCBSA). As a result of the discussions, the drafting group members who developed the initial revisions were asked to consider the comments received and state insurance regulator opinions expressed during the meeting in developing an updated draft for the Working Group to consider later this year.
B. Received an update on the status of drafting efforts to proposed revisions to the Financial Condition Examiners Handbook and the NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual to incorporate elements of ComFrame deemed appropriate for the U.S. system of insurance regulation. The update stated that drafting efforts are underway and the documents will be presented to the Working Group for consideration later this year.

C. Discussed the IAIS’ public consultation on a revised Application Paper on Supervisory Colleges that ends Aug. 24. Working Group members were encouraged to provide comments on the paper to the International Insurance Relations (G) Committee, which will accumulate state insurance regulator comments for submission in an NAIC comment letter.

13. Adopted the report of the Mortgage Guaranty Insurance (E) Working Group, including its May 18 and April 9 minutes. During these minutes, the Working Group took the following action:

B. Adopted the Mortgage Guaranty Insurance Exhibit and instructions.

14. Adopted the report of the Mutual Recognition of Jurisdictions (E) Working Group, including its July 20 minutes. During this meeting, the Working Group took the following action:

A. Discussed the draft Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation.
B. Exposed the document for a 30-day public comment period ending Aug. 20.

15. Adopted the report of the NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group, including its May 17 minutes. During this meeting, the Working Group:


16. Adopted the report of the National Treatment and Coordination (E) Working Group, including its July 17 minutes. During this meeting, the Working Group took the following action:

A. Adopted its May 13 minutes, which included the following action:
   i. Discussed Proposal 2021-01 (Primary Application and Instructions).
   ii. Discussed Proposal 2021-02 (Redomestication Application and Instructions).
   iii. Adopted Proposal 2021-03 (Cybersecurity Contact).
   iv. Adopted Proposal 2021-04 (Biographical Affidavit Cover Letter).
   v. Discussed Form A – Private Equity Company.
B. Adopted proposal 2021-01 (Primary Application and Instructions).
C. Adopted proposal 2021-02 (Redomestication Application and Instructions).
D. Adopted proposal 2021-05 (Form A Review Guidance).
E. Exposed proposal 2021-06 (Disclaimer Form).

17. Adopted the report of the Valuation Analysis (E) Working Group, which met July 26 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss valuation items related to specific companies.

18. Adopted a referral to the Statutory Accounting Principles (E) Working Group that requests consideration of changes to the Working Group’s maintenance policy related to certain terms used in the current document.

19. Adopted revisions to the process for evaluating qualified and reciprocal jurisdictions.

20. Adopted revised charges for the Macroprudential (E) Working Group, which was formerly known as the Liquidity Assessment (E) Subgroup.

Accounting Practices and Procedures (E) Task Force
July 27, 2021 (in lieu of the Summer National Meeting)

1. Adopted its March 23 minutes.

2. Adopted the report of the Statutory Accounting Principles (E) Working Group, which conducted e-votes that concluded July 20, July 12, and April 20, and met May 20. The report included the following action:

A. During its July 20 e-vote, the Working Group exposed agenda item 2021-10: SSAP No. 32R—Clarification of Effective Call Price for a public comment period ending Aug. 6.
B. During its July 12 e-vote, the Working Group adopted its May 20, April 20, and March 15 minutes.
C. During its May 20 meeting, the Working Group adopted the following nonsubstantive revisions to statutory accounting guidance:

i. Revisions reject the following for statutory accounting:
   a. Accounting Standards Update (ASU) 2020-08, Codification Improvements to Subtopic 310-20, Receivables – Nonrefundable Fees and Other Costs. (Ref #2021-02)
   b. ASU 2021-02, Franchisors – Revenue from Contracts with Customers for statutory accounting. (Ref #2021-08)
   c. ASU 2020-11, Financial Services – Insurance: Effective Date and Early Application. (Ref #2021-07)

ii. Revisions incorporate disclosure elements in Statement of Statutory Accounting Principles (SSAP) No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities and a data-capture template for where an entity has transferred assets but retains economic interest within the reporting entity, its related parties, or another member within the holding company group. (Ref #2021-03)

iii. Adopted agenda items supporting disaggregated product identifiers to be used for each separate account product reported in the general interrogatories. This adoption does not result in statutory revisions, but it is reflected in the Working Group recommendation to support blanks proposal 2021-03BWG. (Ref #2020-37 and Ref #2020-38)

iv. Adopted Interpretation (INT) 20-01: ASU 2020-04 – Reference Rate Reform, which provides optional guidance, allowing for the continuation of certain existing hedge relationships and thus does not require hedge redesignation for derivative instruments affected by changes to interest/reference rates due to reference rate reform. (Ref #2021-01)

v. Adopted INT 21-01: Accounting for Cryptocurrencies, which clarifies that directly held cryptocurrencies neither meet the definition of cash in SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments, nor do they meet the definition of an admitted asset per SSAP No. 4—Assets and Nonadmitted Assets when directly held. (Ref #2021-05)

vi. Adopted editorial revisions to retitle SSAP No. 53—Property Casualty Contracts – Premiums to SSAP No. 53—Property and Casualty Contracts – Premiums; correct grammatical errors in SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, paragraph 54; and remove the footnote in the Glossary title and replace it as an opening paragraph with updated verbiage. (Ref #2021-06EP)

vii. Exposed the substantive proposed bond definition to be used for all securities in determining whether they qualify for reporting on Schedule D, Part 1 – Long-Term Bonds. The definition intends to reflect principal concepts to ensure appropriate consideration on whether a structure qualifies as an issuer credit obligation or an asset-backed security (ABS) prior to reporting as a bond. The public comment period ends July 15. (Ref #2019-21)

viii. Exposed nonsubstantive revisions to SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies and SSAP No. 97 to indicate that the equity method valuation reference in SSAP No. 97 can result in a negative equity valuation and to limit the statutory adjustments match in SSAP No. 97, paragraph 9. The exposed revisions are that foreign insurance subsidiary, controlled and affiliated entities (SCAs) shall stop at zero (and thus not be subject to negative equity valuations) when applying paragraph 9 adjustments in cases where the foreign insurance subsidiary is not engaged in providing services to, or holding assets on behalf of, U.S. insurers. The public comment period ends July 15. (Ref #2021-04)

ix. Adopted a response to the Life Risk-Based Capital (E) Working Group on its referral request to consider accounting and reporting aspects of an American Council of Life Insurers (ACLI) proposal regarding real estate in the life risk-based capital (RBC) formula. The adopted response identifies concerns on the reliability and consistency of fair value data to be considered before allowing reporting entities to reduce RBC using the fair value of real estate.

x. Received an update on the following projects and referrals:
   a. Directed a referral to be sent to the Life Actuarial (A) Task Force seeking input regarding whether the Task Force would consider changes to the reserve framework of fixed indexed annuity products, as its response will influence the accounting options for derivatives hedging these products. (Ref #2020-36)
   b. Directed NAIC staff to develop additional revisions to address the diversity in state Affordable Care Act (ACA) reinsurance programs. (Ref #2021-09)
   c. INT 20-10: Reporting Nonconforming Credit Tenant Loans: Contingently exposed nonsubstantive revisions in anticipation of a Valuation of Securities (E) Task Force proposal to revise filing exempt (FE) requirements for credit tenant loans (CTLs). After the Statutory Accounting Principles (E) Working Group’s May 24 meeting, the Valuation of Securities (E) Task Force did not expose the anticipated revisions. Instead, the Task Force exposed edits to clarify that the reference to mortgage loans in the CTL definition pertains to
items in scope of SSAP No. 37—Mortgage Loans, and the Accounting Practices and Procedures Manual (AP&P Manual) determines investment accounting and reporting. With this Task Force action, the revisions to INT 20-10 were not exposed. The Working Group will review INT 20-10 after the Task Force concludes actions after its exposure.

d. Received a response from the Valuation of Securities (E) Task Force regarding CTLs and information regarding Securities Valuation Office (SVO) filings received.

e. During its April 20 e-vote, the Working Group voted to update exposed agenda item 2021-03: SSAP No. 103R – Disclosures to reflect interested parties’ preliminary comments. While minor revisions were proposed to SSAP No. 103R disclosures, the primary changes from the original agenda item were reflected in the data-capture template, which includes instructions, updated capture fields, and column descriptions.

3. Adopted the report of the Blanks (E) Working Group, which met July 22 and took the following action:
   A. Adopted its May 26 minutes, which included the following action:
      i. Adopted an editorial listing and the following eight blanks proposals:
         a. 2021-01 – Add reference to health care receivables line in the Asset page.
         b. 2021-02BWG – Add questions to the General Interrogatories, Part 1 regarding depository institution holding companies as it pertains to the group capital calculation (GCC).
         c. 2021-03BWG – Add category lines to the Separate Accounts General Interrogatories for additional granularity.
         d. 2021-04BWG – Add a General Interrogatory to identify insurers that utilize third parties to pay agent commissions in which the amounts advanced by the third parties are not settled in full within 90 days.
         e. 2021-05BWG – Modify Note 17B(4) to reflect changes made by the Statutory Accounting Principles (E) Working Group reference number 2021-03 regarding transferred assets.
         f. 2021-06BWG – Add crosschecks to the long-term care (LTC) reporting forms to gain consistency.
         g. 2021-07BWG – Add additional line categories to capture collateral type data for all residential mortgage-backed securities (RMBS), commercial mortgage-backed securities (CMBS), and loan-backed and structured securities (LBSS) regardless of reporting category.
         h. 2021-08BWG – Add a new supplement Mortgage Guaranty Insurance Exhibit to capture more information from mortgage guaranty insurers.
      ii. Exposed five proposals for public comment.
   B. Adopted 2021-10BWG – Remove language in quarterly General Interrogatories Part 1, line 4.1 that requires filing of a quarterly merger/history form. The annual form shall still be required.
   C. Adopted its editorial listing.
   E. Deferred four proposals for additional discussion for a 90-day public comment period ending Oct. 22.

4. Adopted its 2022 proposed charges.

5. Adopted revisions to the Model Audit Rule Implementation Guide developed by the NAIC/American Institute of Certified Public Accountants (AICPA) Working Group to collect additional information on the lead engagement partner.

Capital Adequacy (E) Task Force

July 28, 2021 (in lieu of the Summer National Meeting)

1. Adopted its June 30, April 29, and March 23 minutes, which included the following action:
   A. Adopted proposal 2021-04-CA (Investment Income Health Underwriting Factors).
   B. Adopted proposal 2021-07-CA (Receivables for Securities Factors).
   C. Adopted proposal 2021-09-H (Health Bond Factors).
   D. Adopted proposal 2021-06-L (Real Estate Factors – Modified).
   E. Adopted proposal 2021-11-L (Life Bond Factors).
   F. Adopted proposal 2021-13-L (Longevity Risk Factors and Instructions).
   G. Adopted proposal 2021-03-P (Credit Risk Instructions Modification).
   I. Adopted proposal 2021-08-P (P/C Bond Factors).
   J. Adopted proposal 2021-01-L (Real Estate Structure).
   K. Adopted proposal 2021-02-CA (Managed Care Credit Incentives).
   L. Adopted its working agenda.
2. Adopted the report of the Health Risk-Based Capital (E) Working Group, including its July 12 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its June 8, May 25, and April 23 minutes, which included the following action:
      i. Adopted its March 17 minutes.
      ii. Discussed the 20 bond designation factors.
      iii. Received comments and referred proposal 2021-04-CA (Investment Income Health Underwriting Factors) to the Capital Adequacy (E) Task Force.
      iv. Discussed, exposed, and requested the assistance of the American Academy of Actuaries (Academy) in a comprehensive review of the H2 – Underwriting Risk component.
      v. Adopted revisions to the 2021 health risk-based capital (RBC) working agenda.
      vi. Adopted proposal 2021-09-H (Bond Factors).
      vii. Discussed developing a process and the other lines of business to be considered for investment income in the underwriting risk factors.
      viii. Received an update on the Health Test and Health RBC Excessive Growth Charge Ad Hoc Groups.
   B. Adopted the 2021 health RBC newsletter.
   C. Approved the 2020 health RBC statistics.
   D. Received a response from the Academy to review the H2 – Underwriting Risk component in the health RBC formula.
   E. Discussed reviewing the bond factors because of the adoption of the Moody’s bond factors in the life RBC formula.
   F. Discussed developing a process and the lines of business to be considered in the adjustment of the investment income in the underwriting risk factors for comprehensive medical, Medicare supplement, and dental and vision.

3. Adopted the report of the Life Risk-Based Capital (E) Working Group, including its July 21 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its June 11, June 3 and June 4, May 27, May 20, April 29, April 22, April 15, April 6, March 30, and Spring National Meeting minutes, which included the following action:
      i. Adopted proposal 2021-06-L (Real Estate Factors).
      ii. Adopted proposal 2021-11-L (Bond Factors).
      iv. Adopted proposal 2021-12-L (Reinsurance).
   B. Adopted the 2021 life and fraternal RBC newsletter.
   C. Approved the 2020 life and fraternal RBC statistics.
   D. Adopted its updated working agenda.

4. Adopted the report of the Property and Casualty Risk-Based Capital (E) Working Group, including its July 22 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its June 9 and April 27 minutes, which included the following action:
      i. Adopted proposal 2021-05-P (Underwriting Risk Line 1 Factors).
      ii. Adopted proposal 2021-08-P (P/C Bond Factors and Instructions).
      iii. Adopted proposal 2021-03-P (Credit Risk Instruction Modification)
      iv. Forwarded the response to the Restructuring Mechanisms (E) Subgroup.
      v. Heard a presentation on property/casualty (P/C) RBC underwriting risk factors from the Academy.
   B. Adopted the report of the Catastrophe Risk (E) Subgroup, including its July 15 minutes. During this meeting, the Subgroup took the following action:
      i. Adopted its June 1 and April 26 minutes, which included the following action:
         a. Forwarded the response to a request for proposed changes to the P/C RBC catastrophe component.
         c. Discussed the possibility of allowing additional third-party models or adjustments to the vendor models.
      ii. Adopted its working agenda items.
      iv. Heard a presentation from AIR Worldwide regarding its wildfire model.
   C. Adopted the 2021 P/C RBC newsletter.
   D. Adopted the 2020 P/C RBC statistics.
   E. Adopted its 2021 working agenda.
   F. Heard updates from the Academy regarding different projects related to calibrating various components of the underwriting risk and reserve risk.

5. Adopted proposal 2021-04-CA (Modified for Rounding).
6. Adopted its 2021 working agenda.
Examination Oversight (E) Task Force

August 5, 2021 (in lieu of the Summer National Meeting)

1. Adopted its March 25 minutes.
2. Adopted the report of the Electronic Workpaper (E) Working Group, which met July 13 and April 28 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings.
3. Adopted the report of the Financial Analysis Solvency Tools (E) Working Group, which met June 21 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings.
4. Adopted the report of the Financial Examiners Coordination (E) Working Group, which met Aug. 3 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings.
5. Adopted the report of the Financial Examiners Handbook (E) Technical Group, including its July 28 minutes. During this meeting, the Technical Group took the following action:
   A. Discussed and prioritized its 2021 project list.
   B. Received an update on related NAIC working group activities that will affect examination guidance.
6. Adopted the report of the Information Technology (IT) Examination (E) Working Group, including its April 19 minutes. During this meeting, the Working Group took the following action:
   A. Received a referral from the Chief Financial Regulator Forum requesting the development of a mechanism for state departments of insurance (DOIs) to respond to emerging cyber vulnerabilities or exposures during the period in between full scope exams.
   B. Received a referral from the Receivership Financial Analysis (E) Working Group requesting additional guidance for evaluating the quality and portability of policyholder data to ensure the ability to transfer such data in the event of receivership or liquidation.

Financial Stability (E) Task Force

July 27, 2021 (in lieu of the Summer National Meeting)

1. Adopted its May 12 and Feb. 22 minutes, which included the following action:
   A. Heard an update on Financial Stability Oversight Council (FSOC) developments.
   B. Adopted its revised mission and charges.
   C. Adopted the 2020 Liquidity Stress Test (LST) Framework.
   D. Heard an international update.
   E. Heard a macroprudential risk assessment update.
3. Renamed the Liquidity Assessment (E) Subgroup to the Macroprudential (E) Working Group and adopted revised charges for the new group.
4. Heard an international update.
5. Heard a macroprudential risk assessment update.

Receivership and Insolvency (E) Task Force

July 27, 2021 (in lieu of the Summer National Meeting)

1. Adopted its May 20 minutes, which included the following action:
   A. Adopted its March 12 minutes.
   B. Adopted amendments to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450).
2. Adopted the report of the Receivership Financial Analysis (E) Working Group, which met March 22 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss companies in receivership.
3. Adopted the report of the Receivership Law (E) Working Group, including its May 4 minutes. During this meeting, the Working Group took the following action:
   A. Adopted amendments to Model #440 and Model #450. The amendments aimed to address the topic of the continuation of essential services by affiliates of an insurer in receivership, as well as access to data and records held
by affiliates belonging to the insurer in receivership. Guidance related to the amendments will be drafted by the Receiver’s Handbook (E) Subgroup.

4. Adopted the report of the Receiver’s Handbook (E) Subgroup, including its June 14 minutes. During this meeting, the Subgroup took the following action:
   A. Adopted its May 26 minutes, which included the following action:
      i. Discussed its charge.
   B. Formed drafting groups to draft proposed edits to each chapter of the Receiver’s Handbook. The drafting group has started work on the first chapter.

5. Adopted 2022 proposed charges for the Task Force and its working groups and subgroup.

6. Heard an update on international activities. The International Association of Insurance Supervisors (IAIS) Resolution Working Group completed the Application Paper on Resolution Powers and Planning. It will begin work on an application paper on policyholder protection schemes in September.

7. Heard an update on Macroprudential Initiative (MPI) recommendations:
   A. The Task Force will pursue training and outreach to better inform the states of receivership matters. Possible activities include outreach to the states’ legislative liaisons and encouraging Task Force members to discuss receivership matters at zone meetings.
   B. The Task Force will continue to monitor and provide feedback to the Group Solvency Issues (E) Working Group, which has drafted updates to financial analysis guidance for crisis management groups, recovery planning, and resolution planning.

Reinsurance (E) Task Force
July 27, 2021 (in lieu of the Summer National Meeting)

1. Adopted its March 23 minutes.


5. Discussed the draft ReFAWG Review Process for Passorting Certified and Reciprocal Jurisdiction Reinsurers.

6. Discussed the Republic of Korea application to become a qualified jurisdiction.

7. Received a status report on the states’ implementation of the 2019 revisions to the Credit for Reinsurance Model Law (#785), the Credit for Reinsurance Model Regulation (#786), and the implementation of the Term and Universal Life Insurance Reserve Financing Model Regulation (#787).

Risk Retention Group (E) Task Force
July 26, 2021 (in lieu of the Summer National Meeting)

1. Adopted its May 25 minutes, which included the following action:
   A. Discussed the results of the 2021 risk retention group (RRG) survey, which was conducted to identify what is working well and what areas the Task Force can improve related to the non-domiciliary and domiciliary regulation of RRGs.
   B. Discussed the applicability of revisions to the Insurance Holding Company System Model Act (#440) and the Insurance Holding Company System Regulation with Reporting Forms and Instructions (#450) as an accreditation standard for RRGs.
   C. Referred an update to the quarterly non-troubled company procedures for RRGs to the Financial Analysis Solvency Tools (E) Working Group.

2. Adopted its 2022 proposed charges, which remain unchanged from the 2021 charges.

3. Discussed the RRG task list and determined to start work on two items. One item is to draft instructions and guidance for the NAIC Uniform Risk Retention Group Registration Form. The second item is to start work on an information-sharing template that can be prepared and shared by a domiciliary state prior to the development of an insurer profile summary.
Valuation of Securities (E) Task Force

July 15, 2021 (in lieu of the Summer National Meeting)

1. Adopted its May 24 and March 22 minutes, which included the following action:
   A. Adopted an amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to require the filing of private rating letter rationale reports with the NAIC Securities Valuation Office (SVO) beginning Jan. 1, 2022. The amendment includes provisions for deferring and waiving the submission for private letter rating securities in certain situations.
   B. Discussed a proposed amendment to the P&P Manual to permit filing exemption (FE) for credit tenant loan (CTL) and ground lease financing (GLF) transactions. The Task Force directed SVO staff to prepare a new amendment to the P&P Manual following the suggestions proposed by the Statutory Accounting Principles (E) Working Group chairs permitting CTL and GLF transactions that are securities to be FE and expose it for a 30-day public comment period ending June 28.
   C. Discussed the SVO’s response to the Statutory Accounting Principles (E) Working Group referral to the SVO on CTLs.

2. Adopted its 2022 proposed charges.

3. Adopted an amendment to the P&P Manual to add additional instructions for the review of funds to clarify guidance for fund leverage and the use of derivatives.

4. Adopted an amendment to the P&P Manual to permit securities that are CTL-like and GLF-like transactions to use NAIC credit rating provider (CRP) ratings through FE if they are structured as securities.


6. Exposed a proposed amendment to the P&P Manual to permit the SVO to rely on the parent entity’s rating for an unrated and unguaranteed subsidiary in a working capital finance investment (WCFI) program for a 30-day public comment period ending Aug. 16. The proposed amendment was also referred to the Statutory Accounting Principles (E) Working Group for comment.

7. Received NAIC staff reports on:
   B. The status of the NAIC Structured Securities Group’s financial modeling request for proposal (RFP) and implementation of the adopted changes for legacy/non-legacy residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS).

FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE

August 14, 2021

1. Reported that it met Aug. 13 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings, to: 1) discuss state-specific accreditation issues; and 2) vote to award continued accreditation to the insurance departments of Arkansas; District of Columbia; Indiana; Michigan; and New Jersey.

2. Adopted its Spring National Meeting minutes.

3. Adopted its 2022 proposed charges, which remain unchanged from its 2021 charges.


5. Recommended exposure of the 2020 revisions to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) effective for all states Jan. 1, 2026, for a one-year public comment period beginning Jan. 1, 2022. The revisions implement a group capital calculation (GCC) for the purpose of group solvency supervision and a liquidity stress test (LST) for macroprudential surveillance. The exposure was revised from the initial referral to allow GCC filing exemptions to qualifying groups meeting the standards set forth in Model #450, Section 21A and Section 21B, without the requirement to file at least once. The recommended exposure was referred to the Executive (EX) Committee and Plenary for consideration at the Fall National Meeting.
INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE
August 16, 2021
1. Adopted its May 5 and Spring National Meeting minutes, which included the following action:
   A. Approved submission of NAIC comments on the International Association of Insurance Supervisors (IAIS) draft Application Paper on Macroprudential Supervision.
2. Discussed and approved submission of NAIC comments on the IAIS draft Issues Paper on Insurer Culture and draft revised Application Paper on Supervisory Colleges.
3. Heard an update on key 2021 projects and priorities of the IAIS, including: a) implementation assessment activities related to the holistic framework for systemic risk; b) the ongoing insurance capital standard (ICS) monitoring period; and c) the peer review process of Insurance Core Principle (ICP) 9 (Supervisory Review and Reporting) and ICP 10 (Preventive and Corrective Measures); and d) 2022–2023 strategic planning priorities.
4. Heard an update on international activities, including recent virtual meetings and events with international colleagues; plans for the virtual fall 2021 NAIC International Fellows Program; recent meetings of the Organisation for Economic Cooperation and Development (OECD) Insurance and Private Pensions Committee; recent meetings of the Sustainable Insurance Forum (SIF); and an upcoming virtual webinar of the European Union (EU)-U.S. Dialogue Project.

NAIC/CONSUMER LIAISON COMMITTEE
August 14, 2021
1. Announced its Spring National Meeting minutes would be considered for adoption via e-vote.
2. Heard a presentation from the Coalition Against Insurance Fraud and United Policyholders titled, “Helping Consumers Avoid Getting Burned or Blown-Away by Post-Disaster Fraud.” The presenters discussed: a) the cost and impact of natural disasters on consumers; b) estimates of the costs of natural disaster fraud; c) how natural disaster fraud occurs (contractor and repair scams, insurer actions, and consumer fraud); and d) the disparate impact of natural disaster fraud and steps departments of insurance (DOIs) can take to better protect consumers.
3. Heard a presentation from the Center for Economic Justice (CEJ) on the impact of the COVID-19 pandemic on consumer credit scores and insurance underwriting. This is important to state insurance regulators and consumers as it highlighted the use of average credit scoring by industry for historical purposes, which experienced a shift due to the pandemic. A moratorium was requested to pause this practice until the credit score environment has a chance to catch up and normalize following the pandemic. Another request is that state insurance regulators encourage the use of individual credit scores rather than imposing average credit scores that may not be indicative of the individual insurance consumer’s credit experience.
4. Heard a presentation from Health Equity Solutions and The AIDS Institute on regulatory possibilities for promoting equity through telehealth. The COVID-19 pandemic led the states to rapidly increase the scope of telehealth services through public and private payers. Initial reports suggest telehealth services during COVID-19 did more to preserve access for existing patients than to alleviate access disparities and may even have exacerbated these disparities. The rapid scaling up of telehealth capabilities among providers across the country offers lessons about what more needs to be done to ensure that telehealth realizes its promise as a tool for advancing equity. Presenters discussed evaluating utilization data, assessing barriers to telehealth, preserving consumer choice, and safeguarding against unnecessary requirements or cost barriers for in-person care. They said telehealth services have the potential to reduce avoidable emergency department utilization (EDU) and to create access for people who lack transportation or dependent care, or who face stigma in their communities. The presenters said, however, that these benefits will be limited if telehealth services only reach populations who already had access to in-person care.
5. Heard a presentation from Families USA on the implementation of the federal No Surprises Act (NSA) and implications for consumer protections. The presenter provided an overview of the long-standing abusive practice of surprise medical billing and the protections passed into law through the NSA in December 2020. As the release of the first of three interim final rules (IFRs) came out in July, consumer representatives wanted to present ways in which insurance commissioners could be sure consumers have the tools they need to ensure comprehensive protections when this law takes effect in January 2022.
6. Heard the results of the survey by the University of Georgia and Georgians for a Healthy Future. In Spring 2021, consumer representatives commissioned a survey of grassroots consumer organizations to broaden their perspective on insurance issues represented at the NAIC. This presentation described the survey’s goal, methodology, and preliminary results with the aim to bring the expertise, perspectives, and stories from these organizations to state insurance regulators and other NAIC stakeholders.
NAIC/AMERICAN INDIAN AND ALASKA NATIVE LIAISON COMMITTEE

The NAIC/American Indian and Alaska Native Liaison Committee did not meet at the Summer National Meeting.

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EXECUTIVE (EX) COMMITTEE AND PLENARY

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Executive (EX) Committee and Plenary  
Columbus, Ohio  
August 17, 2021

The Executive (EX) Committee met in Columbus, OH, Aug. 17, 2021. The following members participated: David Altmaier, Chair (FL); Dean L. Cameron, Vice Chair (ID); Chlora Lindley-Myers, Vice President (MO); Andrew N. Mais, Secretary-Treasurer (CT); Raymond G. Farmer, Most Recent Past President (SC); Lori K. Wing-Heier (AK); Jim L. Ridling represented by Reyn Norman (AL); Alan McClain (AR); Peni Itula Sapiini Teo (AS); Evan G. Daniels represented by Jon Savary (AZ); Ricardo Lara represented by Bryant Henley (CA); Michael Conway represented by Peg Brown (CO); Karima M. Woods (DC); Trinidad Navarro (DE); John F. King represented by Martin Sullivan (GA); Colin M. Hayashida (HI); Doug Ommen (IA); Dana Popish Severinghaus represented by Kevin Fry (IL); Amy L. Beard (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon (LA); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Eric A. Cioppa (ME); Anita G. Fox (MI); Grace Arnold (MN); Mike Chaney (MS); Troy Downing represented by Bob Biskupiak (MT); Mike Causey represented by Michelle Osborne (NC); Jon Godfread (ND); Eric Dunning (NE); Marlene Caride (NJ); Russell Toal (NM); Linda A. Lacewell represented by My Chi To (NY); Judith L. French represented by Carrie Haughawout (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Larry D. Deiter (SD); Carter Lawrence (TN); Doug Slape (TX); Jonathan T. Pike (UT); Scott A. White (VA); Tregenza A. Roach (VI); Michael S. Pieciak represented by Kevin Gaffney (VT); Mike Kreidler represented by Molly Nollette (WA); Mark Afable (WI); James A. Dodrill (WV); and Jeff Rude (WY).

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

Commissioner Altmaier reported that the Executive (EX) Committee met Aug. 15 and adopted the Aug. 13 report from the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee.

The Executive (EX) Committee adopted the report of the Executive (EX) Committee, which met July 13, June 29, and May 20 and took the following action: 1) discussed creating a new standing Committee on Innovation, Technology, and Cybersecurity; 2) received a mid-year financial update and an overview of the preliminary 2022 budget; 3) adopted the Audit Committee report, including the 2020/2021 Service Organization Control (SOC) reports; 4) adopted the Internal Administration (EX1) Subcommittee’s May 13 minutes; and 5) approved a Fiscal for the Solvency Workpaper Software Modernization Project – Implementation Preparation Phase.

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

The Executive (EX) Committee discussed the potential formation of a standing “H” committee to address issues concerning innovation, technology, and cybersecurity.

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

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

The Executive (EX) Committee received a status report on model law development efforts for amendments to: 1) the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171); 2) the Annuity Disclosure Model Regulation (#245); 3) the Insurance Holding Company System Regulatory Act (#440); 4) the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450); 5) the Life Insurance Disclosure Model Regulation (#580); 6) the Nonadmitted Insurance Model Act (#870); and 7) new models, including the Pet Insurance Model Law and the [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM Model).

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

Director Cameron made a motion, seconded by Director Farmer, to adopt the Aug. 15 report of the Executive (EX) Committee. The motion passed unanimously.
2. **Adopted by Consent the Committee, Subcommittee, and Task Force Minutes of the Spring National Meeting**

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

3. **Adopted Amendments to 2021 Proposed Charges**

Commissioner Mais made a motion, seconded by Director Lindley-Myers, to adopt the amendments to the Special (EX) Committee on Race and Insurance, the Regulatory Framework (B) Task Force, the Antifraud (D) Task Force, and the Financial Stability (E) Task Force charges (Attachment One). The motion passed unanimously.

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

Commissioner Caride reported that the Life Insurance and Annuities (A) Committee met Aug. 16. During this meeting, the Committee adopted its July 19 minutes, which included the following action: 1) adopted its June 30 minutes, which included appointing the Index-Linked Variable Annuity (A) Subgroup; 2) adopted its Spring National Meeting minutes; 3) adopted a frequently asked questions (FAQ) guidance document to assist the states as they move forward with adopting the revisions to the *Suitability in Annuity Transactions Model Regulation* (#275); and 4) adopted a package of 15 *Valuation Manual* amendments.

The Committee adopted the report of the Accelerated Underwriting (A) Working Group, including its July 29 minutes. During this meeting, the Working Group discussed the latest draft of the accelerated underwriting educational report.

The Committee adopted the report of the Life Actuarial (A) Task Force. During this meeting, the Task Force exposed the Society of Actuaries (SOA) 2022 Generally Recognized Expense Table (GRET).

The Committee discussed the next steps for the Life Insurance Illustration Issues (A) Working Group. The Committee asked Richard Wicka (WI) to develop a chair report for its review at the Fall National Meeting. The chair report will detail the work of the group and include a summary of comments that have been received and incorporated into its work product over the years. The Committee will review the report and provide guidance to the Working Group on next steps at the Fall National Meeting.

The Committee heard an update from Workstream Four of the Special (EX) Committee on Race and Insurance. The Workstream intends to convene regular meetings starting in September to achieve its charges/goals.

5. **Adopted Amendments to the *Valuation Manual***

Commissioner Caride reported that a package of 15 *Valuation Manual* amendments was adopted by the Life Insurance and Annuities (A) Committee during its July 19 meeting. Most of these amendments provide technical clarifications and guidance to existing requirements in the *Valuation Manual*.

There are two amendments that are more substantive in nature: 1) Amendment Proposal Form (APF) 2020-09, which modifies the Life Principle-Based Reserving (PBR) Exemption to allow a company that received commissioner approval for the exemption in the prior year to retain its exemption if it meets certain requirements, and not require VM-20, Requirements for Principle-Based Reserves for Life Products, when all new issues arise due to policyholder conversions; and 2) APF 2020-10 (Attachment Two), which allows the use of future mortality improvement beyond the valuation date.

Commissioner Caride made a motion, seconded by Commissioner Donelon, to adopt the package of *Valuation Manual* amendments, excluding APF 2020-10. The motion was adopted by 51 jurisdictions, representing 97.81% of the applicable premiums written.

Commissioner Caride made a motion, seconded by Commissioner Mulready, to adopt APF 2020-10 as an amendment to the *Valuation Manual*. The motion was adopted by 48 jurisdictions, representing 88.75% of the applicable premiums written, with Louisiana, New Mexico, and New York opposed. Commissioner Altmaier confirmed that both votes satisfied the requirements to amend the *Valuation Manual*. 
6. **Adopted Amendments to the Annuity Disclosure Model Regulation (#245)**

Commissioner Caride reported that the amendments to Model #245 were adopted unanimously by the Life Insurance and Annuities (A) Committee at the 2018 Summer National Meeting. Under the current model, the illustration of “non-guaranteed elements” are prohibited. This prohibition could be construed to include participating income annuities because of the formula used to calculate the dividend scale. These amendments allow for the illustration of participating income annuities. At the time these amendments were adopted, the Committee was working on additional revisions to Model #245 to allow, under certain circumstances, the illustration of indices in existence for fewer than 10 years, which is prohibited under Model #245. At that time, the Committee decided to hold the participating income annuity amendments at the Committee level, pending resolution of the indices issue with the intent to move all amendments to Model #245 at one time.

During the Spring National Meeting, the Committee voted to disband the Annuity Disclosure (A) Working Group working on these additional indices amendments, as it was still unable, after many years, to reach consensus.

Commissioner Caride made a motion, seconded by Commissioner Ommen, to adopt the participating income annuity revisions to Model #245 (Attachment Three). The motion passed with California abstaining, noting that California laws are stronger than Model #245, and New York opposing.

Executive Deputy Superintendent To noted that New York would be voting no because “this particular amendment allows insurers to show in their illustrations of expected dividends an assumption of an increase in interest rates over time to a long-term average, which would always be the case even if interest rates were below that average. Illustrations should be a means of showing consumers how a given product works and should not be a means of competition between companies, assuming an increase in interest rates in these illustrations is misleading to consumers.”

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

Commissioner Godfread reported that the Health Insurance and Managed Care (B) Committee met Aug. 16. During this meeting, the Committee adopted its June 22 and Spring National Meeting minutes, which included the following action: 1) adopted the PBM Model; and 2) forwarded the PBM Model to the Executive (EX) Committee and Plenary to consider adoption.

The Health Insurance and Managed Care (B) Committee adopted the report of the Consumer Information (B) Subgroup, which met July 1 and May 25. During these meetings, the Subgroup took the following action: 1) discussed a plan to complete several short consumer guides on the claims process; and 2) discussed draft claims process-related guides; i.e., appeals process, medical necessity, explanation of benefits (EOBs), claims filing, and billing codes. The Subgroup agreed to consider and make proposed edits to the guides over the next few weeks.

The Committee adopted the report of the Health Innovations (B) Working Group, which met July 27. During this meeting, the Working Group took the following action: 1) adopted its Spring National Meeting minutes; 2) discussed its approach to fulfilling charges received from the Special (EX) Committee on Race and Insurance; 3) heard presentations on hospital price transparency requirements from the federal Centers for Medicare & Medicaid Services (CMS) and insurer price transparency requirements from the CMS Center for Consumer Information and Insurance Oversight (CCIIO); 4) heard a presentation from FAIR Health on its research and resources related to health care price transparency; and 5) heard a presentation from Consumers’ Checkbook on ways to make health care price information relevant and understandable for consumers.

The Health Insurance and Managed Care (B) Committee adopted the report of the Regulatory Framework (B) Task Force and the Senior Issues (B) Task Force.

The Committee heard a presentation from Jeff Wu (CCIIO) on the Biden administration’s federal legislative and administrative initiatives and priorities. The presentation included a discussion of the administration’s plans on working with the states with respect to the implementation and enforcement of the provider provisions of the federal No Surprises Act (NSA).

The Committee heard a panel discussion from Molly Smith (American Hospital Association—AHA), Emily Carroll (American Medical Association—AMA), and Melanie de Leon (Federation of State Medical Boards—FSMB) regarding the implementation and enforcement of the NSA’s provider requirements.

The Committee received an update on the work of the Special (EX) Committee on Race and Insurance Workstream Five. The Workstream met July 8 and June 10. During these meetings, the Workstream discussed data collection issues, provider network,
provider directories, and cultural competency. Based on its discussions on data collection, the Workstream released a draft “best practices” document for a public comment period ending Aug. 19. The Workstream plans to discuss any comments received on the draft document during its Aug. 26 meeting. The Workstream anticipates developing a similar “best practices” document on provider network, provider directories, and cultural competency.

8. **Considered for Adoption the Model Law Addressing Licensure or Registration of Pharmacy Benefit Managers (PBMs)**

Commissioner Godfread reported that work to develop the Model Law Addressing Licensure or Registration of Pharmacy Benefit Managers (PBMs) began in 2019 to develop an NAIC model providing state departments of insurance (DOIs) direct authority to regulate PBMs rather than to regulate indirectly through the insurer. This regulatory approach stems from the expanding role of PBMs in the prescription drug supply chain, the resulting impact on consumer access to prescription drugs, and their affordability.

After many meetings and extensive and robust discussions with stakeholders about the proposed model, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup completed work on the model and adopted it in October 2020.

After exposing the proposed model for an additional public comment period, the Regulatory Framework (B) Task Force adopted it in March. The Health Insurance and Managed Care (B) Committee deferred action on the model during the Spring National Meeting because of questions about a proposed drafting note, which provided statutory citations to state laws regulating various PBM business practices.

The Subgroup included this note as a compromise, as some states wanted the model to focus only on PBM licensing and registration provisions, and other states wanted to include substantive provisions addressing certain PBM business practices. The Subgroup also believed there was a lack of national consensus regarding the regulation of these PBM business practices to include in the model’s substantive provisions.

In June, the Committee reconvened to consider adoption of the model. During this meeting, concerns were raised about the potential of a lack of uniformity in adoption by the states—a key component of the NAIC model law development procedures—if states selected different provisions from this proposed drafting note to include in their state law.

Given this concern, some stakeholders suggested that the drafting note was not the appropriate approach to take and instead suggested that a charge be given to the Subgroup to develop a white paper that would examine current and emerging state laws related to the PBM business practices outlined in the drafting note.

Based on these discussions, during its June 22 meeting, the Committee deleted the proposed drafting note and adopted the model.

The Committee took this action as well because the Task Force adopted a charge for the Subgroup to develop a white paper just prior to the Committee’s June 22 meeting. The white paper will explore existing and emerging state laws on PBM business practices, such as price transparency and reporting requirements, rebating, and spread pricing and discuss the implications of the *Rutledge vs. Pharmaceutical Care Management Association (PCMA)* court decision on such business practices.

At its core, this model is a licensure model that state DOIs can use to directly regulate PBMs. Sections 1 through 4 set out the model’s purpose, scope, and definitions. Section 5 provides the PBM licensing provisions, including provisions related to approving initial PBM licenses and renewals. Section 6—Gag Clauses and Other Pharmacy Benefit Managers Prohibited Practices includes language related to gag clauses and information-sharing for the purposes of enforcement. Section 7 of the proposed PBM model provides enforcement language and penalties for any violations of the model. Section 8—Regulations provides that the commissioner may promulgate regulations relating to PBMs that are not inconsistent with the model.

Commissioner Altmaier stated that a model shall only be presented to the Executive (EX) Committee and Plenary for consideration if a minimum two-thirds majority of the responsible parent committee has voted to adopt the model. A member’s vote based on whether he or she will make efforts to have the model introduced in his or her respective state legislature or the law in his or her state already meets or exceeds the minimum national standard set by the model.

Commissioner Schmidt noted that Kansas will be voting “no” on adoption of this PBM model because “as seen in the minutes and materials that came out of the drafting group, including the notes and summary of the issues that the drafting group addressed but did not come to consensus on and the action of the Committee to remove the contentious drafting note, the model law we are voting on does not address the issues that many states are interested in regulating. The drafting group worked hard
on its charge, and its work should be commended. However, the final product before us today is, simply, an ineffective piece of legislation that I doubt will be adopted by a majority of my sister states. I believe the wiser course of action would have been to continue the hard work of drafting model legislation that addresses the substantive issues affecting health care in our states. States will remain free to adopt the model, no PBM legislation, a completely different legislation, or a modified version of the PBM model that includes more substantive topics. As the opposition to including the drafting note was concern about uniformity, we see here another example of bureaucracy interfering with flexible, good government. We will not have uniform adoption, so there is no need to adopt this model.”

Commissioner Dodrill reported that over the past couple of years, West Virginia’s legislature adopted a much more robust statute on licensure and regulations of PBMs. Mr. Henley noted that California will abstain as California law already includes licensure and regulation of PBMs.

Commissioner Navarro reported that Delaware will abstain, as Delaware already passed stronger legislation. Commissioner Godfread will vote “no,” as this is a license and registration model that North Dakota already has. He expressed concerns that he is not sure DOIs are the right place for this function.

Commissioner Donelon asked the sponsor to what extent this model purports to regulate PBMs. Louisiana licenses them as third-party administrators (TPAs), and so does New Jersey.

Jolie H. Matthews (NAIC) noted that the draft model has a direct way for state DOIs to regulate as PBMs versus as a TPA as Louisiana does.

Director Lindley-Myers noted that Missouri will abstain. The Board of Pharmacy is under the DOI already, and there are some provisions Missouri could not enact.

Commissioner Chaney stated that he has no statutory authority to regulate PBMs at this time. Director Fox noted that she would abstain, as it is unlikely Michigan would adopt what has been proposed. Superintendent Toal said New Mexico already has stronger laws and regulations. Commissioner Ommen said Iowa already has licensing and regulatory authority, and this model is significantly different than Iowa’s.

Chief Deputy Commissioner Slape indicated that Texas would support the model, as it has similar laws.

Commissioner Altman and Commissioner Mais expressed their gratitude to NAIC staff and the states involved in the drafting.

Commissioner Lawrence reported that Tennessee has a new PBM law subject to a court challenge, and this model could possibly assist with that challenge.

Commissioner Godfread noted that work will continue on a PBM white paper to address the various remaining issues. He also thanked the drafters.

Director Dunning said he will vote “yes,” as regulation of PBMs and this model has been long awaited as a starting point by the Nebraska legislature.


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

Commissioner Schmidt reported that the Property and Casualty Insurance (C) Committee met Aug. 16 and adopted its Spring National Meeting minutes.
The Committee adopted the reports of its task forces and working groups: the Casualty Actuarial and Statistical (C) Task Force; the Surplus Lines (C) Task Force; the Title Insurance (C) Task Force; the Workers’ Compensation (C) Task Force; the Cannabis Insurance (C) Working Group; the Catastrophe Insurance (C) Working Group; the Pet Insurance (C) Working Group; the Terrorism Insurance Implementation (C) Working Group; and the Transparency and Readability of Consumer Information (C) Working Group.

The Committee adopted an extension for revisions to the proposed Pet Insurance Model Law and adopted updates to the Title Insurance Consumer Shopping Tool Template.

The Committee took the following action: 1) heard a presentation from the Association of Bermuda Insurers and Reinsurers (ABIR) and the Insurance Development Forum on ways to close the insurance protection gap; 2) heard a report on the cyberinsurance market, including results from the Cybersecurity and Identity Theft Insurance Coverage Supplement; 3) heard a report on the private flood insurance market, including results from the Private Flood Insurance Supplement; 4) heard an update on the Special (EX) Committee on Race and Insurance, including the fact that Workstream Three, focused on property/casualty (P/C) insurance issues, will take the new charges and formulate a work plan; and 5) planned a future meeting to hear from interested parties to discuss auto insurance refunds related to reduced driving from the COVID-19 pandemic.

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

Commissioner Clark reported that the Market Regulation and Consumer Affairs (D) Committee met Aug. 16. During this meeting, the Committee adopted its July 27 minutes, which included the following action: 1) adopted its Spring National Meeting minutes; 2) adopted revised charges for the Antifraud (D) Task Force; 3) adopted the short-term, limited-duration (STLD) Market Conduct Annual Statement (MCAS) data call and definitions; 4) adopted the travel insurance MCAS data call and definitions; 5) adopted digital claims data in the private passenger auto (PPA) and homeowners data call and definitions; and 6) heard presentations from a state insurance regulator, an NAIC funded consumer representative, and an industry trade representative on the benefits and challenges of collecting market conduct data annually on a transactional level.

The Committee heard a presentation from Peter Kochenburger (University of Connecticut School of Law) and an NAIC funded consumer representative on claim optimization and the potential of using artificial intelligence (AI) to evaluate the willingness of insureds or claimants to accept values less than the fair and equitable amount. The presenter encouraged state insurance regulators to determine the extent of use of predictive analytics in claim settlements and require insurers to report on the algorithmic models used in claim handling.

The Committee adopted the Regulatory Information Retrieval System (RIRS) proposed coding structure changes.

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

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

Commissioner White reported that the Financial Condition (E) Committee met Aug. 14. During this meeting, the Committee adopted its July 8 and Spring National Meeting minutes, which included the following action: 1) adopted changes to Model #440 and Model #450 that are intended to make explicit, rather than implicit, the regulatory authority that a commissioner should have relative to the continuation of essential services of an insurance company from an affiliate during a receivership; and 2) updated the life risk-based capital (RBC) bond factors effective for the 2021 reporting period.

The Committee adopted the reports of the following task forces and working groups: the Accounting Practices and Procedures (E) Task Force; the Capital Adequacy (E) Task Force; the Examination Oversight (E) Task Force; the Financial Stability (E) Task Force; the Receivables and Insolvency (E) Task Force; the Reinsurance (E) Task Force; the Risk Retention Group (E) Task Force; the Valuation of Securities (E) Task Force; the Group Capital Calculation (E) Working Group; the Group Solvency Issues (E) Working Group; the Mortgage Guaranty Insurance (E) Working Group; the Mutual Recognition of Jurisdictions (E) Working Group; the NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group; and the National Treatment and Coordination (E) Working Group. The report of the Financial Stability (E) Task Force included revised charges.

The Committee adopted a referral to the Statutory Accounting Principles (E) Working Group that requests consideration of changes to the Working Group’s maintenance policy.
The Committee took the following action: 1) adopted revisions to the *Process for Evaluating Qualified and Reciprocal Jurisdictions*; and 2) adopted revised charges for the renamed Macroprudential (E) Working Group.

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

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

Commissioner White reported that the Receivership and Insolvency (E) Task Force drafted the *Guideline for Definition of Reciprocal State in Receivership Laws* as an alternative to address how states define “reciprocal state.” The Guideline provides an optional statutory definition that may be used by states with a reciprocity requirement to effectuate the purposes of provisions regarding the coordination of receiverships involving multiple states.

The Guideline gives states a possible option to resolve the issue of reciprocity and full faith and credit for stays and injunctions. While some states have updated the reciprocity language in their receivership laws, most states’ receivership laws are based on older versions of the NAIC receivership model.

The Guideline does not require a state or jurisdiction to be accredited to be reciprocal, but it uses the same criteria; i.e., essentially that a state have a receivership scheme.

Commissioner White made a motion, seconded by Chief Deputy Commissioner Slape, to adopt the *Guideline for Definition of Reciprocal State in Receivership Laws* (Attachment Five). The motion passed unanimously.

13. **Adopted the Revised SSAP No. 71**

Commissioner White summarized the proposed changes to *Statement of Statutory Accounting Principles (SSAP) No. 71—Policy Acquisition Costs and Commissions* and provided an overview of the key points of the levelized commission agenda item 2019-24, which were adopted by the Financial Condition (E) Committee into the proposed changes to SSAP No. 71.

The proposed revisions “clarify that an insurance entity cannot use third-party structures to recharacterize and delay recognition of liabilities for initial sales commission owed, regardless of how a third-party arrangement is structured with regards to the timing of the payment from the insurers. This guidance clarifies that it is the writing of the insurance contract that obligates the insurer and recognition of expense shall occur consistently among insurers. SSAP No. 71 does not require advanced recognition for expected renewals or normal persistency metrics. When an insurance policy is issued, renewed, or metrics are met that require additional commission, then SSAP No. 71 consistently requires expense recognition for all insurers.”

The Statutory Accounting Principles (E) Working Group began discussion in August 2019 and on March 15 and adopted revisions that are effective Dec. 31. The Working Group vote was 13 states in favor and one state opposed. On March 23, the Accounting Practices and Procedures (E) Task Force adopted these revisions with a vote of 41 members in favor and two opposed (Louisiana and Oklahoma). On April 13, the Committee adopted these same revisions to SSAP No. 71 with a vote of 11-3 (Mississippi, New Mexico, and South Carolina dissenting).

Commissioner White noted that the proposed clarification to SSAP No. 71 is necessary because a handful of companies are using an accounting practice that allows them to expense commissions over several years, while the rest of the industry abides by the current requirements of SSAP No. 71, which requires these commissions to be expensed as they are incurred.

Commissioner White also noted that a permitted accounting practice would be available to the companies in question as well.

Commissioner White made a motion, seconded by Superintendent Cioppa, to adopt the changes to SSAP No. 71 (Attachment Six).
Superintendent Toal made a subsidiary motion, seconded by Commissioner King, to amend the motion to delay the implementation of these proposed changes to SSAP No. 71 to Dec. 31, 2022. The motion failed.

Chief Deputy Commissioner Slape noted, “the issue before us today is one of the foundations of statutory accounting; i.e., that commissions are expensed from day one. These rules have been followed for decades by all companies except those few who have been using off-balance sheets. They have already had three years notice to follow the rules. It defies logic that they need five years to come into compliance. They can seek a permitted practice from the domiciliary regulator instead of coming to this body for an exception.”

Commissioner Navarro noted that, as a domestic regulator of one of the companies in question, he is inclined to grant one more year to comply.

On consideration of the main motion, the motion passed with American Samoa, Arkansas, Delaware, Georgia, Idaho, Louisiana, Mississippi, Montana, New Mexico, and Oklahoma dissenting.

14. Adopted the Amendments to the Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)

Commissioner White reported that the purpose of these revisions is to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including non-regulated entities, specifically for agreements with affiliated entities whose sole business purpose is to provide services to the insurance company.

The changes were unanimously adopted by both the Receivership and Insolvency (E) Task Force and the Financial Condition (E) Committee.

Commissioner White made a motion, seconded by Chief Deputy Commissioner Slape, to adopt the amendments to Model #440 and Model #450 (Attachment Seven). The motion passed unanimously.

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

Commissioner White reported that the Process for Evaluating Qualified and Reciprocal Jurisdictions was first adopted by the NAIC in 2013 to provide a documented evaluation process for creating and maintaining the NAIC List of Qualified Jurisdictions. The document has now been updated to incorporate the 2019 revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) addressing “reciprocal.”

The revised document was exposed by the Reinsurance (E) Task Force in the Spring, modified to address comments from interested parties as well as informal suggestions from the Federal Insurance Office (FIO), and adopted by the Task Force on July 27. On Aug. 14, the Financial Condition (E) Committee unanimously adopted the revised document.

Commissioner White made a motion, seconded by Superintendent Toal, to adopt the amendments to the Process for Evaluating Qualified and Reciprocal Jurisdictions (Attachment Eight). The motion passed unanimously.

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

Director Dunning reported that the Financial Regulation Standards and Accreditation (F) Committee met Aug. 13 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings, to: 1) discuss state-specific accreditation issues; and 2) vote to award continued accreditation to the insurance departments of Arkansas; Indiana; Michigan; New Jersey; and Washington, DC.

The Committee also met Aug. 14 in open session and adopted: 1) its Spring National Meeting minutes; and 2) its 2022 proposed charges, which remain unchanged from its 2021 charges.

The Committee adopted the revisions to the Part A: Laws and Regulations Preamble to account for inclusion of the Term and Universal Life Insurance Reserve Financing Model Regulation (#787), which will be a new accreditation standard effective Sept. 1, 2022, with enforcement beginning Jan. 1, 2023.
The Committee recommended exposure of the 2020 revisions to Model #440 and Model #450 effective for all states Jan. 1, 2026, for a one-year public comment period beginning Jan. 1, 2022. The revisions implement a GCC for the purpose of group solvency supervision and an LST for macroprudential surveillance. The exposure was revised from the initial referral to allow GCC filing exemptions to qualifying groups meeting the standards set forth in Model #450, Section 21A and Section 21B, without the requirement to file at least once.

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

Commissioner Anderson reported that the International Insurance Relations (G) Committee met Aug. 16. During this meeting, the Committee adopted its May 5 and Spring National Meeting minutes, which included the following action: 1) heard an update on upcoming International Association of Insurance Supervisors (IAIS) committee meetings and activities; 2) heard an update on the Organisation for Economic Co-operation and Development (OECD) and other supervisory cooperation activities; 3) approved submission of NAIC comments on the IAIS draft Application Paper on Macroprudential Supervision; 4) heard a presentation on Scalar Methodologies from the American Academy of Actuaries (Academy); 5) heard an update on key 2020–2021 projects of the IAIS; 6) heard an update on international activities; and 7) received an update on NAIC events.

The Committee approved submission of NAIC comments on the IAIS Draft Issues Paper on Insurer Culture and the Draft Revised Application Paper on Supervisory Colleges.

The Committee heard an update on key 2021 projects and priorities of the IAIS, including: 1) implementation assessment activities related to the holistic framework for systemic risk; 2) the ongoing Insurance Capital Standard (ICS) monitoring period; and 3) the peer review process of certain Insurance Core Principles (ICPs) 9 and 10; and 4) 2022–2023 strategic planning priorities.

The Committee heard updates on: 1) international activities, including recent virtual meetings and events with international colleagues; 2) plans for the virtual 2021 NAIC Fall International Fellows Program; 3) recent meetings of the OECD Insurance and Private Pensions Committee; 4) recent meetings of the Sustainable Insurance Forum (SIF); and 5) an upcoming virtual webinar of the European Union (EU)-U.S. Dialogue Project.

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

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

Having no further business, the Executive (EX) Committee and Plenary adjourned.

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

Ongoing Support of NAIC Programs, Products or Services

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

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

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

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

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

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

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

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

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

LIFE INSURANCE AND ANNUITIES (A) COMMITTEE – NEW CHARGES

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

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

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

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

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

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

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

NAIC Support Staff: Andrew J. Beal/Michael F. Consedine
The mission of the Regulatory Framework (B) Task Force is to: 1) develop NAIC model acts and regulations for state health care initiatives; and 2) consider policy issues affecting state health insurance regulation.

Ongoing Support of NAIC Programs, Products and Services

1. The Regulatory Framework (B) Task Force will:
   A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
   B. Review managed health care reforms, their delivery systems occurring in the marketplace and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority and structures.
   C. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
   D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in 2021.
   E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the Employee Retirement Income Security Act (ERISA) (B) Working Group, monitor, analyze and report developments related to association health plans (AHPs).
   F. Monitor, analyze and report, as necessary, developments related to short-term, limited-duration (STLD) coverage.

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

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

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

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

   B. **Develop a white paper to:**
      1) analyze and assess the role PBMs, Pharmacy Services Administrative Organizations (PSAOs) and other supply chain entities, play in the provision of prescription drug benefits;
      2) identify, examine and describe current and emerging state regulatory approaches to PBM business practices, such as price transparency and reporting requirements, rebating and spread pricing, including the implications of the *Rutledge vs. Pharmaceutical Care Management Association (PCMA)* decision on such business practices; and
      3) discuss any challenges, if any, the states have encountered in implementing such laws and/or regulations.

NAIC Support Staff: Jolie H. Matthews/Jennifer R. Cook
The mission of the Antifraud (D) Task Force is to serve the public interest by assisting the state insurance supervisory officials, individually and collectively, through the detection, monitoring and appropriate referral for the investigation of insurance crime, both by and against consumers. The Task Force will assist the insurance regulatory community by conducting the following activities: 1) maintain and improve electronic databases regarding fraudulent insurance activities; 2) disseminate the results of research and analysis of insurance fraud trends, as well as case-specific analysis, to the insurance regulatory community; and 3) provide a liaison function between state insurance regulators, law enforcement (federal, state, local and international), and other specific antifraud organizations. The Task Force will also serve as a liaison with the NAIC Information Technology Group (ITG) and other NAIC committees, task forces and/or working groups to develop technological solutions for data collection and information sharing. The Task Force will monitor all aspects of antifraud activities by its working groups on the following charges.

Ongoing Support of NAIC Programs, Products or Services

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

2. The Antifraud Education Enhancement (D) Working Group will:
   A. Develop seminars, trainings and webinars regarding insurance fraud. Provide three webinars by the 2021 Fall National Meeting.

3. The Antifraud Technology (D) Working Group will:
   A. Review and provide recommendations for the development of an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions.
   B. Evaluate sources of antifraud data and propose methods for enhancing the utilization and exchange of information among state insurance regulators, fraud investigative divisions, law enforcement officials, insurers, and antifraud organizations. Complete by the 2021 Fall National Meeting.

4. The Improper Marketing of Health Insurance (D) Working Group will:
   A. Coordinate with regulators, both on a state and federal level, to provide assistance and guidance monitoring the improper marketing of health plans, and coordinate appropriate enforcement actions, as needed, with other NAIC Committees, task forces, and working groups.
   B. Review existing NAIC Models and Guidelines that address the use of lead generators for sales of health insurance products, and identify models and guidelines that need to be updated or developed to address current marketplace activities.
2021 Revised Charges

FINANCIAL STABILITY (E) TASK FORCE

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

Ongoing Support of NAIC Program, Products or Services

1. The Financial Stability (E) Task Force will:
   A. Consider issues concerning domestic and global financial stability as they pertain to the role of state insurance regulators and make recommendations to the International Insurance Relations (G) Committee, the Government Relations (EX) Leadership Council and/or the Executive (EX) Committee, as appropriate.
      1. Analyze existing post-financial crisis regulatory reforms for their application in identifying macroeconomic trends, including identifying possible areas of improvement or gaps, and propose to the Financial Condition (E) Committee or other relevant committee enhancements and/or additions to further improve the ability of state insurance regulators and the industry to address macroprudential impacts; consult with such committees on implementation, as needed.
   B. Consider state insurance regulators’ input to national and international discussions on macroeconomic vulnerabilities affecting the insurance sector.
      1. Monitor international macroprudential activities at forums like the International Association of Insurance Supervisors (IAIS).
      2. Implement the Macroprudential Initiative (MPI) domestically, which includes enhancements to the U.S. regulatory toolkit as part of the State Ahead initiative.
   C. Serve as a forum to coordinate state insurance regulators’ perspectives on a wide variety of issues arising from the designation of a U.S. insurance group as “systemically important” and “internationally active” both pre- and post-designation, including:
      1. Where appropriate, develop policy recommendations and/or guidance regarding the role, responsibilities and activities of state insurance regulators in the context of consolidated supervision resulting from designation.
      2. Analyze proposed rules by the federal agencies that relate to financial stability.
      3. Analyze proposed policy measures regarding supervisory standards for global systemically important insurers (G-SIIs) and internationally active insurance groups (IAIGs).
      4. Develop comment letters on such analysis for further consideration by the International Insurance Relations (G) Committee, the Government Relations (EX) Leadership Council, and/or the Executive (EX) Committee, as appropriate.

2. The Macroprudential (E) Working Group will:
   A. Oversee the implementation and maintenance of the liquidity stress testing framework for 2020 data as well as future iterations;
   B. Assist with the remaining MPI projects related to counterparty disclosures and capital stress testing as needed;
   C. Continue to develop and administer data collection tools as needed, leveraging existing data where feasible, to provide the Financial Stability (E) Task Force with meaningful macroprudential information regarding how the insurance sector is navigating the prevailing market conditions;
   D. Oversee the development, implementation, and maintenance process for a new Macroprudential Risk Assessment system (i.e., policies, procedures, and tools) to enhance regulators’ ability to monitor industry trends from a macroprudential perspective;
   E. Oversee the documentation of the NAIC’s macroprudential policies, procedures, and tools; and
   F. Provide the Task Force with proposed responses to IAIS and other international initiatives as needed.

The Liquidity Assessment (EX) Subgroup will:
   A. Continue to consider regulatory needs for data related to liquidity risk, and develop recommendations as needed.
   B. Refine and implement a liquidity stress testing framework proposal for consideration by the Financial Condition (E) Committee.
   C. Continue to develop and administer data collection tools, leveraging existing data where feasible, to provide the Financial Stability (EX) Task Force with meaningful macroprudential information regarding how the insurance sector is navigating market conditions affected by the COVID-19 pandemic.
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Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.
   American Academy of Actuaries, Life Reserves Work Group

   Addition of language to clarify the definition of individually underwritten life insurance and the
   applicability of Principle-Based Reserve (PBR) requirements for group insurance contracts with individual
   risk selection issued under insurance certificates.

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

   January 1, 2021, version of the Valuation Manual, with the revisions to APF 2020-11 (adopted by LATF
   on 2/11/21) shown in blue text.

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

   See Appendix

   All proposed changes specific to this amendment proposal are shown in red text.

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

   Individual insurance certificates issued under a group contract which utilize an individual risk selection
   process, pricing, premium rate structures and product features are similar to individual life insurance
   policies. They are currently excluded from VM-20 because they are filed under a group contract, but they
   should be subject to VM-20 due to this similarity. See Appendix.

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

NAIC Staff Comments:

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Notes: APF 2019-33
Appendix

Issue

Certain contracts issued under a master group contract require individual risk selection in order to qualify for issuance of the group insurance certificate; the certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing, and risk classification; and they are managed in a similar manner as individual ordinary life insurance contracts. These individual certificates should follow the same reserve requirements as other individual life contracts of the same product type. Therefore, a change is needed within the Valuation Manual to bring these individual certificates into scope of VM-20.

Six changes are recommended:

1) Within the Reserve Requirements section (Section II), change the minimum reserve requirements to also apply to group life contracts which, other than the difference between issuing a policy and issuing a group certificate, have the same or mostly similar contract provisions, risk selection process, and underwriting as individual ordinary life contracts (Section II, subsection 1.D);

2) Within the Reserve Requirements section (Section II), add a transition period for individual group certificates issued on or before 1/1/2024 (Section II, subsections 1.F.1 and 1.F.2);

3) Within the Reserve Requirements section (Section II), add language and guidance note to subsection 1.G and the corresponding footnote to include premiums from group life contracts which have individual certificates that were issued using individual risk selection processes (Section II, subsection 1.G.1, footnote, and guidance note) and to clarify the Calculation for Exemption (Section II, subsection 1.G.2). Comment notes need to refer to NAIC Blanks (E) Working Group to update the PBR Supplement;

4) Add new paragraph, VM-20 Section 1.B (and reformat to make current paragraph Section 1.A) to clarify group life certificates issued using individual risk selection processes, including a definition and requirements to be met, are subject to the requirements of VM-20;

5) Add guidance note after first sentence in VM-20 Section 2.A.1 that group life certificates that meet the definition for individual risk selection process use the same VM-20 Reserving Categories as defined in Section 2;

6) Draft referral to the NAIC Blanks (E) Working Group to revise the VM-20 Reserves Supplement, Part 2 to report premiums for total Group Life and Group Life with certificates subjected to an individual risk selection process and which meet all of the conditions as defined in VM-20 Section 1.B separately.
II. Reserve Requirements

This section provides the minimum reserve requirements by type of product, as set forth in the seven subsections below, as follows:

1. Life Insurance Products
2. Annuity Products
3. Deposit-Type Contracts
4. Health Insurance Products
5. Credit Life and Disability Products
6. Riders and Supplemental Benefits
7. Claim Reserves

All reserve requirements provided by this section relate to business issued on or after the operative date of the Valuation Manual. All reserves must be developed in a manner consistent with the requirements and concepts stated in the Overview of Reserve Concepts in Section I of the Valuation Manual.

Guidance Note: The terms “policies” and “contracts” are used interchangeably.

Subsection 1: Life Insurance Products

A. This subsection establishes reserve requirements for all contracts issued on and after the operative date of the Valuation Manual that are classified as life contracts as defined in SSAP No. 50 in the AP&P Manual, with the exception of annuity contracts and credit life contracts. Minimum reserve requirements for annuity contracts and credit life contracts are provided below in subsection 2 and subsection 5, respectively.

B. Minimum reserve requirements for variable and nonvariable individual life contracts—excluding guaranteed issue life contracts, preneed life contracts, industrial life contracts, and policies of companies exempt pursuant to the life PBR exemption in paragraph D below subsection 1.G are provided by VM-20, Requirements for Principle-Based Reserves for Life Products, except for election of the transition period in paragraph C below subsection 1.F.1 below. For this purpose, joint life policies are considered individual life.

C. Minimum reserve requirements of VM-20 are considered principle-based valuation requirements for purposes of the Valuation Manual.

D. Minimum reserve requirements for individual certificates under group life contracts (regardless of the issue date of the master group life contract) which meet all the requirements in VM-20 Section 1.B are provided by VM-20, except for election of the transition period in subsection 1.F.1 below.

E. Minimum reserve requirements for life contracts not subject to VM-20 are those pursuant to applicable requirements in VM-A and VM-C. For guaranteed issue life contracts issued after Dec. 31, 2018, mortality tables are defined in VM Appendix M, Mortality Tables (VM-M), and the same table shall be used for reserve requirements as is used for minimum nonforfeiture requirements as defined in VM-02, Minimum Nonforfeiture Mortality and Interest.
F. A company may elect to establish minimum reserves pursuant to applicable requirements in VM-A and VM-C for:

1. Business described in subsection 1.D above and issued on or after the operative date of the Valuation Manual and prior to 1/1/2024.

2. Business not described subsection 1.D, otherwise subject to VM-20 requirements and issued during the first three years following the operative date of the Valuation Manual.

A company electing to establish reserves using the requirements of VM-A and VM-C may elect to use the 2017 Commissioners' Standard Ordinary (CSO) Tables as the mortality standard following the conditions outlined in VM-20 Section 3. If a company during the three years elects to apply VM-20 to a block of such business, then a company must continue to apply the requirements of VM-20 for future issues of this business.

G. Life PBR Exemption

1. A company meeting the at least one of the conditions in subsection 1.G.2 below may file a statement of exemption for individual ordinary life insurance policies or certificates, except for policies or certificates in subsection 1.G.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. If a company has no business issued directly or assumed during the current calendar year that would otherwise be subject to VM-20, a statement of exemption is not required. For a filed statement of exemption, the statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that at least one of the two conditions in subsection 1.G.2 was met, and the statement of exemption must also be included with the NAIC filing for the second quarter of that year.

The domiciliary commissioner may reject such statement prior to September 1 and require the company to follow the requirements of VM-20 for the ordinary life policies or certificates covered by the statement.

If a filed statement of exemption is not rejected by the domiciliary commissioner, the filing of subsequent statements of exemption is not required as long as the company continues to qualify for the exemption; rather, ongoing statements of exemption for each new calendar year will be deemed to not be rejected, unless: 1) the company does not meet either condition in subsection 1.G.2 below, 2) the policies or certificates contain those in subsection 1.G.3 below, or 3) the domiciliary commissioner contacts the company prior to Sept. 1 and notifies them that the statement of exemption is rejected. If any of these conditions occur, then the statement of exemption for the current calendar year is rejected and a new statement of exemption must be filed and not rejected in order for the company to exempt additional policies or certificates. If the company elects to provide an ongoing statement of exemption, rather than include a statement of exemption with the NAIC filing for the second quarter of that year, the company should enter “SEE EXPLANATION” in response to the Life PBR Exemption supplemental interrogatory and provide as an explanation that the company is utilizing an ongoing statement of exemption.

2. Condition for Exemption:

- The company has less than $300 million of ordinary life exemption premiums, and if the company is a member of an NAIC group of life insurers which includes other life insurance companies, the group has combined ordinary life exemption premiums of less than $600 million. The only new policies or certificates that would otherwise be subject to VM-20 being issued or assumed by the company are due to election of policy benefits or features from existing policies or certificates valued under VM-A and VM-C, and the company was exempted from, or otherwise not subject to, the requirements of VM-20 in the prior year.

Exemption premium is determined as follows:
a. The amount reported in the prior calendar year life/health annual statement, Exhibit 1, Part 1, Column 3 (“Ordinary Life Insurance”), line 20.1; plus 
b. The portion of the amount in the prior calendar year life/health annual statement, Exhibit 1, Part 1, Column 3 (“Ordinary Life Insurance”), line 20.2 assumed from unaffiliated companies; minus 
c. Amounts included in either (a) or (b) that are associated with guaranteed issue insurance policies and/or preneed life insurance policies; minus 
d. Amounts included in either (a) or (b) that represent transfers of reserves in force as of the effective date of a reinsurance assumed transaction; plus 
e. Amounts of premium for individual life certificates issued under a group life certificate which meet the conditions defined in VM-20, Section 1.B, and that are not included in either (a) or (b).

Guidance Note: 
(i) Definitions of preneed and guaranteed issue insurance policy are in VM-01.
(ii) For statements of exemption filed for calendar year 2022 and beyond, the amount in subsection 2.e was reported in the prior calendar year life/health annual statement, VM-20 Reserve Supplement, Part 2, if applicable.

3. Policies and Certificates Excluded from the Life PBR Exemption:

   a. Universal life with secondary guarantee (ULSG) policies or certificates, or policies or certificates – other than ULSG – that contain a rider with a secondary guarantee, in which the secondary guarantee does not meet the VM-01 definition of a "non-material secondary guarantee.”

4. Each exemption, or lack of an exemption, outlined in subsection 1.G.1 – subsection 1.G.3 above applies only to policies or certificates issued or assumed in the current year, and it applies to all future valuation dates for those policies or certificates. However, if policies or certificates did not qualify for the Life PBR Exemption during the year of issue but would have qualified for the Life PBR Exemption if the current Valuation Manual requirements had been in effect during the year of issue, then the domiciliary commissioner may allow an exemption for such policies or certificates. The minimum reserve requirements for the ordinary life policies, including individual certificates under group life contracts which meet all the requirements in VM-20 Section 1.B, subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.

VM Change 4 – VM-20: Requirements for Principle-Based Reserves for Life Products

VM-20: Requirements for Principles-Based Reserves for Life Products

Section 1: Purpose

A. These requirements establish the minimum reserve valuation standard for individual life insurance policies issued on or after the operative date of the Valuation Manual and subject to a principle-based valuation with an NPR floor under Model #20. These requirements constitute the Commissioners Reserve Valuation Method (CRVM) for policies of individual life insurance.
B. Individual life certificates under a group life contract shall be subject to the requirements of VM-20 if all of the following are met. These requirements constitute the Commissioners Reserve Valuation Method (CRVM) for such certificates.

1. An individual risk selection process, defined as follows, is used to obtain group life insurance coverage;

An individual risk selection process is one that is based on characteristics of the insured(s) beyond sex, gender, age, tobacco usage, and membership in a particular group. This may include, but is not limited to, completion of an application (beyond acknowledgement of membership to the group, sex, gender and age), questionnaire(s), online health history or tele-interview to obtain non-medical and medical or health history information, prescription history information, avocations, usage of tobacco, family history, or submission of fluids such as blood, Home Office Specimens (HOS), or oral fluid. The resulting risk classification is determined based on the characteristics of the individual insured(s) rather than the group, if any, of which it is a member (e.g., employer, affinity, etc.). The individual certificate holder is charged a premium rate based solely on the individual risk selection process and not on membership in a specific group.

Guidance Note: The use of evidence of insurability does not by itself constitute an individual risk selection process. Use of information obtained from a census or question(s) regarding gender, occupation, age, income and/or tobacco usage solely for purposes of determining a rate classification does not by itself qualify a group as having used an individual risk selection process. Group insurance where the underwriting based on the characteristics of the group and census data but where some individuals are subjected to individual risk selection as a result of compensation level, age, an existing medical condition or impairment, late entry into the group, failure of the group to meet minimum participation requirements or voluntary buy-up of increased coverage does not meet the definition of an individual risk selection process.

2. The individual certificates utilize premiums or cost of insurance schedules and charges based on the individual applicant’s issue age, duration from underwriting, coverage amount and risk classification and there is a stated or implied schedule of maximum gross premiums or net cash surrender value required in order to continue coverage in force for a period in excess of one year;

Guidance Note: Coverage amount does not imply a requirement for banding of premiums or charges but rather rates or charges that are multiplied by number of units of coverage of face amount (or net amount at risk) per $1,000 to obtain the actual premium or charge.

3. The group master contract is designed, priced, solicited, and managed similar to individual ordinary life insurance policies rather than specific to the group as a whole;

4. The individual certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing, and risk classification to individual ordinary life insurance contracts.

5. The individual certificates are issued on or after the operative date of the Valuation Manual except election of the transition period in Section 2, subsection 1.F.1.
VM Change 5 - VM-20: Requirements for Principle-Based Reserves for Life Products

Section 2: Minimum Reserve

A. All policies subject to these requirements shall be included in one of the VM-20 Reserving Categories, as specified in Section 2.A.1, Section 2.A.2 and Section 2.A.3 below.

Guidance Note: Since group insurance subject to an individual risk selection process and meeting all the requirements in Section 1.B is subject to VM-20 requirements, Section 2.A shall apply—meaning that any such contracts will be included in one of the VM-20 Reserving Categories defined by Section 2.A.1, Section 2.A.2, and 2.A.3. All requirements in VM-31 which apply to a VM-20 Reserving Category shall apply to any group insurance subject to individual risk selection that has been included in that VM-20 Reserving Category.

The company may elect to exclude one or more groups of policies from the stochastic reserve calculation and/or the deterministic reserve calculation. When excluding a group of policies from a reserve calculation, the company must document that the applicable exclusion test defined in Section 6 is passed for that group of policies. The minimum reserve for each VM-20 Reserving Category is defined by Section 2.A.1, Section 2.A.2 and Section 2.A.3, and the total minimum reserve equals the sum of the Section 2.A.1, Section 2.A.2 and Section 2.A.3 results below, defined as:
Refer to NAIC Blanks (E) Working Group, request for modification to the supplemental report for the Life PBR Exemption, to show the premiums for group life that utilized an individual risk selection process and meets all of the requirements in VM-20 Section 1.B. as these premiums are currently grouped together with other group insurance in Exhibit 1. As there are other instances where the ordinary life premiums are not included in the determination of the Life PBR Exemption (e.g., for guaranteed issue policies), it may be useful to request addition of the breakdown of premiums used to determine the exemption.

Possible insertion between questions 1 and 2 for disclosure of premiums used in the determination of eligibility for the Life PBR exemption, split by ordinary life and group subject to an individual risk selection process and meeting all of the requirements in VM-20 Section 1.B.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

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

Joint submission by NAIC staff and Staff of Office of Principle-Based Reserving, California Department of Insurance – Clarify areas of confusion relating to the topic of materiality.

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


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

See attached Appendix.

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

See attached Appendix.

NAIC Staff Comments:

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Appendix

ISSUE:

Skipping steps in VM-20 is not allowed on grounds of immateriality. Some companies are skipping some VM-20 requirements altogether, without providing a simplification, approximation, or modeling technique that satisfies the VM-20 Section 2.G requirement that such simplifications neither materially understate nor downwardly bias the reserves. Simply skipping portions of the requirements, such as not computing an NPR, or not computing the DR and/or SR when exclusion tests have not been performed, inherently bias the reserve downward since their omission can only be neutral or decrease the resulting reserve. Without computing even a simplified model for Section 2.G analysis that shows there is not a decrease in the final reserve, this makes the skipping of the step violate Section 2.G. This APF clarifies that these types of omissions are not allowed. This has always been the case, but perhaps needs more emphasis in the Valuation Manual.

SECTION:

VM-20 Section 2.H and new Section 2.I, and VM-20 Section 7.E.1.g

REDLINE:

VM-20 Section 2.H

H. The company shall establish, for the DR and SR, a standard containing the criteria for determining whether an assumption, risk factor or other element of the principle-based valuation has a material impact on the size of the reserve. This standard shall be applied when identifying material risks under VM-20 Section 9.B.1. Such a standard shall also apply to the NPR with respect to VM-20 Section 2.G.

Guidance Note:

For example, the standard may be expressed as an impact of more than X dollars or Y% of the reserve, whichever is greater, where X and Y are chosen in a manner that is meant to stand the test of time and not need periodic revision.

The standard is based on the impact relative to the size of the NPR, DR and SR as opposed to the impact relative to the overall financial statement (e.g., total company reserves or surplus). Reviewing items that may lead to a material misstatement of the financial statement in the current year is appropriate in its own context, but it is not appropriate for identifying material risks for PBR, which itself is an emerging risk.

Note that the criteria apply to the NPR, DR and SR, and not just the final reported reserve. For example, if the DR is less than the NPR, the criteria still apply to the DR.

The standard also applies to exclusion tests, as they are an element of the principle-based valuation.
(new) VM-20 Section 2.I

I. Section 2.G and Section 2.H provide companies some flexibility in assumption setting and modeling methodologies, but they do not allow for skipping mandated steps without providing a valid approximation, simplification, or modeling technique under Section 2.G that neither materially understates nor downwardly biases the reserve.

Examples of omissions that would not satisfy VM-20 Section 2.G: not computing even a simplified NPR, not computing even a simplified DR or SR without having passed the relevant exclusion test(s), omitting prescribed mortality margins, not establishing any lapse margins, not building even a simplified asset model for the DR, using the alternative investment strategy without first determining that it produces a higher reserve than the company investment strategy, and ignoring post-level term losses.

Guidance Note: The issue here is not the use of approximations; it is about skipping mandated VM-20 requirements. Thus, for example, this does not rule out the use of a relatively simple asset model that is acceptable pursuant to VM-20 Section 7.E.1.a, nor the judicious use of the previous year’s assumption development work to save time and effort.

VM-20 Section 7.E.1.g Guidance Note

Guidance Note: VM-31 requires a demonstration of compliance with VM-20 Section 7.E.1.g. In many cases, particularly if the model investment strategy does not involve callable assets, it is expected that the demonstration of compliance will not require running the reserve calculation twice. For example, an analysis of the weighted average net reinvestment spread on new purchases by projection year (gross spread minus prescribed default costs minus investment expenses) of the model investment strategy compared to the weighted average net reinvestment spreads by projection year of the alternative strategy may suffice. The assumed mix of asset types, asset credit quality or the levels of non-prescribed spreads for other fixed income investments may need to be adjusted to achieve compliance. Or, the company may be able to rely on a previous year’s determination as to which strategy produces a higher reserve, if the assets and strategy have not changed very substantially since then.
REASONING:

Some companies have mistakenly believed that it was permissible to skip certain significant steps outlined in VM-20, without using a valid approximation or simplification that they have shown does not materially understate or bias reserves in a downward direction.

Note: Comment letters were received on an earlier draft of this APF, in response to which this newer version has eliminated any mention of PIMR and has made it clearer that a simplified asset model may in some circumstances be acceptable and that a full-blown run of both the actual investment strategy and the alternative investment strategy is not necessarily something that has to be done every year.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

Identification:
Rachel Hemphill, Texas Department of Insurance

Title of the Issue:
Clarify NPR calculation requirements.

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

VM-20 Section 3.B.1 – 3.B.3, and VM-20 Section 3.B.6.d.i

January 1, 2020 NAIC Valuation Manual

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

See attached.

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

Clarify any confusion on whether more direct calculations of the NPR to reflect non-annual premium modes, etc., are allowed. The current guidance note in Section 3.B.3 states that these may be reflected either “directly or through adjusting accounting entries”. However, due to some confusion on this point, I suggest emphasizing that more direct calculation methods are not prohibited. This is consistent with SSAP 51R, Paragraph 24:

24. Since terminal reserves are computed as of the end of a policy year and not the reporting date, the terminal reserve as of policy anniversaries immediately prior and subsequent to the reporting date are adjusted to reflect that portion of the net premium that is unearned at the reporting date.
This is generally accomplished using either the mean reserve method or the mid-terminal method as discussed in paragraphs 25-28. Other appropriate methods, including an exact reserve valuation, may also be used.

For re-exposure, to address both the question posed in the initial exposure of clearly reflecting both mean and mid-terminal adjustments, as well as to address comments received, I recommend language consistent with SSAP 51R, paragraph 24. SSAP 51R paragraphs 25–28 are referenced by paragraph 24. They are provided below for completeness, and specific references for policies subject to the Valuation Manual are highlighted.

**Mean Reserve Method**

25. Under the mean reserve method, the policy reserve equals the average of the terminal reserve at the end of the policy year and the initial reserve (the initial reserve is equal to the previous year’s terminal reserve plus the net annual valuation premium for the current policy year). When reserves are calculated on the mean reserve basis, it is assumed that the net premium for a policy is collected annually at the beginning of the policy year and that policies are issued ratably over the calendar year.

26. However, as premiums are often received in installments more frequently than annually and since the calculation of mean reserves assumes payment of the current policy year’s entire net annual premium, the policy reserve is overstated by the amount of net modal premiums not yet received for the current policy year as of the valuation date. As a result, it is necessary to compute and report a special asset to offset the overstatement of the policy reserve.

27. This special asset is termed “deferred premiums.” Deferred premiums are computed by taking the gross premium (or premiums) extending from (and including) the modal (monthly, quarterly, semiannual) premium due date or dates following the valuation date to the next policy anniversary date and subtracting any such deferred premiums that have actually been collected. Deferred premium assets shall also be reduced by loading. Since the calculation of mean reserves assumes payment of the current policy year’s entire net annual premium, deferred premium assets are considered admitted assets to compensate for the overstatement of the policy reserve. For policies subject to the Valuation Manual requirements, the deferred premium asset will continue to be calculated for the net premium reserve component of the total principle-based reserve.

**Mid-Terminal Method**

28. Under the mid-terminal method, the policy reserves are calculated as the average of the terminal reserves on the previous and the next policy anniversaries. These reserves shall be accompanied by an unearned premium reserve consisting of the portion of valuation premiums paid or due covering the period from the valuation date to the next policy anniversary date. For policies subject to the Valuation Manual requirements, the adjustment to the unearned premium reserve will continue to be calculated for the net premium reserve component of the total principle-based reserve.

Since the guidance note at the end of Section 3.B.3 contains requirements and not just guidance, it should be taken out of a guidance note. This requires moving the four terms to Section 3.B.1 and updating two cross references in VM-20 Section 3.B.6.d.i.

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

NAIC Staff Comments
VM-20 Section 3.B.1 – 3.B.3

B. NPR Calculation

1. For the purposes of Section 3, the following terms apply:
   a. A policy with “multiple secondary guarantees” is one that: a) simultaneously has more than
      one shadow account; b) simultaneously has more than one cumulative premium type of
      guarantee; or c) simultaneously has at least one of each. A single shadow account with a variety
      of possible end dates to the secondary guarantee, depending on the policyholder’s choice of
      funding level, constitutes a single—not multiple—secondary guarantee.

Guidance Note:
Policy designs that are created simply to disguise guarantees or exploit a perceived loophole must
be treated in a manner similar to more typical product designs with similar guarantees. If a policy
contains multiple secondary guarantees, such that a subset of those secondary guarantees in
combination represent an implicit guarantee that would produce a higher NPR if that implicit
guarantee were treated as an explicit secondary guarantee of the policy, then the policy should be
treated as if that implicit guarantee were an explicit guarantee. For example, if there were a policy
with a “sequential secondary guarantee” where only one secondary guarantee applied at any given
point in time but with a series of secondary guarantees strung together with one period ending when
the next one began, the combined terms of the secondary guarantees would be regarded as a single
secondary guarantee.

b. The “fully funded secondary guarantee” at any time is:
   1. For a shadow account secondary guarantee, the minimum shadow account fund value
      necessary to fully fund the secondary guarantee for the policy at that time. For any policy
      for which the secondary guarantee contractually cannot be fully funded in advance, this
      shall be the present value of the contractually permitted premium stream that would fully
      fund the guarantee at the earliest possible date (using the valuation interest rate and
      mortality standard specified in Section 3.C).
   2. For a cumulative premium secondary guarantee, the amount of cumulative premiums
      required to have been paid to that time that would result in no future premium requirements
      to fully fund the guarantee, accumulated with any interest or accumulation factors per the
      contract provisions for the secondary guarantee. For any policy for which the secondary
      guarantee contractually cannot be fully funded in advance, this shall be the present value
      of the contractually permitted premium stream that would fully fund the guarantee at the
      earliest possible date (using the valuation interest rate and mortality standard specified in
      Section 3.C).

c. The “actual secondary guarantee” at any time is:
   1. For a shadow account secondary guarantee, the actual shadow account fund value at that
      time.
   2. For a cumulative premium secondary guarantee, the actual premiums paid to that point
      in time, accumulated with any interest or accumulation factors per the contract provisions
      for the secondary guarantee.

d. The “level secondary guarantee” at any time is:
   1. For a shadow account secondary guarantee, the shadow account fund value that would
      have existed at that time assuming payment of the level gross premium determined
      according to Section 3.B.6.c.i.
ii. For a cumulative premium secondary guarantee, the amount of cumulative level gross premiums determined according to Section 3.B.6.c.i, accumulated with any interest or accumulation factors per the contract provisions for the secondary guarantee.

2. Section 3.B.4, Section 3.B.5 and Section 3.B.6 provide the calculation of a terminal NPR under the assumption of an annual mode gross premium. In Section 3.B.4, Section 3.B.5 and Section 3.B.6, the gross premium referenced is the gross premium for the policy assuming an annual premium mode.

3. Since terminal NPRs are computed as of the end of a policy year and not the reporting date, the terminal NPR as of policy anniversaries immediately prior and subsequent to the reporting date are adjusted to reflect that portion of the net premium that is unearned at the reporting date. This is generally accomplished using either the mean reserve method or the mid-terminal method as discussed in SSAP 51R. Other appropriate methods, including an exact reserve valuation, may also be used.

VM-20 Section 3.B.6.d.i

As of the valuation date for the policy being valued, determine the actual secondary guarantee, denoted ASGx+t, as outlined in Section 3.B.4.c and the fully funded secondary guarantee, denoted FFSGx+t, as outlined in Section 3.B.1.b.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

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

Tim Cardinal, FSA, MAAA, CERA. Cardinalis 1 Consulting.
Clarity and introduce a third permissible technique for the calculation of company experience rates.

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


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

See attached Appendix.

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

See attached Appendix and Excel file.
Appendix

SECTION:

REDLINE:
9.C.2.d.vi. If the company uses the aggregate comp any experience for a group of mortality segments when determining the company experience mortality rates for each of the individual mortality segments in the group, the company shall use one of the following methods:

a. Use techniques to further subdivide the aggregate experience into the various mortality segments (e.g., start with aggregate non-smoker and then use the conservation of total deaths principle, normalization or other approach to divide the aggregate mortality into super preferred, preferred and residual standard non-smoker class assumptions).

b. Use techniques to adjust the experience of each mortality segment in the group to reflect the aggregate company experience for the group (e.g., by credibility weighting the individual mortality segment experience with the aggregate company experience for the group).

c. Use a two-step sequential method, which
   1) forms subgroups which are groups of mortality segments and are subsets of the aggregate class of mortality segments being aggregated,
   2) uses techniques as in (b) to adjust the experience of each subgroup from (1) to reflect the aggregate company experience for the group and conserve deaths, and
   3) finally, uses techniques as in (a) to further subdivide the subgroups' adjusted experience from (2) into the various mortality segments while conserving each subgroup's deaths determined in step (2)'s conservation of deaths.

For example, if mortality segments vary by sex, risk class, and face bands, then
   1) segments that differ by face band are aggregated to form subgroups that vary just by sex and risk class,
   2) the subgroups' mortality experience is credibility weighted with the aggregate company experience for the group and normalized, and
   3) the subgroups' adjusted mortality experience are then subdivided into the various mortality segments based on credible, external face band relativities and conservation of deaths is applied to each subgroup's normalized deaths determined in (2).

REASONING:
A minor point is clarity. “Either” can mean one or both. The intent is one of a) or b) but not both. The major issue is both a) and b) have weaknesses in contexts with high levels of granularity resulting in a large number of mortality segments such as 120 or 360 segments. For example consider a block with 360 mortality segments determined by 2 sexes x 6 risk classes x 5 face bands x 3 product types x 2 underwriting types (such as full and accelerated). A company may have very high credibility for each of the 12 segments as determined by 2 sexes x 6 risk classes but have very low credibility for each of the 360 segments. Both a) and b) could produce company experience rates that negate the very reasons a company uses a high level of granularity. Using b) for example, all segment rates would be equal to the aggregate A/E rates, which is equivalent to no granularity. By applying b) to subgroups and applying a) to divide the subgroups, the proposed technique c) is more robust drawing upon a) and b)'s strengths.
while mitigating their weakness. If there is one subgroup which is the aggregate then a) is a special case of c). If each subgroup is a segment then b) is a special case of c). See the attached excel file that adds two examples to the NAIC examples for a) and b). Example 8 is an example of a correct way to apply c) and Example 9 is an incorrect way.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

Identification:
Rachel Hemphill, Texas Department of Insurance

Title of the Issue:
1. Modify Life PBR Exemption to not require annual exemption requests if the company continues to
meet the premium thresholds and does not have any ULSG with material SG.
2. Not require VM-20 when all new issues arise due to policyholders exercising guarantees or options
(e.g. for conversion) in existing policies valued under VM-A/VM-C.

2. Identify the document, including the date if the document is “released for comment,” and the location in
the document where the amendment is proposed:
Valuation Manual Section II, Subsection 1.D
January 1, 2020 NAIC Valuation Manual

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

4. State the reason for the proposed amendment? (You may do this through an attachment.)
Reduce filing burden for companies and state regulators by making the Life PBR Exemption a one-time
filing until conditions for the exemption change. Allow exemption for companies that do not meet the
premium thresholds, but are only issuing new policies that would be subject to VM-20 due to policyholders
exercising guarantees or options (e.g. for conversion) from existing policies being valued under the pre-
PBR framework.

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

NAIC Staff Comments:
Valuation Manual Section II, Subsection 1.D

D. Life PBR Exemption

1. A company meeting at least one of the conditions in D.2 below may file a statement of exemption for ordinary life insurance policies, except for policies in D.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. If a company has no business issued directly or assumed during the current calendar year that would otherwise be subject to VM-20, a statement of exemption is not required. For a filed statement of exemption, the statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that at least one of the two conditions in D.2 was met and the statement of exemption must also be included with the NAIC filing for the second quarter of that year.

The domiciliary commissioner may reject such statement prior to Sept. 1 and require the company to follow the requirements of VM-20 for the ordinary life policies covered by the statement.

If a filed statement of exemption is not rejected by the domiciliary commissioner, the filing of subsequent statements of exemption is not required as long as the company continues to qualify for the exemption; rather, ongoing statements of exemption for each new calendar year will be deemed not to be rejected, unless: 1) the company fails to meet either condition in D.2 below, 2) the policies contain those in D.3 below, or 3) the domiciliary commissioner contacts the company prior to Sept. 1 and notifies them that the statement of exemption is rejected. If any of these three events occur, then the statement of exemption for the current calendar year is rejected and a new statement of exemption must be filed and not rejected in order for the company to exempt additional policies. In the case of an ongoing statement of exemption, rather than include a statement of exemption with the NAIC filing for the second quarter of that year, the company should enter “SEE EXPLANATION” in response to the Life PBR Exemption supplemental interrogatory and provide as an explanation that the company is utilizing an ongoing statement of exemption.

2. Conditions for Exemption:
   a. The company has less than $300 million of ordinary life premiums, and if the company is a member of an NAIC group of life insurers, the group has combined ordinary life premiums of less than $600 million.
   b. The only new policies subject to VM-20 being issued or assumed by the company are due to election of policy benefits or features from existing policies that are being valued under VM-A and VM-C and the company was exempted from, or otherwise not subject to, the requirements of VM-20 in the prior year.

3. Policies Excluded from the Life PBR Exemption:
   a. Universal life with secondary guarantee (ULSG) policies with a secondary guarantee that does not meet the VM-01, Definitions for Terms in Requirements, definition of a “non-material secondary guarantee.”

4. Each exemption, or lack of an exemption, applies only to policies issued or assumed in the current year, and it applies to all future valuation dates for those policies. The minimum reserve requirements for the ordinary life policies subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.
Valuation Manual Section II, Subsection 1.D - Footnote

1 Premiums are measured as total (first year, single, and renewal) direct plus total (first year, single, and renewal) reinsurance assumed from an unaffiliated company from the ordinary life line of business reported in the prior calendar year life/health annual financial statement, Exhibit 1, Part 1, Column 3, “Ordinary Life Insurance” excluding premiums for guaranteed issue policies and preneed life contracts and excluding amounts that represent the transfer of reserves in force as of the effective date of a reinsurance assumed transaction and are reported in Exhibit 1 Part 1, Column 3 as ordinary life insurance premium. Preneed is as defined in VM-01.
Life Actuarial (A) Task Force
Amendment Proposal Form 2020-10
Exposed for a 12-day public comment period ending June 7, 2021

Request for Comment: During the exposure, commenters are specifically asked to address the four versions exposed for the handling of YRT for the 2017-2019 issue years.

Please submit comments to Reggie Mazyck (RMazyck@naic.org) by COB 5/25/21.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

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


Reflect a prudent level of mortality improvement beyond the valuation date.

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


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

See attached Appendix.

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

We propose to reflect a prudent level of mortality improvement beyond the valuation date, using SOA analysis for best estimate future mortality improvement and margin. The requirements also need to be clarified for the handling of historical or anticipated future mortality deterioration (i.e., negative improvement).

With the reflection of a prudent level of future mortality improvement in the mortality assumption, the interim 1/2cx approach to YRT is a reasonable consideration for a long-term approach.

For LATF consideration for re-exposure, there are four versions of the handling of the 2017-2019 issue year carveout from the interim YRT solution: 1) the original exposure, removing the carveout with the 1/2cx being made a longer term approach, 2) a modified version that removes the carveout, but makes that removal contingent on the first set of SOA future mortality rates being adopted, in case of delay, 3) a modified version that removes the carveout, but allows for a phase-in of the effect of this change, and 4) a version making the carveout long-term. These versions are presented starting on Page 6 of this document, after the other edits which do not vary based on this options.
Appendix

VM-20 Section 6.A.2.b.v:

v. Anticipated mortality improvement beyond the projection start date shall be reflected in the mortality assumption for the purpose of calculating the stochastic exclusion ratio. The future mortality improvement factors shall be no greater than the unloaded factors determined by the SOA, adopted by LATF, and published on the SOA website, at [link/reference to SOA site TBD].

Guidance Note: Mortality improvement may be positive or negative (i.e., deterioration). The anticipated mortality improvement may be lower than the rates published by the SOA, for example, if the company’s best estimate for mortality improvement for a particular block, such as simplified issue, is lower. Prior to adoption by LATF of the first set of future mortality improvement factors, the future mortality improvement rates shall be 0%.

To allow time for companies to reflect the updated mortality improvement rates, the rates that are to be used in the year-end YYYY valuation should be adopted by LATF and published on the SOA website by September of YYYY. If this timeline is not met, then at the company’s option they may use the mortality improvement rates for the prior year (year YYYY-1).

VM-20 Section 9.C.2.h:

h. Mortality improvement shall not be incorporated beyond the valuation date in the company experience mortality rates. However, historical mortality improvement from the central point of the underlying company experience data to the valuation date may be incorporated.

Guidance Note: Future mortality improvement is not applied to the company experience mortality rates, since it would be duplicative of the future mortality improvement that is applied to the prudent estimate assumptions for mortality in Section 9.C.7.f.

VM-20 Section 9.C.3.g:

g. Mortality improvement shall not be incorporated beyond the valuation date in the industry basic table. However, historical mortality improvement from the date of the industry basic table (e.g., Jan. 1, 2008, for the 2008 VBT and July 1, 2015, for the 2015 VBT) to the valuation date shall be incorporated using the improvement factors for the applicable industry basic table as determined by the SOA, adopted by LATF, and published on the SOA website, https://www.soa.org/research/topics/indiv-val-exp-study-list/ (Mortality Improvement Rates for AG-38 for Year-End YYYY).

Guidance Note: Future mortality improvement is not applied to the industry basic table, since it would be duplicative of the future mortality improvement that is applied to the prudent estimate assumptions for mortality in Section 9.C.7.f.
To allow time for companies to reflect the updated mortality improvement rates, the rates that are to be used in the year-end YYYY valuation should be adopted by LATF and published on the SOA website by September of YYYY. If this timeline is not met, then at the company’s option they may use the most recent set of prior mortality improvement rates adopted by LATF and published on the SOA website.

VM-20 Section 9.C.7.a:
If applicable industry basic tables are used in lieu of company experience as the anticipated experience assumptions, or if the level of credibility of the data as provided in Section 9.C.5 is less than 20%, the prudent estimate assumptions for each mortality segment shall equal the respective mortality rates in the applicable industry basic tables as provided in Section 9.C.3, adjusted as necessary pursuant to Section 9.C.7.e and for any applicable improvement pursuant to Section 9.C.3.g, plus the prescribed margin as provided in Section 9.C.6.c, plus any applicable additional margin pursuant to Section 9.C.6.d.v and/or Section 9.C.6.d.vi. Future mortality improvement, pursuant to Section 9.C.7.f, shall be applied to the prudent estimate assumption for mortality.

Section 9.C.7.b.vi:
Beginning in the first policy duration after policy duration E, the prudent estimate mortality assumptions for each policy in a given mortality segment are determined as a weighted average of the company experience mortality rates with margins and the applicable industry basic table with margins, in which the weights on the company rates grade linearly from 100% down to 0%. This grading must be completed—i.e., must reach 100% of industry table—no later than the beginning of the first policy duration after policy duration Z (the determination of the applicable industry basic table is described in Section 9.C.3). Thus, the prudent estimate mortality rate, prior to any adjustments pursuant to Sections 9.C.7.c, 9.C.7.d, 9.C.7.e and 9.C.7.f below, is:

VM-20 Section 9.C.7.f (new section):
Twenty years of future mortality improvement that the company anticipates beyond the valuation date shall be applied to the prudent estimate assumptions for mortality, using prudent future mortality improvement factors no greater than the loaded factors determined by the SOA, adopted by LATF, and published on the SOA website, at [link/reference to SOA site TBD].

Guidance Note: Mortality improvement may be positive or negative (i.e., deterioration). The anticipated mortality improvement may be lower than the rates published by the SOA, even zero, for example, if the company’s best estimate for mortality improvement for a particular block, such as simplified issue, is lower. Prior to adoption by LATF of the first set of future mortality improvement factors, the future mortality improvement rates shall be 0%.

To allow time for companies to reflect the updated mortality improvement rates, the rates that are to be used in the year-end YYYY valuation should be adopted by LATF and published on the SOA website by September of YYYY. If this timeline is not met, then at the company’s option they may use the mortality improvement rates for the prior year (year YYYY-1).
VM-31 Section 3.D.3.i:

i. **Mortality Improvement** – Description of and rationale for the mortality improvement assumptions applied up to the valuation date and the mortality improvement assumptions applied beyond the valuation date. Such a description shall include the assumed start and end dates of the improvements and a table of the annual improvement percentage(s) used, both without and with margin, separately for company experience and the industry basic table(s), along with a sample calculation of the adjustment (e.g., for a male preferred nonsmoker age 45).

VM-31 Section 3.D.11.c.i:

i. If the company believes the method used to determine anticipated experience mortality assumptions includes an implicit margin, the company can adjust the anticipated experience assumptions to remove this implicit margin for this reporting purpose only. If any such adjustment is made, the company shall document the rationale and method used to determine the anticipated experience assumption.

*Deleted*: Adjustments for any adjustments to mortality assumptions for...
C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled; see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.

VM-20 Section 8.C.18 and Guidance Note:

18.

When the reinsurance ceded or assumed is on a non-guaranteed YRT or similar basis, the corresponding reinsurance cash flows do not need to be modeled. Rather, for a ceding company, the post-reinsurance-ceded DR or SR shall be the pre-reinsurance-ceded DR or SR pursuant to Section 8.D.2, plus any applicable provision pursuant to Section 8.C.15 and Section 8.C.17, minus the NPR reinsurance credit from Section 8.B. For an assuming company, the DR or SR for the business assumed on a non-guaranteed YRT or similar basis shall be set equal to the NPR from Section 3.B.8, plus any applicable provision pursuant to Section 8.C.16 and Section 8.C.17. In the case where there are also other reinsurance arrangements that are not on a non-guaranteed YRT or similar basis, the reinsurance credit shall include the modeled reinsurance credit reflecting those other reinsurance arrangements. In particular, where there are also other reinsurance arrangements that are dependent on the non-guaranteed YRT or similar actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.

Deleted: For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020:

The above method is an interim approach. A longer-term solution to YRT is intended to be adopted by state insurance regulators, after state insurance regulators and industry have had additional time to consider and evaluate the variety of approaches that have been put forward as a potential long-term solution.
2017-2019 for Long-Term YRT – Version 2:

VM-20 Section 8.C, introductory paragraph:

C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020 up until adoption by LATF of the first set of unloaded future mortality improvement factors, at which point this shall apply for all policies issued on or after Jan. 1, 2017:

For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled; see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.

VM-20 Section 8.C.18 and Guidance Note:

18. For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020 up until adoption by LATF of the first set of unloaded future mortality improvement factors, at which point this shall apply for all policies issued on or after Jan. 1, 2017:

When the reinsurance ceded or assumed is on a non-guaranteed YRT or similar basis, the corresponding reinsurance cash flows do not need to be modeled. Rather, for a ceding company, the post-reinsurance-ceded DR or SR shall be the pre-reinsurance-ceded DR or SR pursuant to Section 8.D.2, plus any applicable provision pursuant to Section 8.C.15 and Section 8.C.17, minus the NPR reinsurance credit from Section 8.B. For an assuming company, the DR or SR for the business assumed on a non-guaranteed YRT or similar basis shall be set equal to the NPR from Section 3.B.8, plus any applicable provision pursuant to Section 8.C.16 and Section 8.C.17. In the case where there are also other reinsurance arrangements that are not on a non-guaranteed YRT or similar basis, the reinsurance credit shall include the modeled reinsurance credit reflecting those other reinsurance arrangements. In particular, where there are also other reinsurance arrangements that are dependent on the non-guaranteed YRT or similar actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.

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Guidance Note: The above method is an interim approach. A longer-term solution to YRT is intended to be adopted by state insurance regulators, after state insurance regulators and industry have had additional time to consider and evaluate the variety of approaches that have been put forward as a potential longer-term solution.
2017-2019 for Long-Term YRT – Version 3:

C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled; see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.

For policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020, the company may elect, with domiciliary commissioner approval, a phase-in of the current methodology for non-guaranteed YRT reinsurance with allowance for future mortality improvement from the methodology in the 2021 Valuation Manual for non-guaranteed YRT reinsurance without allowance for future mortality improvement, provided that the company uses a weighted average of the results from the two methodologies, with the weight for the prior methodology being no more than (20XX-YYYY)/(20XX-2021), where YYYY is the current valuation year and 20XX is the final year of the phase-in. A company may elect to phase in these requirements over a 3-year period beginning Jan. 1, 2022 and ending Dec. 31, 2024. A company may elect a longer phase-in period of up to seven years beginning Jan. 1, 2022 and ending Dec. 31, 2028, with approval of the domiciliary commissioner.

VM-20 Section 8.C.18 and Guidance Note:

18.

When the reinsurance ceded or assumed is on a non-guaranteed YRT or similar basis, the corresponding reinsurance cash flows do not need to be modeled. Rather, for a ceding company, the post-reinsurance-ceded DR or SR shall be the pre-reinsurance-ceded DR or SR pursuant to Section 8.D.2, plus any applicable provision pursuant to Section 8.C.15 and Section 8.C.17, minus the NPR reinsurance credit from Section 8.B. For an assuming company, the DR or SR for the business assumed on a non-guaranteed YRT or similar basis shall be set equal to the NPR from Section 3.B.8, plus any applicable provision pursuant to Section 8.C.16 and Section 8.C.17. In the case where there are also other reinsurance arrangements that are not on a non-guaranteed YRT or similar basis, the reinsurance credit shall include the modeled reinsurance credit reflecting those other reinsurance arrangements. In particular, where there are also other reinsurance arrangements that are dependent on the non-guaranteed YRT or similar actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.

For policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020, the company may elect, with domiciliary commissioner approval, a phase-in of the current methodology for non-guaranteed YRT reinsurance with allowance for future mortality improvement from the methodology in the 2021 Valuation Manual for non-guaranteed YRT reinsurance without allowance for future mortality improvement, provided that the company uses a weighted average of the results from the two methodologies, with the weight for the prior methodology being no more than (20XX-YYYY)/(20XX-2021), where YYYY is the
current valuation year and 20XX is the final year of the phase-in. A company may elect to phase in these requirements over a 3-year period beginning Jan. 1, 2022 and ending Dec. 31, 2024. A company may elect a longer phase-in period of up to seven years beginning Jan. 1, 2022 and ending Dec. 31, 2028, with approval of the domiciliary commissioner.

VM-31 Section 3.D.8.g (new):

g. Phase-In: If electing a phase-in period as described in VM-20 Section 8.C, documentation of the length of the phase-in approved by the company’s domiciliary commissioner, the result of the current and prior methodologies, the weights applied to each result, and confirmation that reinsurance assumptions for the calculation of the prior methodology are discussed in Section 3.D.8.h above.
2017-2019 for Long-Term YRT – Version 4:

C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020:

For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled; see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.

VM-20 Section 8.C.18 and Guidance Note:

18. For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020:

When the reinsurance ceded or assumed is on a non-guaranteed YRT or similar basis, the corresponding reinsurance cash flows do not need to be modeled. Rather, for a ceding company, the post-reinsurance-ceded DR or SR shall be the pre-reinsurance-ceded DR or SR pursuant to Section 8.D.2, plus any applicable provision pursuant to Section 8.C.15 and Section 8.C.17, minus the NPR reinsurance credit from Section 8.B. For an assuming company, the DR or SR for the business assumed on a non-guaranteed YRT or similar basis shall be set equal to the NPR from Section 3.B.8, plus any applicable provision pursuant to Section 8.C.16 and Section 8.C.17. In the case where there are also other reinsurance arrangements that are not on a non-guaranteed YRT or similar basis, the reinsurance credit shall include the modeled reinsurance credit reflecting those other reinsurance arrangements. In particular, where there are also other reinsurance arrangements that are dependent on the non-guaranteed YRT or similar actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.

Deleted: Guidance Note: The above method is an interim approach. A longer-term solution to YRT is intended to be adopted by state insurance regulators, after state insurance regulators and industry have had additional time to consider and evaluate the variety of approaches that have been put forward as a potential longer-term solution.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

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

Rachel Hemphill, TDI – Allows exemption of policies from prior issue years when there is a change in the Life PBR Exemption requirements.

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


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

Valuation Manual Section II, Subsection 1.D

D. Life PBR Exemption

1. A company meeting the at least one of the conditions in D.2 below may file a statement of exemption for ordinary life insurance policies, except for policies in D.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. If a company has no business issued directly or assumed during the current calendar year that would otherwise be subject to VM-20, a statement of exemption is not required. For a filed statement of exemption, the statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that at least one of the two conditions in D.2 was met based on premiums from the prior calendar year annual statement and the statement of exemption must also be included with the NAIC filing for the second quarter of that year.

The domiciliary commissioner may reject such statement prior to Sept. 1 and require the company to follow the requirements of VM-20 for the ordinary life policies covered by the statement.

If a filed statement of exemption is not rejected by the domiciliary commissioner, the filing of subsequent statements of exemption is not required as long as the company continues to qualify for the exemption; rather, ongoing statements of exemption for each new calendar year will be deemed not to be rejected, unless: 1) the company does not meet either condition in D.2 below, 2) the policies contain those in D.3 below, or 3) the domiciliary commissioner contacts the company prior to Sept. 1 and notifies them that the statement of exemption is rejected. If any of these three events occur, then the statement of exemption for the current calendar year is rejected and a new statement of exemption must be filed and not rejected in order for the company to exempt additional policies. In the case of an ongoing statement of exemption, rather than include a statement of exemption with the NAIC filing for the second quarter of that year, the company should enter “SEE

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EXPLANATION™ in response to the Life PBR Exemption supplemental interrogatory and provide as an explanation that the company is utilizing an ongoing statement of exemption.

2. Conditions for Exemption:
   a. The company has less than $300 million of ordinary life premiums1, and if the company is a member of an NAIC group of life insurers, the group has combined ordinary life premiums1 of less than $600 million; or
   b. The only new policies that would otherwise be subject to VM-20 being issued or assumed by the company are due to election of policy benefits or features from existing policies valued under VM-A and VM-C and the company was exempted from, or otherwise not subject to, the requirements of VM-20 in the prior year.

3. Policies Excluded from the Life PBR Exemption:
   a. Universal life with secondary guarantee (ULSG) policies with a secondary guarantee that does not meet the VM-01, Definitions for Terms in Requirements, definition of a “non-material secondary guarantee.”

4. Each exemption, or lack of an exemption, outlined in D.1 – D.3 above applies only to policies issued or assumed in the current year, and it applies to all future valuation dates for those policies. However, if policies did not qualify for the Life PBR Exemption during the year of issue but would have qualified for the Life PBR Exemption if the current Valuation Manual requirements had been in effect during the year of issue, then the domiciliary commissioner may allow an exemption for such policies. The minimum reserve requirements for the ordinary life policies subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.

Valuation Manual Section II, Subsection 1.D - Footnote

1 Premiums are measured as total (first year, single, and renewal) direct plus total (first year, single, and renewal) reinsurance assumed from an unaffiliated company from the ordinary life line of business reported in the prior calendar year life/health annual financial statement, Exhibit 1, Part 1, Column 3, “Ordinary Life Insurance” excluding premiums for guaranteed issue policies and preneed life contracts and excluding amounts that represent the transfer of reserves in force as of the effective date of a reinsurance assumed transaction and are reported in Exhibit 1 Part 1, Column 3 as ordinary life insurance premium. Preneed is as defined in VM-01.

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

Addresses the exemption of policies issued in 2020 and 2021 (such as conversions) that may be exempted under the 2022 Valuation Manual requirements but did not qualify under the 2020 or 2021 Valuation Manual requirements.
### Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force Amendment Proposal Form*

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

   **Identification:**
   Dany Provencher, Appointed Actuary, Industrial Alliance group of companies

   **Title of the issue:**
   Asset collar when modeled reserve is negative

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

   **Valuation Manual, Jan. 1 2020 Edition**
   VM-20 Section 7.D.3

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

   If for all model segments combined, the aggregate annual statement value of the final starting assets, less the corresponding PIMR balance, is
   (a) less than 98% of the modeled reserve; or
   (i) 98% of the modeled reserve if modeled reserve is positive;  
   (ii) 102% of the modeled reserve if modeled reserve is negative; or
   (b) greater than the largest of:
   (i) 102% of the modeled reserve;  
   (ii) the NPR for the same set of policies, net of due and deferred premiums thereon; and
   (iii) zero,
   then the company shall provide documentation in the PBR Actuarial Report that provides reasonable assurance that the modeled reserve is not materially understated as a result of the estimate of the amount of starting assets.

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

   If modeled reserve is negative, using assets corresponding to 100% of modeled reserve, would not fall within the asset collar.

---

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.
Life Actuarial (A) Task Force
Amendment Proposal Form 2021-03
Exposed for a 21-day public comment period ending May 3, 2021

The proposed guidance note presumes that Section 6.C.5.n refers to how cohorts and weights are unaffected by changes in interest rates at each reporting date because the discount rate for the calculations is fixed, but it indicates that periodic updates to underlying prescribed assumptions may require recalculation. LATF is requesting comments on this interpretation and its applicability to this RMD change vs. Standard Projection assumption updates more broadly.

Please submit comments to Reggie Mazyck (RMazyck@naic.org) by COB 5/3/21.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

American Academy of Actuaries, Variable Annuity Reserves & Capital Work Group

Update the reference to the required minimum distribution (RMD) age in the VM-21 Standard Projection Amount for the Setting Every Community Up for Retirement Enhancement (SECURE) Act change.

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

January 1, 2021, version of the Valuation Manual

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

In VM-21, Section 6.C.5:

i. For tax-qualified contracts, add the following to the revised GAPV^2 corresponding to an initial withdrawal age of the federal required minimum distribution (RMD) age.

\[
0.50 \times \left\{ \begin{array}{ll}
0.95 - \sum_{i=\text{base age}} \text{GAPV}^2_{\text{adjusted, scaled}}, & \text{if contract is a tax-qualified GMWB} \\
0.85 - \sum_{i=\text{issue age}} \text{GAPV}^2_{\text{adjusted, scaled}}, & \text{if contract is a tax-qualified hybrid GMIB}
\end{array} \right.
\]

j. Scale the revised GAPV^2 values at all future initial withdrawal ages—i.e., all ages greater than the federal required minimum distribution (RMD) age, as identified in the preceding step—such that the sum of the revised GAPV^2 values equals 0.95 for tax-qualified GMWB contracts and 0.85 for tax-qualified hybrid GMIB contracts again.

n. The cohorts and their associated weights as determined in Section 6.C.5.a through Section 6.C.5.k are for a contract with attained age equal to its issue age. Because the discount rate used in this determination is fixed, generally these calculations only need to be performed once for a given set of contracts with a certain issue age, guaranteed benefit product, and tax status.

Guidance Note: Cohorts and their associated weights may need to be revised if prescribed assumptions are updated.
4. State the reason for the proposed amendment? (You may do this through an attachment.)

The Standard Projection’s withdrawal delay cohort method includes an adjustment at the required minimum distribution (RMD) age. The SECURE Act changed the RMD age from 70.5 to 72. This proposed amendment implements the change by directly referencing the RMD age. The direct reference will reduce Valuation Manual maintenance for any future changes.

The proposed guidance note presumes that Section 6.C.5.n refers to how cohorts and weights are unaffected by changes in interest rates at each reporting date because the discount rate for the calculations is fixed, but it indicates that periodic updates to underlying prescribed assumptions may require recalculations. LATF is requesting comments on this interpretation and its applicability to this RMD change vs. Standard Projection assumption updates more broadly.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

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

Brian Bayerle, ACLI – edits adopted changes to VM-02 for improved clarity and to remove potential circularity.

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

Valuation Manual (January 1, 2021 edition), VM-02 Section 3.A

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

See attached.

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

Subsequent the adopted changes to the federal tax code (IRC S. 7702), this proposed change would clarify the language in the previously adopted edits to VM-02 to avoid any potential circularity.
Valuation Manual VM-02

Section 3: Interest

A. The nonforfeiture interest rate for any life insurance policy issued in a particular calendar year beginning on and after the operative date of the Valuation Manual shall be equal to 125% of the calendar year statutory valuation interest rate defined for the NPR in the Valuation Manual for a life insurance policy with nonforfeiture values, whether or not such sections apply to such policy for valuation purposes, rounded to the nearer one-quarter of 1%, provided, however, that the nonforfeiture interest rate shall not be less than the Applicable Accumulation Test Minimum Rate in the Cash Value Accumulation Test under Section 7702 (Life Insurance Contract Defined) of the U.S. Internal Revenue Code.

Guidance Note: For flexible premium universal life insurance policies as defined in Section 3.D of the Universal Life Insurance Model Regulation (9585), this is not intended to prevent an interest rate guarantee less than the nonforfeiture interest rate.

Deleted: applicable interest rate prescribed to meet the definition of life insurance
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force

Amendment Proposal Form*

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

Identification: David Neve, VP and Consulting Actuary, Actuarial Resources Corporation

Title of the Issue: Clarify the definition of modeled company investment strategy and the comparison to the alternative investment strategy.

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

January 1, 2020 NAIC Valuation Manual
- VM-01 VM-21 Section 4.D

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

See attached.

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

There is an inconsistency in VM-20/VM-21 and VM-31 regarding the term “model investment strategy”. The term “model investment strategy” is used throughout VM-20 and VM-21 to describe the investment strategy used in the model as a proxy for the company’s actual investment strategy. However, VM-31 uses the term “modeled company investment strategy” in several places rather than “model investment strategy”. “Modeled company investment strategy” is the preferred term, so VM-20 and VM-21 have been modified to use “modeled company investment strategy” so that the terminology in VM-20, VM-21 and VM-31 are consistent.

Also, to address the ambiguity of whether the final investment strategy in the model is the initial investment strategy based on the company’s investment strategy or the alternative investment strategy when the alternative strategy is constraining, the term “modeled company investment strategy” has been added to the definitions in VM-01 (and a parenthetical has been added to VM-31) to clarify that the term refers to the investment strategy in the model prior to comparison to the alternative investment strategy. In addition, VM-21 has been modified to be consistent with the wording in VM-20 to clarify that the assets in the alternative investment strategy should use the same weighted average life (WAL) as the assets in the modeled company investment strategy.
VM-01 Changes:

VM-01 provides definitions for terms used in the Valuation Manual. The definitions in VM-01 do not apply to documents outside the Valuation Manual even if referenced or used by the Valuation Manual, such as the AP&P Manual. Some terms in the Valuation Manual may be defined in specific sections of the Valuation Manual instead of being defined in VM-01.

- The term “margin” means an amount included in the assumptions used to determine the modeled reserve that incorporates conservatism in the calculated value consistent with the requirements of the various sections of the Valuation Manual. It is intended to provide for estimation error and adverse deviation.
- The term “modeled company investment strategy” means the investment strategy used in the model that is intended to be a representation of the actual investment strategy of the company. It is before the comparison is made to the alternative investment strategy. It does not refer to the alternative investment strategy when the alternative investment strategy is constraining.
- The term “modeled reserve” means the deterministic reserve on the policies determined under VM-20 Section 2.A.1.a, 2.A.2.a and 2.A.3.b, plus the greater of the deterministic reserve and the stochastic reserve on the policies determined under Section 2.A.1.b, 2.A.2.b and 2.A.3.c.

VM-20 Changes:

Section 7: Cash-Flow Models
E. Reinvestment Assets and Disinvestment

1. At the valuation date and each projection interval as appropriate, model the purchase of general account reinvestment assets with available cash and net asset and liability cash flows in a manner that is representative of and consistent with the company’s investment policy for each model segment, subject to the following requirements:
   a. The modeled company investment strategy may incorporate a representation of the actual investment policy that ranges from relatively complex to relatively simple. In any case, the PBR Actuarial Report shall include documentation supporting the appropriateness of the representation relative to actual investment policy.
   b. The final maturities and cash-flow structures of assets purchased in the model, such as the patterns of gross investment income and principal repayments or a fixed or floating rate interest basis, shall be determined by the company as part of the model representation.
   c. The combination of price and structure for fixed income investments and derivative instruments associated with fixed income investments shall appropriately reflect the then-current U.S. Department of the Treasury (Treasury Department) curve along the relevant scenario and the requirements for gross asset spread assumptions stated below.
   d. For purchases of public non-callable corporate bonds, use the gross asset spreads over Treasuries prescribed in Section 9.F.8.a through Section 9.F.8.c. (For purposes of this
subsection, “public” incorporates both registered and 144a securities.) The prescribed spreads reflect current market conditions as of the model start date and grade to long-term conditions based on historical data at the start of projection year four.

e. For transactions of derivative instruments associated with fixed income investments, reflect the prescribed assumptions in Section 9.F.8.d for interest rate swap spreads.

f. For purchases of other fixed income investments, if included in the *modeled company investment strategy*, set assumed gross asset spreads over Treasuries in a manner that is consistent with, and results in reasonable relationships to, the prescribed spreads for public non-callable corporate bonds and interest rate swaps as defined in Section 9.F.8.

g. Notwithstanding the above requirements, the modeled reserve shall be the higher of that produced by the *modeled company investment strategy* and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the *modeled company investment strategy* and are all public non-callable corporate bonds with gross asset spreads, asset default costs and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of a clearly defined hedging strategy (in compliance with Section 7.L) are not affected by this requirement.

### Guidance Note: VM-31 requires a demonstration of compliance with VM-20 Section 7.E.1.g. In many cases, particularly if the modeled company investment strategy does not involve callable assets, it is expected that the demonstration of compliance will not require running the reserve calculation twice. For example, an analysis of the weighted average net reinvestment spread on new purchases by projection year (gross spread minus prescribed default costs minus investment expenses) of the *modeled company investment strategy* compared to the weighted average net reinvestment spreads by projection year of the alternative strategy may suffice. The assumed mix of asset types, asset credit quality or the levels of non-prescribed spreads for other fixed income investments may need to be adjusted to achieve compliance.

### VM-21 Changes:

**Section 4: Determination of the Stochastic Reserve**

**D. Projection of Assets**

**4. General Account Assets**

**a. General account assets shall be projected, net of projected defaults, using assumed investment returns consistent with their book value and expected to be realized in future periods as of the date of valuation. Initial assets that mature during the projection and positive cash flows projected for future periods shall be invested in a manner that is representative of and consistent with the company’s investment policy, subject to the following requirements:**

**i. The final maturities and cash flow structures of assets purchased in the model, such as the patterns of gross investment income and principal repayments or a
fixed or floating rate interest basis, shall be determined by the company as part
of the model representation;

ii. The combination of price and structure for fixed income investments and
derivative instruments associated with fixed income investments shall
appropriately reflect the projected Treasury Department curve along the
relevant scenario and the requirements for gross asset spread assumptions stated
below;

iii. For purchases of public non-callable corporate bonds, follow the requirements
defined in VM-20 Sections 7.E, 7.F and 9.F. The prescribed spreads reflect
current market conditions as of the model start date and grade to long-term
conditions based on historical data at the start of projection year four;

iv. For transactions of derivative instruments associated with fixed income
investments, reflect the prescribed assumptions in VM-20 Section 9.F for
interest rate swap spreads;

v. For purchases of other fixed income investments, if included in the modeled
corporate fixed income investments, set assumed gross asset spreads over U.S.
Treasuries in a manner that is consistent with, and results in reasonable
relationships to, the prescribed spreads for public non-callable corporate bonds
and interest rate swaps.

b. Notwithstanding the above requirements, the stochastic reserve shall be the higher of
those produced by the modeled company investment strategy and that produced by
substituting an alternative investment strategy in which the fixed income reinvestment
assets have the same weighted average life (WAL) as the reinvestment assets in the
modeled company investment strategy and are all public non-callable corporate bonds
with gross asset spreads, asset default costs, and investment expenses by projection year
that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and
50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of a
clearly defined hedging strategy are not affected by this requirement.

Drafting Note: This limitation is being referred to Life Actuarial (A) Task Force for review.

VM-31 Changes:
Section 3: PBR Actuarial Report Requirements

D. Life Report – This subsection establishes the Life Report requirements for individual life insurance
policies valued under VM-20:

6. Assets – The following information regarding the asset assumptions used by the company in
performing a principle-based valuation under VM-20:

r. Modeled Company Investment Strategy and Reinvestment Assumptions - Description
of the modeled company investment strategy (before comparison to the alternative
investment strategy), including asset reinvestment and disinvestment assumptions, and
documentation supporting the appropriateness of the modeled company investment strategy compared to the actual investment policy of the company.

s. **Alternative Investment Strategy** – Documentation demonstrating compliance with VM-20 Section 7.E.1.g, showing that the modeled reserve is the higher of that produced using the modeled company investment strategy and the alternative investment strategy.

F. **VA Report** – This subsection establishes the VA Report requirements for variable annuity contracts valued under VM-21.

6. **General Account Assets** – The following information regarding the general account asset assumptions used by the company in performing a principle-based valuation under VM-21:

a. **Modeled Company Investment Strategy and Reinvestment Assumptions** – Description of the modeled company investment strategy (before the comparison to the alternative investment strategy), including asset reinvestment and disinvestment assumptions, and documentation supporting the appropriateness of the modeled company investment strategy compared to the actual investment policy of the company.

b. **Alternative Investment Strategy** – Documentation demonstrating compliance with VM-21 Section 4.D.4.b showing that the stochastic reserve is the higher of that produced using the modeled company investment strategy and the alternative investment strategy.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force

Amendment Proposal Form*

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

Angela McNabb & Pat Allison – NAIC staff support

Revisions to VM-50 and VM-51 to allow for data experience reporting to be performed by a reinsurer or third-party administrator and a correction to VM-51 Appendix 4.

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


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

See attached redline document.

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

This APF is needed for the following reasons:

1. VM-51 Appendix 4 includes a column indicating the position within the data file for each field. This is not valid as the NAIC’s RDC system was designed to accept comma delimited files. This APF will remove that column.

2. The VM-51 Section 2.B states that companies must submit data for all their direct written business prior to reinsurance ceded. The only exception is in the case of assumption reinsurance where policies have been legally novated. The NAIC has received feedback from a number of companies indicating that they have business that is reinsured and fully administered by the reinsurer. Since the ceding companies do not have the data, it represents a hardship for them to submit this business.

3. Currently, VM-51 Appendix 4 only allows one company code. In order to allow a reinsurer or third-party administrator to submit data on behalf of the direct writer, the NAIC must be able to identify both the submitting company and the direct writer of the block of business. This APF adds an additional field to accomplish this. By having the submitting company’s code, any questions the NAIC has regarding the data can be directed to the submitting company without fear of breaching confidentiality.

4. Having separate identifiers for the submitting company and direct writer will allow the NAIC to validate the reconciliations required by VM-50 Section 4.B.3.

Below are examples showing how the reconciliations would work according to the amended language in VM-50 Section 4.B.3.

Example 1: This example illustrates the scenario described in redlined language in VM-50 Section 4.B.3.c. Company A is a direct writer selected for VM-51 reporting.

- The company has retained and administers 35,000 policies (out of a total of 100,000).
- Company B (a reinsurer not selected to submit their own business) administers 50,000 policies for Company A.
Company C (a reinsurer selected to submit their own direct business) administers 15,000 policies for Company A.

### RECONCILIATION FOR COMPANY A (Direct Writer)

<table>
<thead>
<tr>
<th>Policy Count</th>
<th>Insurance Amount</th>
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<td>100,000</td>
<td>2,500,000,000</td>
</tr>
<tr>
<td>(50,000)</td>
<td>(1,250,000,000)</td>
</tr>
<tr>
<td>(15,000)</td>
<td>(50,000,000)</td>
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<tr>
<td><strong>Totals included in Company A’s data submissions</strong></td>
<td><strong>1,200,000,000</strong></td>
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</table>

**Example 2:** This example illustrates the scenario described in the redlined language in VM-50 Section 4.B.3.a. Company D is another direct writing company selected for VM-51 reporting. Company B has been asked by Companies A and D to submit data Company B has assumed and administers.

- Company B administers 50,000 policies for Company A.
- Company B administers 100,000 policies for Company D.
- Company B is not required to reconcile to their Annual Statement since they were not selected to submit their direct business.
- In this example, Company B is a reinsurer. However, Company B could also be a third-party administrator that is not an insurance company.

### RECONCILIATION FOR COMPANY B

<table>
<thead>
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<tr>
<td>100,000</td>
<td>1,500,000,000</td>
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<tr>
<td><strong>Totals included in Company B’s data submission</strong></td>
<td><strong>2,750,000,000</strong></td>
</tr>
</tbody>
</table>

**Example 3:** This example illustrates the scenario described in redlined language in VM-50 Section 4.B.3.b. Company C has also been asked by company A to submit data Company C has assumed and administers.

- Company C has 1,500,000 policies reported in their Annual Statement.
- Company C has 250,000 of reinsurance assumed policies which should not be included in their submission. Reinsurance assumed should only be included when the ceding company requests that the reinsurer report it on their behalf.
- Company C has 1,250,000 policies of direct written business that they must report.
- In addition to Company C’s direct written business, they will also be reporting 15,000 policies that they administer on behalf of Company A (per Company A’s request).

### RECONCILIATION FOR COMPANY C

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<tr>
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<td>174,000,000,000</td>
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<td>15,000</td>
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<tr>
<td><strong>Totals included in Company C’s data submissions</strong></td>
<td><strong>174,050,000,000</strong></td>
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VM-50: Experience Reporting Requirements

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Section 1: Overview

A. Purpose of the Experience Reporting Requirements

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

B. PBR and the Need for Experience Data

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

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

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

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

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

5. The collection of experience data will provide a basis for establishing and updating the assumptions and margins prescribed by regulators in the Valuation Manual.

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

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

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

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

Section 2: Statutory Authority and Experience Reporting Agent

A. Statutory Authority

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

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

3. Section 4A(5) of Model #820 defines the data to be collected to be confidential.

B. Experience Reporting Agent

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

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

Section 3: Experience Reporting Requirements

A. Statistical Plans

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

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

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

B. Role and Responsibilities of the Experience Reporting Agent

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

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

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

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

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

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

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

6. The Experience Reporting Agent will obtain and undergo at least annual external audits to validate that controls with respect to data security and related topics are consistent with industry standards and best practices. The Experience Reporting Agent will provide a copy of any report prepared in connection with such an audit, upon a company’s request. In the event of a material deficiency identified in the external audit or in the event of an identified security breach affecting the Experience Reporting Data, the Experience Reporting Agent shall notify the NAIC, and the states that have directed the Experience Reporting Agent to collect this information, of the nature and extent of such an issue. In the event of an identified security breach affecting Experience Reporting Data, the Experience Reporting Agent shall also notify any insurer whose data was affected. Upon good cause shown, the Experience Reporting Agent will take reasonable actions to protect the data under its control, including that the data submission process may be suspended until the security issue has been remediated. If data submission is suspended under this section, the Experience Reporting Agent will work with the states that have directed collection to issue appropriate guidance modifying the requirements of VM 51, Section 2.D. The term “good cause” shall mean that there is the chance of irreparable harm upon continuing the transmission of the data to the Experience Reporting Agent. Once the security issue has been remediated, the Experience Reporting Agent shall notify the NAIC and the states that have directed the Experience Reporting Agent to collect this information. The Experience Reporting Agent shall also notify any insurer whose data was affected. The revised schedule shall provide for reasonable timing for companies to provide such data.

C. Role of Other Organizations

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

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

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

3. Analyze data, including any summarized or aggregated data, produced by the Experience Reporting Agent;
4. Create initial experience tables and any revised tables;
5. Provide feedback in the development and evaluation of requests for proposal for services related to the reporting of experience requirement;
6. Create statutory valuation tables as appropriate and necessary;
7. Determine and produce additional industry experience tables or reports that might be suggested by the data collected;
8. Work with the Life Actuarial (A) Task Force or Health Actuarial (B) Task Force, in accordance with the Valuation Manual governance process, in developing new reporting formats and modifying current experience reporting formats;
9. Support a close working relationship among all parties having an interest in the success of the experience reporting requirement.

Section 4: Data Quality and Ownership

A. General Requirements

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

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

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

B. Specific Requirements

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

2. Each submission of data filed by an insurance company with the Experience Reporting Agent shall be balanced against a set of control totals provided by the company with the data submission. At a minimum, these control totals shall include applicable record counts, claim counts, amounts insured and claim amounts. Any submission that does not balance to the control totals shall be referred to the company for review and resolution.

3. Each company submitting experience data and each company on whose behalf data is being submitted as required in VM-51 will perform a reconciliation between its submitted experience data with its statistical and financial data, and provide an explanation of differences, to the Experience Reporting Agent. The reconciliation must include policy count and insurance amount.
   a. If a third-party administrator that is not an insurance company or an insurance company not required to submit their direct data is submitting data on behalf of an insurance company, the reconciliation will consist of separate lines identifying each insurance company for whom this entity is submitting data.
   b. If the third-party administrator is an insurance company that is required to submit their direct data, the reconciliation must include separate lines identifying each additional company whose data is being submitted.
   c. The reconciliation to company statistical and financial data for both the direct writer and the reinsurer or third-party administrator must include lines indicating the amount of business that is being reported by the reinsurer or third-party administrator. The NAIC will use this information to confirm that all in-scope business is reported and there is no double counting of policies.

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

5. Where quality would not appear to be significantly compromised, the Experience Reporting Agent may use records with missing or invalid data if such invalid or missing data do not involve a field that is relevant or would affect the credibility of the report. For companies with a body of data for a state, line of business, product type or observation period that fails to meet these standards, the Experience Reporting Agent will use its discretion, with regulatory disclosure of key decisions made, regarding the omission of the entire body of data or only including records with valid data. Completeness of reports is desirable, but not at the risk of including a body of data that appears to have an unreasonably high chance of significant errors.
6. Errors of a consistent nature are referred to as “systematic.” Incorrect coding instructions can introduce errors of a consistent nature. Programming errors within the data processing system of insurer company can also produce systematic miscoding as the system converts data to the required formats for experience reporting. Most systematic errors will produce data that, when reviewed using tests designed to reveal various types of systematic errors, will appear unreasonable and likely to be in error. In addition, some individual coding errors may produce erroneous results that show up when exposures and losses are compared in a systematic fashion. Such checking often cannot, however, provide a conclusive indication that data with unusual patterns is incorrect. The Experience Reporting Agent will perform tests and look at trends using previously reported data to determine if systematic errors or unusual patterns are occurring.

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

8. At a minimum, reasonability checks by the Experience Reporting Agent will include:
   a. An unusually large percentage of company data reported under a single or very limited number of categories;
   b. Unusual or unlikely reporting patterns in a company’s data;
   c. Claim amounts that appear unusually high or low for the corresponding exposures;
   d. Reported claims without corresponding policy values and exposures;
   e. Unreasonable loss frequencies or amounts in comparison to ranges of expectation that recognize statistical fluctuation;
   f. Unusual shifts in the distribution of business from one reporting period to the next.

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

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

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

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

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

C. Ownership of Data

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

2. The Experience Reporting Agent will be responsible for maintaining data, error reports, logs and other intermediate work products, and reports for use in processing, documentation, production and reproduction of reports provided to state insurance regulators in accordance with the Valuation Manual. The Experience Reporting Agent will be responsible for demonstrating such reproducibility at the request of state insurance regulators or an auditor designated by state insurance regulators.

Section 5: Experience Data

A. Introduction

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

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

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

B. Design of Reports Linked to Purpose

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

C. Basic Report Designs

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

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

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

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

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

D. Supplemental Reports

1. For specific lines of business and types of experience data, state insurance regulators may request additional reports from the Experience Reporting Agent. State insurance regulators also may request custom reports, which may contain specific data or experience not regularly produced in other reports.
2. The regulator and the Experience Reporting Agent must negotiate time schedules for producing supplemental reports. The information in these reports is limited by the amount of data actually available and the manner in which it has been reported.

E. Reports to State Insurance Departments
   The Experience Reporting Agent will periodically provide the following reports to state insurance departments:
   1. A list of companies whose data is included in the compilation.
   2. A list of companies whose data was excluded from the compilation because it fell outside of the tolerances set for missing or invalid data, or for any other reason.

Section 6: Confidentiality of Data

A. Confidentiality of Experience Data
   1. The confidentiality of the experience data, experience materials and related information collected pursuant to the Valuation Manual is governed by state laws based on Section 14.A.(5) of Model #820. The following information is considered “confidential information” by state laws based on Section 14A(5) of the Model #820:
      Any documents, materials, data and other information submitted by a company under Section 13 of [the Standard Valuation Law] (collectively, “experience data”) and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies thereof, created or produced in connection with such experience data, in each case that include any potentially company-identifying or personally identifiable information, that is provided to or obtained by the commissioner (together with any “experience data,” the “experience materials”) and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such experience materials.

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

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

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

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

a. State, federal or international regulatory agencies;

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

c. The NAIC, and its affiliates and subsidiaries;

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

e. Other individuals or entities, including contractors or subcontractors of the Experience Reporting Agent, otherwise assisting the Experience Reporting Agent or state insurance regulators in fulfilling the purposes of VM-50. These other individuals or entities may provide services related to a variety of areas of expertise, such as assisting with performing industry experience studies, developing valuation mortality tables, data editing and data quality review. These other individuals and entities shall be subject to the same standards as the Experience Reporting Agent with respect to the maintenance of confidential information.
VM-51: Experience Reporting Formats

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Section 1: Introduction

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

B. Each statistical plan shall contain the following information:

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

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

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

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

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

6. The experience data reports to be produced.

Section 2: Statistical Plan for Mortality

A. Type of Experience Collected Under This Statistical Plan

The type of experience to be collected under this statistical plan is mortality experience.
B. Scope of Business Collected Under This Statistical Plan

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

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

   a. As defined in VM-50 Section 4.B.3, the reconciliation to company statistical and financial data for both the direct writing company and all reinsurers and/or third-party administrators must include lines indicating the amount of business that is being reported by the reinsurers and/or third-party administrators. The Experience Reporting Agent will compare the reconciliations for all business submitted by the direct writer and any reinsurers and/or third-party administrators to ensure that all business is included and there is no double counting of policies.

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

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

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

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

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

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

Data for this statistical plan for mortality will be compiled using a calendar year method. The reporting calendar year is the calendar year that the company submits the experience data. The observation calendar year is the calendar year of the experience data that is reported. The observation calendar year will be two years prior to the reporting calendar year. For example, if the current calendar year is 2018 and that is the reporting calendar year, the company is to report the experience data that was in-force or issued in calendar year 2016, which is the observation calendar year.

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

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

ii. Report terminations that were incurred in calendar year 20XX and reported before July 1, 20XX+1. However, exclude rescinded policies (e.g., 10-day free look exercises) from the data submission.

For any reporting calendar year, the data call will occur during the second quarter, and data is to be submitted according to the requirements of the Valuation Manual in effect during that calendar year. Data submissions must be made by Sept. 30 of the reporting calendar year. Corrections of data submissions must be completed by Dec. 31 of the reporting calendar year.

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

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

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

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

Generally, each policy number represents a policy issued as a result of ordinary underwriting. If a single life policy, the base policy on a single life has the policy number and a segment number of 1. On a joint life policy, each life has separate records with the same policy number. The base policy on the first life has a segment number of 1, and the base policy on the second life has a segment number of 2. Policies that cover more than two lives are not to be submitted.
Term/paid up riders or additional amounts of insurance purchased through dividend options on a policy issued as a result of ordinary underwriting are to be submitted. Each rider is on a separate record with the same policy number as the base policy and has a unique segment number. The details on the rider record may differ from the corresponding details on the base policy record. If underwriting in addition to the base policy underwriting is done, the coverage is given its own policy number.

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

Plans of insurance should be carefully matched with the three-digit codes in item 19, Plan. These plans of insurance are important because they will be used not only for mortality experience data collection, but also for policyholder behavior experience data collection. It is expected that most policies will be matched to three-digit codes that specify a particular policy type rather than select a code that indicates a general plan type.

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

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

ii. For policies issued on or after Jan. 1, 1990, companies must:
   a) Document the percentage that the face amount of policies excluded are relative to the face amount of submitted policies issued on or after Jan. 1, 1990; and
   b) Certify that this requirement presents a hardship due to fields not readily available in their systems/databases or legacy computer systems that continue to be used for older issued policies and differ from computer systems for newer issued policies.

F. Experience Data Reports Required by This Statistical Plan

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

2. The Experience Reporting Agent will provide to the SOA or other actuarial professional organizations an experience data report of aggregated experience that does not disclose a company’s identity, which will be used to develop industry mortality experience and valuation mortality tables.
3. As long as a company is licensed in a state, that state insurance regulator will be given access to a company’s experience data that is stored on a confidential database at the Experience Reporting Agent. Access by the state insurance regulator will be controlled by security credentials issued to the state insurance regulator by the Experience Reporting Agent.
Appendix 1: Preferred Class Structure Questionnaire

PREFERRED CLASS STRUCTURE QUESTIONNAIRE

Fill out this preferred class structure questionnaire based on companywide summaries, such as underwriting guideline manuals, compilations of issue instructions or other documentation.

The purpose of this preferred class structure questionnaire is to gather information on different preferred class structures. This questionnaire varies between nonsmoker/non-tobacco and smoker/tobacco users and provides for variations by issue year, face amount and plan. If the company has the standard Relative Risk Score (RR Score) information available, the company should map its set of preferred class structure to sets of RR Scores. Except for new preferred class structures or new sets of RR Scores applied to existing preferred class structure(s), the response to the questionnaire should remain the same from year to year.

If a company has determined sets of RR Scores for its preferred class structures, it should provide separate preferred class structure responses for each set of RR Scores applied to a preferred class structure. If a company has not determined sets of RR Scores for its preferred class structures, it should fill out this questionnaire with its preferred class structures and update the preferred class structure questionnaire at such future time that sets of RR Scores for the preferred class structures are determined. When sets of RR Scores are used, there is to be a one-to-one correspondence between a preferred class structure and a set of RR Scores.

The information given in this questionnaire will be used both to map a set of RR Scores to policy level data and as a check on the policy-level data submission. Submit this questionnaire along with the initial data submission to the Experience Reporting Agent.

Each preferred class structure must include at least two classes (e.g., one preferred class and one standard class). Make as many copies of this preferred class structure questionnaire as necessary for your individual life business and submit in addition to policy-level detail information.

<table>
<thead>
<tr>
<th>Company</th>
<th>NAIC Company Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Date</td>
</tr>
</tbody>
</table>

PREFERRED CLASS STRUCTURE – Part 1 Nonsmokers/Non-Tobacco Users

Preferred class structure must have at least one preferred and one standard class. Use multiple copies of this page if needed for nonsmokers/non-tobacco users

Number of Nonsmoker/Non-Tobacco User Risk Classes

a) Issue Date Range \textit{Date} through \textit{Date}

b) Issue Age Range \textit{Date} through \textit{Date}

c) Face Amount Range \textit{Date} through \textit{Date}

d) Plan Types (use three-digit codes from item 19, Plan)

Number of Nonsmoker/Non-Tobacco User Risk Classes

a) Issue Date Range \textit{Date} through \textit{Date}

b) Issue Age Range \textit{Date} through \textit{Date}

c) Face Amount Range \textit{Date} through \textit{Date}

d) Plan Types (use three-digit codes from item 19, Plan)
Number of Nonsmoker/Non-Tobacco User Risk Classes
   a) Issue Date Range \( \text{Date through Date} \)
   b) Issue Age Range \( \text{Date through Date} \)
   c) Face Amount Range \( \text{Date through Date} \)
   d) Plan Types (use three-digit codes from item 19, Plan)

Number of Nonsmoker/Non-Tobacco User Risk Classes
   a) Issue Date Range \( \text{Date through Date} \)
   b) Issue Age Range \( \text{Date through Date} \)
   c) Face Amount Range \( \text{Date through Date} \)
   d) Plan Types (use three-digit codes from item 19, Plan)

Number of Nonsmoker/Non-Tobacco User Risk Classes
   a) Issue Date Range \( \text{Date through Date} \)
   b) Issue Age Range \( \text{Date through Date} \)
   c) Face Amount Range \( \text{Date through Date} \)
   d) Plan Types (use three-digit codes from item 19, Plan)

PREFERRED CLASS STRUCTURE – Part 2 Smokers/Tobacco Users

Preferred class structure must have at least one preferred and one standard class. Use multiple copies of this page if needed for smokers/tobacco users

Number of Smoker/Tobacco User Risk Classes
   a) Issue Date Range \( \text{Date through Date} \)
   b) Issue Age Range \( \text{Date through Date} \)
   c) Face Amount Range \( \text{Date through Date} \)
   d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes
   a) Issue Date Range \( \text{Date through Date} \)
   b) Issue Age Range \( \text{Date through Date} \)
   c) Face Amount Range \( \text{Date through Date} \)
   d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes
   a) Issue Date Range \( \text{Date through Date} \)
   b) Issue Age Range \( \text{Date through Date} \)
   c) Face Amount Range \( \text{Date through Date} \)
   d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes
   a) Issue Date Range \( \text{Date through Date} \)
   b) Issue Age Range \( \text{Date through Date} \)
   c) Face Amount Range \( \text{Date through Date} \)
   d) Plan Types (use three-digit codes from item 19, Plan)
Number of Smoker/Tobacco User Risk Classes

a) Issue Date Range Date through Date
b) Issue Age Range Date through Date
c) Face Amount Range Date through Date
d) Plan Types (use three-digit codes from item 19, Plan)
Appendix 2: Mortality Claims Questionnaire

MORTALITY CLAIMS QUESTIONNAIRE

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

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

<table>
<thead>
<tr>
<th>Company</th>
<th>NAIC Company Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Date</td>
</tr>
</tbody>
</table>

MORTALITY CLAIMS

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

2. The death claim amounts are to be for the total face amount and on a gross basis (before reinsurance). The data is based on:
   a. Total face amount (for policies that include the cash value in addition to the face amount as a death benefit, use only the face amount) as specified OR
      Other (describe):
      If not as specified, indicate time period for which this occurred: ___________ - ___________
   b. Gross basis (before reinsurance) as specified OR Other (describe):
      If not as specified, indicate time period for which this occurred: ___________ - ___________
      Is this the same basis used for face amounts included in the study data? ☐ Yes ☐ No

3. The date that the termination is reported is to be used for the termination reported date. The date that the termination actually occurred is to be used for the actual termination date. What dates are used for death claims in the study data with respect to?
   a) Termination reported date
      If not reported, indicate basis for dates provided ☐ Reported date ☐ Other (describe):
   b) Actual termination date for death claims:
      If not date of death, indicate basis for dates provided ☐ Date of death ☐ Other (describe):

4. Death claims pending at the end of the observation period but paid during the subsequent six months following the observation year are to be included in the data submission. Claims that are still pending at the end of the six month run out are -to be included.
Are such pending claims included in the study data? □ Yes □ No

If no indicate time period for which this occurred: ________________

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

□ Yes □ No

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

6. For death claims on policies issued before 1990:

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

If no, indicate approach used:

7. Please briefly describe any other unique aspects of the death claims data that are not covered above.
Appendix 3: Additional Plan Code Form

If you need an additional plan code(s) for a product(s) in addition to those plan codes in Item 19, Plan, of the statistical plan for life insurance mortality, fill in this form using plan codes in the range 300 to 999. Your data submission should reflect the plan codes in this form. Make as many copies as necessary for your individual life business and submit in addition to policy-level information. When this form is used, it must be sent to the Experience Reporting Agent at the time that data is submitted.

Completed by: ______________________ Title: _______________________________
Company: ________________________ NAIC Company Code: _________________ Date: ______
Phone Number: _____________________ Email: ____________________________

Add comments or attachments where necessary.

Enter unique three-digit plan codes for each product.

<table>
<thead>
<tr>
<th>Plan Code For Product I</th>
<th>Plan Code for Product II</th>
<th>Plan Code for Product III</th>
</tr>
</thead>
</table>

Enter specific plan names for each product.

A. General Product Information

<table>
<thead>
<tr>
<th>Product I</th>
<th>Product II</th>
<th>Product III</th>
</tr>
</thead>
<tbody>
<tr>
<td>In what year was each product introduced?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Briefly describe the product.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enter three-digit plan code in the range 300 to 999.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
B. For the products listed, please fit each product into one of the categories below.

<table>
<thead>
<tr>
<th>Categories for Product I</th>
<th>Categories for Product II</th>
<th>Categories for Product III</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Traditional Whole Life Plans</td>
<td>1 Traditional Whole Life Plans</td>
<td>1 Traditional Whole Life Plans</td>
</tr>
<tr>
<td>2 Term Insurance Plans</td>
<td>2 Term Insurance Plans</td>
<td>2 Term Insurance Plans</td>
</tr>
<tr>
<td>5 Variable Life Plans (without Secondary Guarantees)</td>
<td>5 Variable Life Plans (without Secondary Guarantees)</td>
<td>5 Variable Life Plans (without Secondary Guarantees)</td>
</tr>
<tr>
<td>6 Variable Life Plans with Secondary Guarantees</td>
<td>6 Variable Life Plans with Secondary Guarantees</td>
<td>6 Variable Life Plans with Secondary Guarantees</td>
</tr>
<tr>
<td>7 Nonforfeiture</td>
<td>7 Nonforfeiture</td>
<td>7 Nonforfeiture</td>
</tr>
<tr>
<td>8 Other</td>
<td>8 Other</td>
<td>8 Other</td>
</tr>
</tbody>
</table>
Appendix 4: Mortality Data Elements and Format

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>LENGTH</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1–9</td>
<td>9</td>
<td>Submitting Company ID</td>
<td>ID number representing the company submitting this file. If the company has an NAIC Company Code, then that code must be used. If the company does not have an NAIC Company Code, the company’s Federal Employer Identification Number (FEIN) must be used. If the direct writer is the company submitting the data, items 1 and 2 must contain the same value.</td>
</tr>
<tr>
<td>2</td>
<td>1–5</td>
<td>5</td>
<td>NAIC Company Code of the Direct Writer of Business</td>
<td>The NAIC Company Code of the company that wrote the business being reported. In the case of assumption reinsurance where the assuming company is legally responsible for all benefits and claims paid, the assuming company is considered to be the direct writer. If the direct writer is the company submitting the data file, items 1 and 2 must contain the same value.</td>
</tr>
<tr>
<td>3</td>
<td>6–9</td>
<td>4</td>
<td>Observation Year</td>
<td>Enter Calendar Year of Observation</td>
</tr>
<tr>
<td>4</td>
<td>10–29</td>
<td>20</td>
<td>Policy Number</td>
<td>Enter Policy Number. For Policy Numbers with length less than 20, left justify the number, and blank fill the empty columns. Any other unique identifying number can be used instead of a Policy Number for privacy reasons.</td>
</tr>
<tr>
<td>5</td>
<td>30–32</td>
<td>3</td>
<td>Segment Number</td>
<td>If only one policy segment exists, enter segment number ‘1.’ For a single life policy, the base policy is to be put in the record with segment number ‘1.’ Subsequent policy segments are in separate records with information about that coverage and differing segment numbers. If a joint life policy, the base policy of the first life is to be put in a separate record with segment number ‘1,’ and the base policy of the second life is to be put in a separate record with segment number ‘2.’ Joint life policies with more than two lives are not to be submitted. Subsequent policy segments are in separate records with information about that coverage and differing segment numbers. Policy segments with the same policy number are to be submitted for: a) Single life policies; b) Joint life policies; c) Term/paid up riders; or d) Additional amounts of insurance including purchase through dividend options.</td>
</tr>
<tr>
<td>6</td>
<td>33–34</td>
<td>2</td>
<td>State of Issue</td>
<td>Use standard, two-letter state abbreviation codes (e.g., NY for New York)</td>
</tr>
<tr>
<td>ITEM</td>
<td>COLUMN</td>
<td>LENGTH</td>
<td>DATA ELEMENT DESCRIPTION</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>--------</td>
<td>--------</td>
<td>--------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| 7    | 1      | Gender | 0 = Unknown or unable to subdivide  
1 = Male  
2 = Female  
3 = Unisex – Unknown or unable to identify  
4 = Unisex – Male  
5 = Unisex – Female |
| 8    | 8      | Date of Birth | Enter the numeric date of birth in YYYYMMDD format |
| 9    | 1      | Age Basis | 0 = Age Nearest Birthday  
1 = Age Last Birthday  
2 = Age Next birthday |
| 10   | 3      | Issue Age | Enter the insurance Issue Age |
| 11   | 8      | Issue Date | Enter the numeric calendar year in YYYYMMDD format. |
| 12   | 1      | Smoker Status (at issue) | Smoker status should be submitted where reliable.  
0 = Unknown  
1 = No tobacco usage  
2 = Nonsmoker  
3 = Cigarette smoker  
4 = Tobacco user |
| 13   | 1      | Preferred Class Structure Indicator | 0 = If no reliable information on multiple preferred and standard classes is available or if the policy segment was issued substandard or if there were no multiple preferred and standard classes available for this policy segment or if preferred information is unknown.  
1 = If this policy was issued in one of the available multiple preferred and standard classes for this policy segment.  
Note: If Preferred Class Structure Indicator is 0, or if preferred information is unknown, leave next four items blank. |
<p>| 14   | 1      | Number of Classes in Nonsmoker Preferred Class Structure | If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 3 or 4, or if preferred information is unknown, leave blank. For nonsmoker or no tobacco usage policies that could have been issued as one of multiple preferred and standard classes, enter the number of nonsmoker preferred and standard classes available at time of issue. |</p>
<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>LENGTH</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>50</td>
<td>1</td>
<td>Non smoker Preferred Class</td>
<td>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 3 or 4, or if preferred information is unknown, leave blank. For nonsmoker policy segments that could have been issued as one of multiple preferred and standard classes: 1 = Best preferred class 2 = Next Best preferred class after 1 3 = Next Best preferred class after 2 4 = Next Best preferred class after 3 5 = Next Best preferred class after 4 6 = Next Best preferred class after 5 7 = Next Best preferred class after 6 8 = Next Best preferred class after 7 9 = Next Best preferred class after 8 Note: The policy segment with the highest nonsmoker Preferred Class number should have that number equal to the Number of Classes in Nonsmoker Preferred Class Structure.</td>
</tr>
<tr>
<td>16</td>
<td>60</td>
<td>1</td>
<td>Number of Classes in Smoker Preferred Class Structure</td>
<td>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 1 or 2, or if preferred information is unknown, leave blank. For smoker or tobacco user policies that could have been issued as one of multiple preferred and standard classes, enter the number of smoker preferred and standard classes available at time of issue.</td>
</tr>
<tr>
<td>17</td>
<td>64</td>
<td>1</td>
<td>Smoker Preferred Class</td>
<td>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 1 or 2, or if preferred information is unknown, leave blank. For smoker policy segments that could have been issued as one of multiple preferred and standard classes: 1 = Best preferred class 2 = Next Best preferred class after 1 3 = Next Best preferred class after 2 4 = Next Best preferred class after 3 5 = Next Best preferred class after 4 6 = Next Best preferred class after 5 7 = Next Best preferred class after 6 8 = Next Best preferred class after 7 9 = Next Best preferred class after 8 Note: The policy segment with the highest Smoker Preferred Class number should have that number equal to the Number of Classes in Smoker Preferred Class Structure.</td>
</tr>
<tr>
<td>ITEM</td>
<td>COLUMN</td>
<td>LENGTH</td>
<td>DATA ELEMENT</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>------</td>
<td>--------</td>
<td>--------</td>
<td>--------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| 18   | 62-63  | 2      | Type of Underwriting Requirements | If underwriting requirement of ordinary business is reliably known, use code other than “99.” Ordinary business does not include separate lines of business, such as simplified issue/guaranteed issue, worksite, individually solicited group life, direct response, final expense, preneed, home service and COLI/BOLI/CHOLI.  
01 = Underwritten, but unknown whether fluid was collected  
02 = Underwritten with no fluid collection  
03 = Underwritten with fluid collected  
06 = Term Conversion  
07 = Group Conversion  
09 = Not Underwritten  
99 = For issues where underwriting requirement unknown or unable to subdivide |
| 19   | 64     | 1      | Substandard Indicator | 0 = Policy segment is not substandard  
1 = Policy segment is substandard  
2 = Policy segment is uninsurable  
Note:  
a. All policy segments that are substandard need to be identified as substandard or uninsurable.  
b. Submission of substandard policies is optional.  
c. If feasible, identify substandard policy segments where temporary flat extra has ceased as substandard. |
| 20   | 65-67  | 3      | Plan         | Exclude from contribution: spouse and children under family policies or riders. If Form for Additional Plan Codes was submitted for this policy, enter unique three-digit plan number(s) that differ from the plan numbers below:  
000 = If unable to distinguish among plan types listed below  
100 = Joint life plan unable to distinguish among joint life plan types listed below  
Permanent Plans:  
010 = Traditional fixed premium fixed benefit permanent plan  
011 = Permanent life (traditional) with term  
012 = Single premium whole life  
013 = Econolife (permanent life with lower premiums in the early durations)  
014 = Excess interest whole life  
015 = First to die whole life plan (submit separate records for each life)  
016 = Second to die whole life plan (submit separate records for each life)  
017 = Joint whole life plan – unknown whether 015 or 016 (submit separate records for each life) |
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>018</td>
<td>Permanent products with non-level death benefits</td>
</tr>
<tr>
<td>019</td>
<td>Permanent plans 010, 011, 012, 013, 014, 015, 016, 017, 018 combined (i.e. unable to separate)</td>
</tr>
</tbody>
</table>

**Term Insurance Plans:**

- **020** = Term (traditional level benefit and attained age premium)
- **021** = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for five years)
- **211** = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 10 years)
- **212** = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 15 years)
- **213** = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 20 years)
- **214** = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 25 years)
- **215** = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 30 years)
- **022** = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 10 years)
- **221** = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 15 years)
- **222** = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 20 years)
- **223** = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 25 years)
- **224** = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 30 years)
- **023** = Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 15 years)
- **231** = Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 20 years)
- **232** = Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 25 years)
- **233** = Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 30 years)
- **024** = Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 20 years)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>241</td>
<td>Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>242</td>
<td>Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 30 year)</td>
</tr>
<tr>
<td>025</td>
<td>Term (level death benefit with guaranteed level premium for 25 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>251</td>
<td>Term (level death benefit with guaranteed level premium for 25 years and anticipated level term period for 30 year)</td>
</tr>
<tr>
<td>026</td>
<td>Term (level death benefit with guaranteed level premium for 30 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>027</td>
<td>Term (level death benefit with guaranteed level premium period equal to anticipated level term period where the period is other than five, 10, 15, 20, 25 or 30 years)</td>
</tr>
<tr>
<td>271</td>
<td>Term (level death benefit with guaranteed level premium period not equal to anticipated level term period, where the periods are other than five, 10, 15, 20, 25 or 30 years)</td>
</tr>
<tr>
<td>028</td>
<td>Term (decreasing benefit)</td>
</tr>
<tr>
<td>040</td>
<td>Select ultimate term (premium depends on issue age and duration)</td>
</tr>
<tr>
<td>041</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for 15 years)</td>
</tr>
<tr>
<td>042</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for 20 years)</td>
</tr>
<tr>
<td>043</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for 25 years)</td>
</tr>
<tr>
<td>044</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for 30 years)</td>
</tr>
<tr>
<td>045</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for period other than 15, 20, 25 or 30 years)</td>
</tr>
<tr>
<td>046</td>
<td>Economatic term</td>
</tr>
<tr>
<td>059</td>
<td>Term plan, unable to classify</td>
</tr>
<tr>
<td>101</td>
<td>First to die term plan (submit separate records for each life)</td>
</tr>
<tr>
<td>102</td>
<td>Second to die term plan (submit separate records for each life)</td>
</tr>
<tr>
<td>103</td>
<td>Joint term plan – unknown whether 101 or 102 (submit separate records for each life)</td>
</tr>
</tbody>
</table>

**Universal Life Plans (Other than Variable), issued without a Secondary Guarantee:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>061</td>
<td>Single premium universal life</td>
</tr>
<tr>
<td>062</td>
<td>Universal life (decreasing risk amount)</td>
</tr>
<tr>
<td>063</td>
<td>Universal life (level risk amount)</td>
</tr>
<tr>
<td>064</td>
<td>Universal life – unknown whether code 062 or 063</td>
</tr>
<tr>
<td>065</td>
<td>First to die universal life plan (submit separate records for each life)</td>
</tr>
<tr>
<td>066</td>
<td>Second to die universal life plan (submit separate records for each life)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>067</td>
<td>Joint life universal life plan – unknown whether code 065 or 066 (submit separate records for each life)</td>
</tr>
<tr>
<td>068</td>
<td>Indexed universal life</td>
</tr>
<tr>
<td>067</td>
<td>Joint life universal life plan – unknown whether code 065 or 066 (submit separate records for each life)</td>
</tr>
<tr>
<td>068</td>
<td>Indexed universal life</td>
</tr>
<tr>
<td>071</td>
<td>Single premium universal life with secondary guarantees</td>
</tr>
<tr>
<td>072</td>
<td>Universal life with secondary guarantees (decreasing risk amount)</td>
</tr>
<tr>
<td>073</td>
<td>Universal life with secondary guarantees (level risk amount)</td>
</tr>
<tr>
<td>074</td>
<td>Universal life with secondary guarantees – unknown whether code 072 or 073</td>
</tr>
<tr>
<td>075</td>
<td>First to die universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td>076</td>
<td>Second to die universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td>077</td>
<td>Joint life universal life plan with secondary guarantees unknown whether code 075 or 076 (submit separate records for each life)</td>
</tr>
<tr>
<td>078</td>
<td>Indexed universal life with secondary guarantees</td>
</tr>
<tr>
<td>080</td>
<td>Variable life</td>
</tr>
<tr>
<td>081</td>
<td>Variable universal life (decreasing risk amount)</td>
</tr>
<tr>
<td>082</td>
<td>Variable universal life (level risk amount)</td>
</tr>
<tr>
<td>083</td>
<td>Variable universal life – unknown whether code 081 or 082</td>
</tr>
<tr>
<td>084</td>
<td>First to die variable universal life plan (submit separate records for each life)</td>
</tr>
<tr>
<td>085</td>
<td>Second to die variable universal life plan (submit separate records for each life)</td>
</tr>
<tr>
<td>086</td>
<td>Joint life variable universal life plan – unknown whether 084 or 085 (submit separate records for each life)</td>
</tr>
<tr>
<td>090</td>
<td>Variable life with secondary guarantees</td>
</tr>
<tr>
<td>091</td>
<td>Variable universal life with secondary guarantees (decreasing risk amount)</td>
</tr>
<tr>
<td>092</td>
<td>Variable universal life with secondary guarantees (level risk amount)</td>
</tr>
<tr>
<td>093</td>
<td>Variable universal life with secondary guarantees – unknown whether code 091 or 092</td>
</tr>
<tr>
<td>094</td>
<td>First to die variable universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td>095</td>
<td>Second to die variable universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
</tbody>
</table>
096 = Joint life variable universal life plan with secondary guarantees – unknown whether code 094 or 095 (submit separate records for each life)

**Nonforfeiture:**
098 = Extended term
099 = Reduced paid-up
198 = Extended term for joint life (submit separate records for each life)
199 = Reduced paid-up for joint life (submit separate records for each life)

<table>
<thead>
<tr>
<th>21</th>
<th>08</th>
<th>1</th>
<th>In-force Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>If the policy segment was not in force at the end of the calendar year of observation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>If the policy segment was in force at the end of the calendar year of observation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>22</th>
<th>69–80</th>
<th>12</th>
<th>Face Amount of Insurance at Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face amount of the policy segment at its issue date rounded to nearest dollar. If policy provides payment of cash value in addition to face amount, include face amount and do not include cash value. If the policy was issued during the observation year, the Face Amount of Insurance at the Beginning of the Observation Year should be blank.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>23</th>
<th>81–92</th>
<th>12</th>
<th>Face Amount of Insurance at the Beginning of the Observation Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face amount of the policy segment at the beginning of the calendar year of observation rounded to nearest dollar. If policy provides payment of cash value in addition to face amount, include face amount and do not include cash value. Exclude extra amounts attributable to 7702 corridors. If the policy was issued during the observation year, the Face Amount at the Beginning of the Observation Year should be blank.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>24</th>
<th>93–104</th>
<th>12</th>
<th>Face Amount of Insurance at the End of the Observation Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face amount of the policy segment at the end of the calendar year of observation rounded to nearest dollar. If policy provides payment of cash value in addition to face amount, include face amount, and do not include cash value. Exclude extra amounts attributable to 7702 corridors. If In-force Indicator is 0, enter face amount of the policy segment at the time of termination, if available; otherwise, leave blank.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>25</th>
<th>405–416</th>
<th>12</th>
<th>Death Claim Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>If In-force Indicator is 1, leave blank. Death claim amount rounded to the nearest dollar. If In-force Indicator is 0 and Cause of Termination is 04, then enter the face amount. If In-force Indicator is 0 and Cause of Termination is not 04, then leave blank. If the policy provides payment of cash value in addition to face amount, report face amount, and do not include cash value.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Column</td>
<td>Start</td>
<td>End</td>
<td>Length</td>
</tr>
<tr>
<td>--------</td>
<td>-------</td>
<td>-----</td>
<td>--------</td>
</tr>
<tr>
<td>26</td>
<td>117</td>
<td>124</td>
<td>8</td>
</tr>
<tr>
<td>27</td>
<td>125</td>
<td>132</td>
<td>8</td>
</tr>
<tr>
<td>28</td>
<td>133</td>
<td>134</td>
<td>2</td>
</tr>
<tr>
<td>29</td>
<td>145</td>
<td>144</td>
<td>10</td>
</tr>
<tr>
<td>30</td>
<td>145</td>
<td>154</td>
<td>10</td>
</tr>
</tbody>
</table>
Except for level term segments specified above, leave blank for non-base segments.

For the base segments for ULSG and VLSG with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, enter the annualized billed premium for the policy year that includes the beginning of the observation year. Round to the nearest dollar.

For policies issued in the observation year, leave blank. If unknown, leave blank.

<table>
<thead>
<tr>
<th>31</th>
<th>155–164</th>
<th>10</th>
<th>Annualized Premium at the End of Observation, if available. Otherwise Annualized Premium as of Year/Actual Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, for each segment that has Item 20, with the Inforce Indicator = 1, enter the annualized premium for the policy year that includes the end of the observation year. Otherwise, enter the annualized premium that would have been paid at the end of the observation year. If end of year premium is not available, enter the annualized premium as of the Actual Termination Date (Item 26). Except for level term segments specified above, leave blank for non-base segments. For the base segments for ULSG and VLSG with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, use the annualized billed premium. For base segments that have Item 20, with the Inforce Indicator =1, enter the annualized billed premium for the policy year that includes the end of the observation year. Otherwise, enter the annualized billed premium that would have been paid at the end of the observation year. If end of year premium is not available, enter the annualized premium as of the Actual Termination Date (Item 26). Round to the nearest dollar. If unknown, leave blank.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>32</th>
<th>165–166</th>
<th>2</th>
<th>Premium Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>01 = Annual 02 = Semiannual 03 = Quarterly 04 = Monthly Bill Sent 05 = Monthly Automatic Payment 06 = Semimonthly 07 = Biweekly 08 = Weekly 09 = Single Premium 10 = Other / Unknown</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>33</th>
<th>167–176</th>
<th>10</th>
<th>Cumulative Premium Collected as of the Beginning of Observation Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>If not ULSG or VLSG, leave blank. For ULSG, and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>177-186</td>
<td>10</td>
<td>Cumulative Premium Collected as of the End of Observation Year if available. Otherwise Cumulative Premium Collected as of Actual Termination Date</td>
</tr>
</tbody>
</table>
|   |   |   | 1) For non-base segments, leave blank.  
2) For base segments, enter the cumulative premium collected since issue, as of the beginning of the observation year. Round to the nearest dollar.  
For policies issued in the observation year, leave blank. If unknown, leave blank.  
If not ULSG or VLSG, leave blank.  
For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:  
1) For non-base segments, leave blank.  
2) For base segments in force at the end of the observation year, enter the cumulative premium collected as of the end of the observation year.  
3) For base segments terminated during the observation year, enter the cumulative premium collected since issue, as of the Actual Termination Date (Item 26).  
Round to the nearest dollar.  
If unknown, leave blank. |
| 35 | 187-188 | 2 | ULSG/VLSG Premium Type |
|   |   |   | For non-base segments, leave blank.  
If not ULSG or VLSG, leave blank.  
For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:  
00 = Unknown  
01 = Single premium  
02 = ULSG/VLSG Whole life level premium  
03 = Lower premium (term like)  
04 = Other |
| 36 | 189-190 | 2 | Type of Secondary Guarantee |
|   |   |   | For non-base segments, leave blank.  
If not ULSG or VLSG, leave blank.  
For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:  
00 = Unknown  
01 = Cumulative Premium without Interest (Single Tier)  
02 = Cumulative Premium without Interest (Multiple Tier)  
03 = Cumulative Premium without Interest (Other)  
04 = Cumulative Premium with Interest (Single Tier)  
05 = Cumulative Premium with Interest (Multiple Tier)  
06 = Cumulative Premium with Interest (Other)  
11 = Shadow Account (Single Tier) |
<table>
<thead>
<tr>
<th></th>
<th>37</th>
<th>191-200</th>
<th>10</th>
<th>Cumulative Minimum Premium as of the Beginning of Observation Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>38</td>
<td>201-210</td>
<td>10</td>
<td>Cumulative Minimum Premium as of the End of Observation Year/ Actual Termination Date</td>
</tr>
</tbody>
</table>

If not ULSG or VLSG, leave blank.

For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:

If Item 35, Type of Secondary Guarantee is blank, 00, 11, 12, 13 or 23, leave blank.

If Item 35, Type of Secondary Guarantee is 01, 02, 03, 04, 05, 06, 21 or 22:

1) Leave non-base segments, blank.
2) For base segments:
   Enter the cumulative minimum premiums, including applicable interest, for all policy years
   up to the beginning of the observation year.

Round to the nearest dollar.

For policies issued in the observation year, leave blank.

If unknown, leave blank.

For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan:

If Item 35, Type of Secondary Guarantee is blank, 00, 11, 12, 13 or 23, leave blank.

If Item 35, Type of Secondary Guarantee is 01, 02, 03, 04, 05, 06, 21 or 22:

1) For non-base segments, leave blank.
2) For base segments inforce at the end of the observation year, enter the cumulative minimum premiums, including applicable interest, up to the end of the observation year.
3) For base segments terminated during the observation year, enter the cumulative minimum premiums, including applicable interest, up to the Actual Termination Date (Item 26)

Round to the nearest dollar.

12 = Shadow Account (Multiple Tier)
13 = Shadow Account (Other)
21 = Both Cumulative Premium without Interest and Shadow Account
22 = Both Cumulative Premium with Interest and Shadow Account
23 = Other, not involving either Cumulative Premium or Shadow Account
| 39 | 211-220 | 10 | Shadow Account Amount at the Beginning of Observation Year | If unknown, leave blank. 
| **39** | **211-220** | **10** | **Shadow Account Amount at the Beginning of Observation Year** | **If not ULSG, or VLSG, leave blank.** 
| | | | | **For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:** 
| | | | | **If Item 35, Type of Secondary Guarantee is blank, 00, 01, 02, 03, 04, 05, 06, or 23 leave blank.** 
| | | | | **If Item 35, Type of Secondary Guarantee is 11, 12, 13, 21 or 22:** 
| | | | | 1) Leave non-base segments blank. 
| | | | | 2) For base segments: 
| | | | | Enter total amount of the Shadow Account at the beginning of the observation year. The Shadow Account can be positive, zero or negative. 
| | | | | Round to the nearest dollar. 
| | | | | For policies issued in the observation year, leave blank. 
| | | | | If unknown, leave blank. 
| 40 | 221-230 | 10 | Shadow Account Amount at the End of Observation Year/Actual Termination Date | If unknown, leave blank. 
| **40** | **221-230** | **10** | **Shadow Account Amount at the End of Observation Year/Actual Termination Date** | **If not ULSG, or VLSG, leave blank.** 
| | | | | **For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:** 
| | | | | **If Item 35, Type of Secondary Guarantee is blank, 00, 01, 02, 03, 04, 05, 06, or 23 leave blank.** 
| | | | | **If Item 35, Type of Secondary Guarantee is 11, 12, 13, 21 or 22:** 
| | | | | 1) For non-base segments, leave blank. 
| | | | | 2) For base segments in force at the end of the observation year, enter the total amount of the Shadow Account at the end of the observation year. The Shadow Account can be positive, zero or negative. 
| | | | | 3) For base segments terminated during the observation year, enter the total amount of the Shadow Account as of the Actual Termination Date (Item 26). The Shadow Account can be positive, zero or negative. 
| | | | | Round to the nearest dollar. 
| | | | | If unknown, leave blank. 
| 41 | 231-240 | 10 | Account Value at the Beginning of Observation Year | For non-base segments, leave blank. 
| **41** | **231-240** | **10** | **Account Value at the Beginning of Observation Year** | **For non-base segments, leave blank.** 
| | | | | **If not ULSG or VLSG, leave blank.** 
| | | | | **For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, the policy Account Value (gross of any loan) at the Beginning of the Observation Year. The policy**
Account Value can be positive, zero or negative. Round to the nearest dollar. For policies issued in the observation year, leave blank. If unknown, leave blank.

| 42 | 241-250 | 10 | Account Value at the End of Observation Year/Actual Termination Date | For non-base segments, leave blank. If not ULSG or VLSG, leave blank. For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: 1) If policy is in force at the end of observation year, enter the policy Account Value (gross of any loan) at the end of the Observation Year. The policy Account Value can be positive, zero or negative. 2) If policy terminated during the observation year, enter the policy Account Value (gross of any loan) as of the Actual Termination Date (Item 26). The policy Account Value can be positive, zero or negative. Round to the nearest dollar. If unknown, leave blank. |

| 43 | 251-260 | 10 | Amount of Surrender Charge at the Beginning of Observation Year | For non-base segments, leave blank. If not ULSG or VLSG, leave blank. For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan, enter the dollar Amount of the Surrender Charge as of the Beginning of the Observation Year. Round to the nearest dollar. For policies issued in the observation year, leave blank. If unknown, leave blank. |

<p>| 44 | 261-270 | 10 | Amount of Surrender Charge at the End of Observation Year/Actual Termination Date | For non-base segments, leave blank. If not ULSG or VLSG, leave blank. For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: 1) If policy is in force at the end of observation year, enter the dollar amount of the Surrender Charge at the end of the Observation Year. 2) If policy terminated during the observation year, enter the dollar amount of the Surrender Charge |</p>
<table>
<thead>
<tr>
<th>Item</th>
<th>271-272</th>
<th>Description</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>Operative Secondary Guarantee at the Beginning of Observation Year</td>
<td>The company defines whether a secondary guarantee is in effect for a policy with a secondary guarantee at the beginning of the Observation Year. If Item 35, Type of Secondary Guarantee is blank, leave blank. If Item 35, Type of Secondary Guarantee is 00 through 23: 1) For non-base segments, leave blank. 2) For base segments: 00 = If unknown whether the secondary guarantee is in effect 01 = If secondary guarantee is not in effect 02 = If secondary guarantee is in effect 03 = If all secondary guarantees have expired</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>Operative Secondary Guarantee at the End of Observation Year/Actual Termination Date</td>
<td>The company defines whether a secondary guarantee is in effect for a policy with a secondary guarantee at the end of the Observation Year/Actual Termination Date. If Item 35, Type of Secondary Guarantee is blank, leave blank. If Item 35, Type of Secondary Guarantee is 00 through 23: 1) For non-base segments, leave blank. 2) For base segments in force at the end of observation year, enter the appropriate value below as of the end of observation year: 00 = If unknown whether the secondary guarantee is in effect 01 = If secondary guarantee is not in effect 02 = If secondary guarantee is in effect 03 = If all secondary guarantees have expired 3) For base segments terminated during the observation year, enter the appropriate value below as of the Actual Termination Date (Item 26): 00 = If unknown whether the secondary guarantee is in effect 01 = If secondary guarantee is not in effect 02 = If secondary guarantee is in effect 03 = If all secondary guarantees have expired</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>State of Domicile</td>
<td>Use standard, two-letter state abbreviations codes (e.g., FL for Florida) for the state of the policy owner’s domicile. If unknown or outside of the U.S., leave blank.</td>
<td></td>
</tr>
</tbody>
</table>
This page intentionally left blank.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force

Amendment Proposal Form*

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

Identification: David Neve, VP and Consulting Actuary, Actuarial Resources Corporation of GA
Title of the Issue: Clarify ULSG NPR calculation requirements

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

January 1, 2021 NAIC Valuation Manual, but incorporating APF 2020-03
Section 2.A.3 Section 3.B.1, 2, 5 and 6 Section 6.B.5.b
Section 3.A Section 3.C.2 and 3

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

See attached.

As a general overview, Section 3.B.5 stayed in 3.B.5 but was renumbered, but Section 3.B.6 was moved to 3.B.5.b and c.

Below is a detailed summary of the items that were moved to a new section (and/or renumbered) but were not redlined. In some cases, the wording was redlined after it was moved (if the wording changed).

<table>
<thead>
<tr>
<th>Prior version</th>
<th>New version</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.B.5 last half of first sentence</td>
<td>3.B.5.a</td>
</tr>
<tr>
<td>3.B.5 2nd and 3rd sentence</td>
<td>3.B.5.d</td>
</tr>
<tr>
<td>3.B.5.a thru g</td>
<td>renumbered as 3.B.5.d.i thru vii</td>
</tr>
<tr>
<td>3.B.6.a</td>
<td>3.B.5.b</td>
</tr>
<tr>
<td>3.B.6.b</td>
<td>3.B.5.c</td>
</tr>
<tr>
<td>3.B.6.c</td>
<td>3.B.5.c.i (with sub-bullets renumbered)</td>
</tr>
<tr>
<td>3.B.6.d</td>
<td>3.B.5.c.ii (with sub-bullets renumbered)</td>
</tr>
<tr>
<td>3.B.6.e</td>
<td>3.B.5.c.iii (with sub-bullets renumbered)</td>
</tr>
</tbody>
</table>
4. State the reason for the proposed amendment? (You may do this through an attachment.)

The NPR calculation requirements for ULSG products are currently contained in Section 3.B.5 and 3.B.6 of the Valuation Manual. The current wording takes the reader back and forth between Section 3.B.5 and 3.B.6 when trying to follow the reserve calculation for ULSG products, which can be confusing. And the current wording also has led some people to incorrectly interpret Section 3.B.5 to be applicable to UL products without a SG.

The APF combines the current 3.B.5 and 3.B.6 sections into a single section labeled 3.B.5 and clarifies how to determine the NPR when the policy duration at the valuation date is either prior to, or after the SG has expired. Importantly, no change has been made to the current requirements, only the formatting of the requirements to make them easier to follow. Note that the new wording has flipped the order of the old 3.B.5 and 3.B.6 when combining them in the new 3.B.5, but this movement is not shown as a tracked change (since no changes were made to the existing reserve calculation requirements in the two sections).

Section 3.A has also been revised to eliminate the confusion that can arise on whether the NPR for products in the All Other VM-20 Reserving Category is still a VM-20 reserve. The NPR requirement for products in the All Other VM-20 Reserving Category has been moved to Section 3.B.6.

Impacted references have been updated.
ATTACHMENT

Section 2: Minimum Reserve

A. All policies subject to these requirements shall be included in one of the VM-20 Reserving Categories, as specified in Section 2.A.1, Section 2.A.2 and Section 2.A.3 below.

1. Term Reserving Category —

2. ULSG Reserving Category —

   c. The due and deferred premium asset, if any, shall be based on the valuation net premiums computed in accordance with Section 3.B.5.d, for the base policy, determined without regard to any NPR floor amount from Section 3.D.2.

3. All Other VM-20 Reserving Category— All policies and riders belonging to the All Other VM-20 Reserving Category are to be included in Section 2.A.3.c unless the company has elected to exclude a group of them from the stochastic reserve calculation or both the deterministic and stochastic reserve calculations and has applied the applicable exclusion test defined in Section 6, passed the test and documented the results.

Section 3: Net Premium Reserve

A. Applicability

1. The NPR for each policy must be determined on a seriatim basis pursuant to Section 3.

2. When valuing term riders pursuant to Paragraph E in “Riders and Supplemental Benefits Requirements” in Section II, the reserve requirements for term policies are applicable.

B. NPR Calculation

1. For the purposes of Section 3, the following terms apply:

   b. The “level secondary guarantee” at any time is:

      i. For a shadow account secondary guarantee, the shadow account fund value that would have existed at that time assuming payment of the level gross premium determined according to Section 3.B.5.c.i.1

      ii. For a cumulative premium secondary guarantee, the amount of cumulative level gross premiums determined according to Section 3.B.5.c.i.1, accumulated with any interest or accumulation factors per the contract provisions for the secondary guarantee.

2. Section 3.B.4 and Section 3.B.5 provide the calculation of a terminal NPR under the assumption of an annual mode gross premium. In Section 3.B.4 and Section 3.B.5, the gross premium referenced is the gross premium for the policy assuming an annual premium mode.

3. All Other VM-20 Reserving Category— All policies and riders belonging to the All Other VM-20 Reserving Category are to be included in Section 2.A.3.c unless the company has elected to exclude a group of them from the stochastic reserve calculation or both the deterministic and stochastic reserve calculations and has applied the applicable exclusion test defined in Section 6, passed the test and documented the results.
benefits less the actuarial present value of future annual valuation net premiums as follows:

5. For all policies and riders within the ULSG Reserving Category, the NPR shall be determined as follows:
   a. If the policy duration on the valuation date is prior to the point when all secondary guarantee periods have expired, the NPR shall be the greater of the reserve amount determined in Section 3.B.5.c and the reserve amount determined in Section 3.B.5.d, subject to the floors specified in Section 3.D.2.
   b. If the policy duration on the valuation date is after the expiration of all secondary guarantee periods, the NPR shall be the reserve amount determined according to Section 3.B.5.d only, subject to the floors specified in 3.D.2.
   c. A reserve amount for the policy shall be calculated assuming the secondary guarantee is in effect as described below. If the policy has multiple secondary guarantees, the NPR shall be calculated as below for the secondary guarantee that provides the greatest NPR as of the valuation date. For the purposes of this subsection, let n be the longest number of years the policy can remain in force under the provisions of the secondary guarantee. However, if a shorter period produces a materially greater NPR, then n shall be that shorter number of years.
      i. As of the policy issue date:
         1. Determine the level gross premium at issue, assuming payments are made each year for which premiums are permitted to be paid, such period defined as v years in this subsection, that would keep the policy in force to the end of year n, based on policy provisions, including the secondary guarantee provisions, such as mortality, interest and expenses. In no event shall v be greater than n for purposes of the NPR calculated in this subsection.
         2. Determine the annual valuation net premiums at issue as that uniform percentage (the valuation net premium ratio) of the respective gross premiums such that at issue the actuarial present value of future valuation net premiums over the n-year period shall equal the actuarial present value of future benefits over the n-year period. The valuation net premium ratio determined shall not change for the policy.
         3. Using the level gross premium from Section 3.B.5.c.i.1 above, determine the value of the expense allowance components for the policy at issue as x₁, y₁-₅ and z₁ defined below.
            x₁ = a first-year expense equal to the level gross premium at issue
            y₁-₅ = an expense equal to 10% of the level gross premium and applied in each year from the second through fifth policy year
            z₁ = a first-year expense of $2.50 per $1,000 of insurance issued
            The expense allowance shall be amortized over the span of years in the secondary guarantee period during which premiums are permitted to be paid. Eₜ,v, the expense allowance balance as of the end of the policy year t, shall be computed as follows:
            \[ Eₜ,v = VNPR \times \left( x₁ \times \frac{1}{v} + y₁ \times \frac{1}{v} \times 5 + \sum_{j=1}^{5} z₁ \times j \right) \]
            for \( t < v \)
            \[ Eₜ,v = 0 \]
            for \( t ≥ v \)
            Where:
            \( j = 1, 2, ... \) (number of completed years since issue)
After the policy issue date, on each future valuation date, the NPR shall be determined as follows:

1. As of the valuation date for the policy being valued, determine the actual secondary guarantee, denoted ASG_{x+t}, as outlined in Section 3.B.1.c and the fully funded secondary guarantee, denoted FFSG_{x+t}, as outlined in Section 3.B.1.b.

2. Divide ASG_{x+t} by FFSG_{x+t}, with the resulting ratio capped at 1. The ratio is intended to measure the level of prefunding for a secondary guarantee, which is used to establish reserves. Assumptions within the numerator and denominator of the ratio, therefore, must be consistent in order to appropriately reflect the level of prefunding. As used here, “assumptions” include any factor or value, whether assumed or known, which is used to calculate the numerator or denominator of the ratio.

3. Compute the net single premium (NSP_{x+t}) on the valuation date for the coverage provided by the secondary guarantee for the period of time ending at attained age x+n, using the interest, lapse and mortality assumptions prescribed in Section 3.C below. The net single premium (NSP) shall include consideration for death benefits only.

4. The NPR for an insured age x at issue at time t shall be according to the formula below:

\[ \text{VNPR} = \frac{\text{C}_{x+t}}{\sigma} \]

where C_{x+t} = 0 when t = 1

\[ \sum_{n=1}^{t-5} \left( 1 - \frac{t}{T} \right) \]

when 2 \leq t \leq 5

\[ = C_{x+5} \]

when t > 5

Guidance Note: For a non-integer value of t, E_{x+t} is obtained by taking the present value at duration t of E_{x+t} where T is the next higher integer; i.e., entails discounting by valuation interest, mortality, and lapse for the fractional year between the valuation date and next anniversary (T - t).

A reserve amount for the policy shall be calculated assuming the secondary guarantee is not in effect. The reserve amount shall be determined by the policy features and guarantees of the policy without considering any secondary guarantee provisions, as follows:

i. Determine the level gross premium at issue, assuming payments are made each year for which premiums are permitted to be paid, such period defined as “s” in this subsection, that would keep the policy in force for the entire period coverage is to be provided based on the policy guarantees of mortality, interest, and mortality.

ii. Determine the annual valuation net premiums as that uniform percentage (the valuation net premium ratio) of the respective gross premiums, such that at issue the actuarial present value of future valuation net premiums over the n-year period shall equal the actuarial present value of future benefits over the n-year period. The valuation net premium ratio determined shall not change for the policy.

A reserve amount for the policy shall be calculated assuming the secondary guarantee is not in effect. The reserve amount shall be determined by the policy features and guarantees of the policy without considering any secondary guarantee provisions, as follows:

i. Determine the level gross premium at issue, assuming payments are made each year for which premiums are permitted to be paid, such period defined as “s” in this subsection, that would keep the policy in force for the entire period coverage is to be provided based on the policy guarantees of mortality, interest, and mortality.

ii. Determine the annual valuation net premiums as that uniform percentage (the valuation net premium ratio) of the respective gross premiums, such that at issue the actuarial present value of future valuation net premiums over the n-year period shall equal the actuarial present value of future benefits over the n-year period. The valuation net premium ratio determined shall not change for the policy.
value of future valuation net premiums shall equal the actuarial present value of future benefits.

iii. Using the level gross premium from Section 3.B.5.d.i, determine the value of the expense allowance components for the policy at issue as \( x_1 \), \( y_{2-5} \), and \( z_1 \) defined below.

- \( x_1 \): a first-year expense equal to the level gross premium at issue
- \( y_{2-5} \): an expense equal to 10% of the level gross premium and applied in each year from the second through fifth policy year
- \( z_1 \): a first-year expense of $2.50 per $1,000 of insurance issued

The expense allowance shall be amortized over the period during which premiums are permitted to be paid. \( z_{1+t} \), the expense allowance balance, as of the end of policy year \( t \), shall be calculated as follows:

\[
E_{x+t} = VNPR \cdot a_{x+t-1} \left( (x_1 + x_1) / a_{x+1} + y_{2-5} \cdot C_{x+t} \right) \quad \text{for } t < s
\]

\[
E_{x+t} = 0 \quad \text{for } t \geq s
\]

Where:

\[
t = 1, 2, \ldots \quad \text{(number of completed years since issue)}
\]

\[
VNPR = \text{Valuation Net Premium Ratio from 3.B.5.d.i above}
\]

\[
C_{x+t} = \begin{cases} 0 & \text{when } t = 1 \\ \sum_{s=1}^{t} (1 / a_{s+1}) & \text{when } 2 \leq t \leq 5 \\ C_{x+5} & \text{when } t > 5 \\ \end{cases}
\]

iv. For a policy issued at age \( x \), at any duration \( t \), the net premium reserve shall equal:

\[
m_{x+t} \cdot r_{x+t}
\]

Where:

1. \( m_{x+t} \): the actuarial present value of future benefits less the actuarial present value of future valuation net premiums and less the unamortized expense allowance for the policy, \( E_{x+t} \).

Guidance Note: For a non-integer value of \( t \), \( E_{x+t} \) is obtained by taking the present value at duration \( t \) of \( E_{x+T} \), where \( T \) is the next higher integer; i.e., entails discounting by valuation interest and survivorship for the fractional year between the valuation date and the next anniversary (\( T - t \)).

2. Let:

\[
e_{x+t} = \max(\text{the actual policy fund value on the valuation date}, 0)
\]

\[
f_{x+t} = \text{the policy fund value on the valuation date is that amount which, together with the payment of the future level gross premiums determined in Section 3.B.5.d.i above, keeps the policy in force for the entire period coverage is to be provided, based on the policy guarantees of mortality, interest and expenses.}
\]

Then set \( v_{x+t} \) equal to:

\[
1, \text{ if } f_{x+t} \leq 0
\]
\[
\min\left[\frac{e_{x+t}}{f_{x+t}}, 1\right], \text{ otherwise}
\]

v. The future benefits used in determining the value of \(m_{x+t}\) shall be based on the greater of \(e_{x+t}\) and \(f_{x+t}\) together with the future payment of the level gross premiums determined in Section 3.B.5.d above, and assuming the policy guarantees of mortality, interest and expenses.

vi. The values of \(\bar{d}\) are determined using the NPR interest, mortality and lapse assumptions applicable on the valuation date.

vii. Actuarial present values referenced in this Section 3.B.5.d are calculated using the interest, mortality and lapse assumptions prescribed in Section 3.C.

6. For all policies and riders within the All Other VM-20 Reserving Category, the NPR shall be determined pursuant to applicable methods in VM-A and VM-C for the basic reserve. The mortality tables to be used are those defined in Section 3.C.1 and in VM-M Section 1.H.

7. The actuarial present value of future benefits equals the present value of future benefits including, but not limited to, death, endowment (including endowments intermediate to the term of coverage) and cash surrender benefits. Future benefits are before reinsurance and before netting the repayment of any policy loans.

8. For life insurance coverage that the company has assumed on a YRT basis, the reinsurer’s net premium reserve shall be one half year’s cost of insurance for the reinsured net amount at risk.

C. Net Premium Reserve Assumptions

2. Interest Rates

a. For NPR amounts calculated according to Section 3.B.5.d:

b. For NPR amounts calculated according to Section 3.B.4 or Section 3.B.5.e.

3. Lapse Rates

a. For NPR amounts calculated according to Section 3.B.5.d, the lapse rates used shall be 0% per year during the premium paying period and 0% per year thereafter.

b. For NPR amounts calculated according to Section 3.B.5.e, the lapse rate, \(L_{x+t}\), for an insured age \(x\) at issue for all durations subsequent to the valuation date shall be determined as follows:

i. Determine the ratio \(R_{x+t}\) where:

\[
R_{x+t} = \frac{FFSG_{x+t} - ASG_{x+t}}{FFSG_{x+t} - LSG_{x+t}} \text{ but not } > 1 \text{ and not } < 0
\]

Where:

- \(FFSG_{x+t}\) = the fully funded secondary guarantee on the valuation date for the insured age \(x\) at issue
- \(ASG_{x+t}\) = the actual secondary guarantee on the valuation date for the insured age \(x\) at issue

Deleted: a

Deleted: ULSG

Deleted: as follows. Prior to the point when all secondary guarantee periods have expired, the NPR shall, subject to the floors specified in Section 3.D.2, be the greater of the reserve amount determined according to Section 3.B.5, assuming the policy has no secondary guarantees, and the reserve amount for the policy determined according to the methodology and requirements in Section 3.B.6.a through Section 3.B.6.e below.

Deleted:

Commented [MR18]: CA Suggestion #2

Commented [MR19]: CA Suggestion #3

Commented [MR20]: CA suggestion #3

Deleted: 6

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\[ LSG_{x+t} \] - the level secondary guarantee on the valuation date for the insured age \( x \) at issue

**Guidance Note:** The FFSG\(_{x+t} \), ASG\(_{x+t} \), and LSG\(_{x+t} \) are based on the secondary guarantee values as of the valuation date and will remain constant throughout the cash flow projection. This will result in a constant lapse assumption, calculated as of the valuation date, that does not vary by duration throughout the cash flow projection for the NPR calculation.

ii. As of the valuation date, which is \( t \) years after issue, the annual lapse rate for the policy shall be assumed to be level for all future years and denoted as \( L_{x+t} \), which shall be set equal to:

\[ L_{x+t} = R_{x+t} \cdot 0.01 + (1 - R_{x+t}) \cdot 0.005 \cdot r_{x+t} \]

Where \( r_{x+t} \) is the ratio determined in Section 3.B.5.d.iv.2.

**Guidance Note:** By similar logic, it follows (from ASG\(_{x+t} \) being 0 when \( t=0 \)) that the level annual lapse rate to be used in the calculations in Section 3.B.5.c.i.2 and 3.B.5.c.i.3 is 1%. On the other hand, when performing the calculations in Section 3.B.5.c.ii.3, \( L_{x+t} \), though level, is not generally equal to what it was for the same policy on the previous valuation date.

### Section 6: Stochastic and Deterministic Exclusion Tests

#### B. Deterministic Exclusion Test (DET)

5. For purposes of determining the valuation net premiums used in the demonstration in Section 6.B.2:

a. If pursuant to Section 2, the NPR for the group of policies is the minimum reserve required under VM-A and VM-C, then the valuation net premiums are determined according to those minimum reserve requirements.

b. If the NPR is determined according to Section 3.B.4 or Section 3.B.5, then the lapse rates assumed for all durations shall for the purposes of the DET be set to 0%.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

Identification:
PBR Staff of Texas Department of Insurance

Title of the Issue:
1. Address determination of materiality. VM-21 often refers to materiality but is missing a discussion on how materiality is determined.
2. Address use of approximations and simplifications in VM-21.

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

VM-21 Section 1.E (new), VM-21 Section 3.H (new), VM-31 Section 3.E.1, VM-31 Section 3.F.2.e

January 1, 2021 NAIC Valuation Manual

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

See attached.

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

1. VM-21 often refers to materiality but is missing a discussion on how materiality is determined (a materiality standard), as VM-20 has in VM-20 Section 2.H. Moreover, the current language of Materiality in the VA Summary in VM-31 Section 3.E.1 (2021 edition) is based on the Life PBR Summary in VM-31 (2019 edition). The language of Materiality in the VA Summary in Section 3.E.1 of VM-31 should be updated, consistent with adding a new section to VM-21 to address materiality.

For reference, here are the relevant VM-20 passages:

**VM-20 Section 2.H**
The company shall establish, for the DR and SR, a standard containing the criteria for determining whether an assumption, risk factor or other element of the principle-based valuation has a material impact on the size of the reserve. This standard shall be applied when identifying material risks. Such a standard shall also apply to the NPR with respect to VM-20 Section 2.G.

**VM-31 Section 3.C.1**
Life Summary –The PBR Actuarial Report shall contain a Life Summary of the critical elements of all sub-reports of the Life Report as detailed in Section 3.D. In particular, this Life Summary shall include:

1. VM-20 Materiality – The standard established by the company pursuant to VM-20 Section 2.H.

2. While it is common for companies to use a significant number of approximations, simplifications, and modeling efficiency techniques for their VM-21 valuation, VM-21 is missing an explicit allowance of approximations, simplifications, or modeling efficiency techniques. To understand the impact of the large number of approximations, simplifications, and modeling efficiency techniques, they should be covered in one location in the PBR reporting for VA, in contrast to the current reporting where they are scattered throughout the PBR Report. VM-20 Section 2.G does not allow simplifications to bias the reserve downward. This addresses the concern that a large number of immaterial simplifications could add up to a material understatement. VM-21 needs an assurance that simplifications do not compound one another to become material even more than VM-20, due to the very larger number of simplifications commonly used.

VM-21 Section 1.E (new)

Materiality

The company shall establish a standard containing the criteria for determining whether an assumption, risk factor or other element of the principle-based valuation has a material impact on the size of the reserve or TAR. This standard shall be applied when identifying material risks.

VM-21 Section 3.H (new)

H. A company may use simplifications, approximations and modeling efficiency techniques to calculate the stochastic reserve and/or the additional standard projection amount required by this section if the company can demonstrate that the use of such techniques does not understate TAR by a material amount, and the expected value of TAR calculated using simplifications, approximations and modeling efficiency techniques is not less than the expected value of TAR calculated that does not use them.

Guidance Note:

Examples of modeling efficiency techniques include, but are not limited to:

1. Choosing a reduced set of scenarios from a larger set consistent with prescribed models and parameters.
2. Generating a smaller liability or asset model to represent the full seriatim model using grouping compression techniques or other similar simplifications.

There are multiple ways of providing the demonstration required by Section 3.H. The complexity of the demonstration depends upon the simplifications, approximations or modeling efficiency techniques used. Examples include, but are not limited to:

1. Rounding at a transactional level in a direction that is clearly and consistently conservative or is clearly and consistently unbiased with an obviously immaterial impact on the result (e.g., rounding to the nearest dollar) would satisfy 3.H without needing a demonstration. However,
rounding to too few significant digits relative to the quantity being rounded, even in an unbiased way, may be material and in that event, the company may need to provide a demonstration that the rounding would not produce a material understatement of TAR.

2. A brute force demonstration involves calculating the minimum reserve both with and without the simplification, approximation or modeling efficiency technique, and making a direct comparison between the resulting TAR. Regardless of the specific simplification, approximation or modeling efficiency technique used, brute force demonstrations always satisfy the requirements of Section 3.H.

3. Choosing a reduced set of scenarios from a larger set consistent with prescribed models and parameters and providing a detailed demonstration of why it did not understat TAR by a material amount and the expected value of TAR would not be less than the expected value of TAR that would otherwise be calculated. This demonstration may be a theoretical, statistical or mathematical argument establishing, to the satisfaction of the insurance commissioner, general bounds on the potential deviation in the TAR estimate rather than a brute force demonstration.

4. Justify the use of randomly sampling withdrawal ages for each contract instead of following the exact prescribed WDCM method by demonstrating that the random sampling method is materially equivalent to the exact prescribed approach, and the simplification does not materially reduce the Additional Standard Projection Amount and the final reported TAR. In particular, the company should demonstrate that the statistical variability of the results based on the random sampling approach is immaterial by testing different random sets, e.g., if randomly selecting a withdrawal age for each contract, the probability distribution of the withdrawal age should be stable and not vary significantly when using different random number sets.

VM-31 Section 3.E.1

VA Summary - The PBR Actuarial Report shall contain a VA Summary of the critical elements of all sub-reports of the VA Report as detailed in Section 3.F. In particular, this VA Summary shall include:

1. Materiality - The Standard established by the company pursuant to VM-21 Section 1.E.

VM-31 Section 3.F.2.e

c. Approximations, Simplifications, and Modeling Efficiency Techniques - A description of each approximation, simplification or modeling efficiency technique used in reserve or TAR calculations, and a statement that the required VM-21 Section 3.H demonstration is available upon request and shows that: 1) the use of each approximation, simplification, or modeling efficiency technique does not understat TAR by a material amount; and 2) the expected value of TAR is not less than the expected value of TAR calculated without using the approximation, simplification, or modeling efficiency technique.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.
   Angela McNabb & Pat Allison – NAIC staff support

2. Identify the document, including the date if the document is “released for comment,” and the location in the
document where the amendment is proposed:
   January 1, 2021, version of the Valuation Manual – VM-51 Appendix 4

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

<table>
<thead>
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<th>ITEM</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| 11   | 1 | Smoker Status (at issue) | Smoker status should be submitted where reliable.  
0 = Unknown  
1 = No tobacco usage  
2 = Nonsmoker  
3 = Cigarette smoker  
4 = Tobacco user |

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

   In the event that additional underwriting is done after issue, it is possible that the preferred class would be
   inconsistent with the smoker status at issue. By removing the “at issue” specification, the smoker status would then
   be the current smoker status.

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

NAIC Staff Comments:

<table>
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<th>Received</th>
<th>Reviewed by Staff</th>
<th>Distributed</th>
<th>Considered</th>
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<td>6/3/2021</td>
<td>RM</td>
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Notes: APF 2021-10
REQUEST FOR NAIC MODEL LAW DEVELOPMENT

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

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

1. Name of group to be responsible for drafting the model:
   
   Annuity Disclosure (A) Working Group of the Life Insurance and Annuities (A) Committee

2. NAIC staff support contact information:
   
   Jennifer Cook  
   jcook@naic.org  
   202-471-3986

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

   The Working Group would like to revise Section 6—Standards for Illustrations in the Annuity Disclosure Model Regulation (#245) to address issues identified by the Working Group related to innovations of annuity products currently in the marketplace that are not addressed or not adequately addressed in the current standards.

4. Does the model law meet the Model Law Criteria?  
   X Yes  
   or  
   ☐ No  
   (Check one)

   (If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

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

      If yes, please explain why: Consumers should receive accurate disclosures of the annuities they are purchasing.

   b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?  
      X Yes  
      or  
      ☐ No  
      (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?  
   ☐ 1  
   ☐ 2  
   ☐ 3  
   ☐ 4  
   ☐ 5  
   (Check one)

   High Likelihood  
   Low Likelihood

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

☐ 1  X 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood  Low Likelihood

Explanation, if necessary:

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

☐ 1  X 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood  Low Likelihood

Explanation, if necessary:

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

Not an accreditation standard

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

No.
**ANNUITY DISCLOSURE MODEL REGULATION**

Table of Contents

Section 1. Purpose
Section 2. Authority
Section 3. Applicability and Scope
Section 4. Definitions
Section 5. Standards for the Disclosure Document and Buyer’s Guide
Section 6. Standards for Annuity Illustrations
Section 7. Report to Contract Owners
Section 8. Penalties
Section 9. Separability
Section 10. [Optional] Recordkeeping
Section 11. Effective Date

Appendix A. Annuity Illustration Example

* * * * *

Section 6. Standards for Annuity Illustrations

* * * * *

F. An illustration shall conform to the following requirements:

(1) The illustration shall be labeled with the date on which it was prepared;

(2) Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the disclosure document (e.g., the fourth page of a seven-page disclosure document shall be labeled “page 4 of 7 pages”);

(3) The assumed dates of premium receipt and benefit payout within a contract year shall be clearly identified;

(4) If the age of the proposed insured is shown as a component of the tabular detail, it shall be issue age plus the numbers of years the contract is assumed to have been in force;

(5) The assumed premium on which the illustrated benefits and values are based shall be clearly identified, including rider premium for any benefits being illustrated;

(6) Any charges for riders or other contract features assessed against the account value or the crediting rate shall be recognized in the illustrated values and shall be accompanied by a statement indicating the nature of the rider benefits or the contract features, and whether or not they are included in the illustration;

(7) Guaranteed death benefits and values available upon surrender, if any, for the illustrated contract premium shall be shown and clearly labeled guaranteed;

(8) Except as provided in Paragraph (22), the non-guaranteed elements underlying the non-guaranteed illustrated values shall be no more favorable than current non-guaranteed elements and shall not include any assumed future improvement of such elements. Additionally, non-guaranteed elements used in calculating non-guaranteed illustrated values at any future duration shall reflect any planned changes, including any planned changes that may occur after expiration of an initial guaranteed or bonus period;
In determining the non-guaranteed illustrated values for a fixed indexed annuity, the index-based interest rate and account value shall be calculated for three different scenarios: one to reflect historical performance of the index for the most recent ten (10) calendar years; one to reflect the historical performance of the index for the continuous period of ten (10) calendar years out of the last twenty (20) calendar years that would result in the least index value growth (the “low scenario”); one to reflect the historical performance of the index for the continuous period of ten (10) calendar years out of the last twenty (20) calendar years that would result in the most index value growth (the “high scenario”). The following requirements apply:

(a) The most recent ten (10) calendar years and the last twenty (20) calendar years are defined to end on the prior December 31, except for illustrations prepared during the first three (3) months of the year, for which the end date of the calendar year period may be the December 31 prior to the last full calendar year;

(b) If any index utilized in determination of an account value has not been in existence for at least ten (10) calendar years, indexed returns for that index shall not be illustrated. If the fixed indexed annuity provides an option to allocate account value to more than one indexed or fixed declared rate account, and one or more of those indexes has not been in existence for at least ten (10) calendar years, the allocation to such indexed account(s) shall be assumed to be zero;

(c) If any index utilized in determination of an account value has been in existence for at least ten (10) calendar years but less than twenty (20) calendar years, the ten (10) calendar year periods that define the low and high scenarios shall be chosen from the exact number of years the index has been in existence;

(d) The non-guaranteed element(s), such as caps, spreads, participation rates or other interest crediting adjustments, used in calculating the non-guaranteed index-based interest rate shall be no more favorable than the corresponding current element(s);

(e) If a fixed indexed annuity provides an option to allocate the account value to more than one indexed or fixed declared rate account:
   (i) The allocation used in the illustration shall be the same for all three scenarios; and
   (ii) The ten (10) calendar year periods resulting in the least and greatest index growth periods shall be determined independently for each indexed account option.

(f) The geometric mean annual effective rate of the account value growth over the ten (10) calendar year period shall be shown for each scenario;

(g) If the most recent ten (10) calendar year historical period experience of the index is shorter than the number of years needed to fulfill the requirement of subsection H, the most recent ten (10) calendar year historical period experience of the index shall be used for each subsequent ten (10) calendar year period beyond the initial period for the purpose of calculating the account value for the remaining years of the illustration;

(h) The low and high scenarios: (i) need not show surrender values (if different than account values); (ii) shall not extend beyond ten (10) calendar years (and therefore are not subject to the requirements of subsection H beyond subsection H(1)(a)); and (iii) may be shown on a separate page. A graphical presentation shall also be included comparing the movement of the account value over the ten (10) calendar year period for the low scenario, the high scenario and the most recent ten (10) calendar year scenario; and
The low and high scenarios should reflect the irregular nature of the index performance and should trigger every type of adjustment to the index-based interest rate under the contract. The effect of the adjustments should be clear; for example, additional columns showing how the adjustment applied may be included. If an adjustment to the index-based interest rate is not triggered in the illustration (because no historical values of the index in the required illustration range would have triggered it), the illustration shall so state;

10. The guaranteed elements, if any, shall be shown before corresponding non-guaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements (e.g., “see page 1 for guaranteed elements”);

11. The account or accumulation value of a contract, if shown, shall be identified by the name this value is given in the contract being illustrated and shown in close proximity to the corresponding value available upon surrender;

12. The value available upon surrender shall be identified by the name this value is given in the contract being illustrated and shall be the amount available to the contract owner in a lump sum after deduction of surrender charges, bonus forfeitures, contract loans, contract loan interest and application of any market value adjustment, as applicable;

13. Illustrations may show contract benefits and values in graphic or chart form in addition to the tabular form;

14. Any illustration of non-guaranteed elements shall be accompanied by a statement indicating that:
   (a) The benefits and values are not guaranteed;
   (b) The assumptions on which they are based are subject to change by the insurer; and
   (c) Actual results may be higher or lower;

15. Illustrations based on non-guaranteed credited interest and non-guaranteed annuity income rates shall contain equally prominent comparisons to guaranteed credited interest and guaranteed annuity income rates, including any guaranteed and non-guaranteed participation rates, caps or spreads for fixed indexed annuities;

16. The annuity income rate illustrated shall not be greater than the current annuity income rate unless the contract guarantees are in fact more favorable;

17. Illustrations shall be concise and easy to read;

18. Key terms shall be defined and then used consistently throughout the illustration;

19. Illustrations shall not depict values beyond the maximum annuitization age or date;

20. Annuity benefits shall be based on contract values that reflect surrender charges or any other adjustments, if applicable; and

21. Illustrations shall show both annuity income rates per $1000.00 and the dollar amounts of the periodic income payable.

22. For participating immediate and deferred income annuities:
   (a) Illustrations may not assume any future improvement in the applicable dividend scale (or scales, if more than one dividend scale applies, such as for a flexible premium annuity);
   (b) Illustrations must reflect the equitable apportionment of dividends, whether performance meets, exceeds or falls short of expectations;
(c) If the dividend scale is based on a portfolio rate method, the portfolio rate underlying the illustrated dividend scale shall not be assumed to increase;

(d) If the dividend scale is based on an investment cohort method, the illustrated dividend scale should assume that reinvestment rates grade to long-term interest rates, subject to the following conditions:

(i) Any assumptions as to future investment performance in the dividend formula must be consistent with assumptions that are reflected in the marketplace within the normal range of analyst forecasts and investor behavior; these assumptions may not be changed arbitrarily, notwithstanding changes in markets or economic conditions, and must be consistent with assumptions that the issuer uses with respect to other lines of business; and

(ii) The illustrated dividend scale should assume that reinvestment rates grade to long-term interest rates, based on U.S Treasury bonds. For the purposes of this grading, the assumed long-term rates should not exceed the rates calculated using the formula in subparagraph iii, below, based on the time to maturity or reinvestment (the “Tenor”) of the investments supporting the cohort of policies.

(iii) Maximum long-term interest rates should be calculated for tenors of 3 months (or less), 5 years, 10 years and 20 years (or more), using U.S Treasury rates. For each tenor, the maximum long-term interest rate will vary over time, based on historical interest rates as they emerge. The formula for the maximum long-term interest rate is the average of the median bond rate over the last 600 months and the average bond rate over the last 120 months, rounded to the nearest quarter of one percent (0.25%).

(iv) The maximum long-term interest rate for a tenor should be recalculated once per year, in January, using historical rates as of December 31 of the calendar year two years prior to the calendar year of the calculation date. The historical rate for each month is the rate reported for the last business day of the month.

(v) Grading to the maximum long-term interest rates should take place over:

(I) No less than 20 years from issue if U.S. Treasury rates as of the illustration date are below the long-term rates; or

(II) No more than 20 years from the issue if the U.S. Treasury rates as of the illustration date are above the long-term rates.

(vi) When the 10-year U.S. Treasury rate is less than the 10-year maximum long-term interest rate, an additional illustrated dividend scale should be presented. This additional illustrated dividend scale shall satisfy the following conditions:

(I) Assume that reinvestment U.S. Treasury rates do not exceed the initial investment U.S. Treasury rates, and

(II) Illustrate dividends no less than half of the dividends illustrated under the current dividend scales.

(III) If (a) and (b) above are in conflict—i.e., if half of the current dividends are greater than would be permitted by Condition (a)—then the reinvestment U.S. Treasury rates should equal the initial investment U.S. Treasury rates.
(vii) The illustration should include a disclosure that is substantially similar to the following:

The illustrated current dividend scale is based on interest rates that are assumed to gradually [increase/decrease] from current interest rates to long-term interest rates, over a period of [twenty] years. By regulation, the long-term assumed interest rates cannot and do not exceed the rates listed in column (c) of the table below.

(vii) If the illustration contains an additional dividend scale pursuant to subparagraph (vi) above, then the illustration should also include a disclosure that is substantially similar to the following:

The additional illustrated dividend scale is based on interest rates that are assumed no to increase and do not exceed the interest rates in column (b) of the table below.

<table>
<thead>
<tr>
<th>Tenor</th>
<th>Current Interest Rate</th>
<th>Long Term</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Treasury Rate as of 12/31/2016</td>
<td>Mean Reversed Treasury Rate</td>
</tr>
<tr>
<td>3 Month (or less)</td>
<td>0.51%</td>
<td>3.00%</td>
</tr>
<tr>
<td>5 Year</td>
<td>1.93%</td>
<td>4.50%</td>
</tr>
<tr>
<td>10 Year</td>
<td>2.45%</td>
<td>5.00%</td>
</tr>
<tr>
<td>20 Years (or more)</td>
<td>3.06%</td>
<td>5.50%</td>
</tr>
</tbody>
</table>
ANNUITY DISCLOSURE MODEL REGULATION (#245)

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

The Annuity Disclosure Model Regulation (#245) was revised to address its application to participating income annuities.

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

The Annuity Disclosure (A) Working Group of the Life Insurance and Annuities (A) Committee was responsible for drafting the revisions.

States Participating:

- Mike Yanacheak, Chair, Iowa
- Chris Struk, Florida
- Julie Holmes and Craig VanAalst, Kansas
- Adewole Odumade, Maryland
- John Robinson, Minnesota
- Frank Stone, Oklahoma
- Sarah Neil/Matt Gendron, Rhode Island
- Doug Danzeiser/Phil Reyna, Texas

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

In 2016, the Life Insurance and Annuities (A) Committee adopted a charge for the Annuity Disclosure (A) Working Group to: “Review and revise, as necessary, Section 6—Standards for Annuity Illustrations in the Annuity Disclosure Model Regulation (#245) to take into account the disclosures necessary to inform consumers in light of the product innovations currently in the marketplace.”

At the 2017 Summer National Meeting, the Executive (EX) Committee and Plenary adopted a Request for NAIC Model Law Development “to revise Section 6—Standards for Illustrations in the Annuity Disclosure Model Regulation (#245) to address issues identified by the Working Group related to innovations of annuity products currently in the marketplace that are not addressed or addressed adequately in the current standards.”

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

The Annuity Disclosure (A) Working Group met six times to discuss an issue identified under its charge: that the model prohibits the illustration of “non-guaranteed elements,” which could be construed to include participating income annuities because of the formula used to calculate the dividend scale.

New York Life had been working with state insurance regulators since 2015 to develop language for inclusion in Model #245 to allow for the illustration of participating income annuities. The Working Group heard presentations explaining the issue and discussed a proposal forwarded by New York Life. The Working Group reviewed, discussed and revised the proposal. All drafts and comments were posted on the NAIC website. On March 2, 2018, the Working Group adopted draft revisions addressing participating income annuities.

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

The Annuity Disclosure (A) Working Group met Nov. 22, 2016; Dec. 14, 2017; March 9, 2017; April 13, 2017; Feb. 15 2018; March 2, 2018; and June 4, 2018. All drafts and comments were posted to the NAIC website. The Working Group adopted the revisions addressing participating income annuities on March 2, 2018, and the Life Insurance and Annuities (A) Committee adopted the revisions during the 2018 Summer National Meeting. These revisions were adopted and held by the Committee pending resolution of an additional issue that the Working Group identified. The Working Group did not end up
making any additional revision to the model. During the 2021 Spring National Meeting, the Committee agreed to disband the Working Group once these revisions to Model #245 were considered by the Membership.

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

During its Feb. 15 meeting, the Working Group discussed concerns that the American Academy of Actuaries (Academy) raised with the participating income annuity proposal. The Academy was concerned that the proposal deviated from the current standard in its use of projected improvements and that it did not apply the change consistently across product types. New York Life explained that the proposal was purposefully narrow in scope to address a particular issue with a particular product; only participating income annuities include the potential for additional income in the form of dividends based on the divisible surplus of the company. New York Life also worked with Missouri to revise the proposal to include additional disclosures about future rate assumptions, and it included a requirement that consumers are shown an additional, more conservative illustrated scale when current interest rates are less than the long-term interest rates.

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

None.
REQUEST FOR NAIC MODEL LAW DEVELOPMENT

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

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

1. Name of group to be responsible for drafting the model:

Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force

2. NAIC staff support contact information:

Jolie Matthews jm.matthews@naic.org

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

The Subgroup has a charge to consider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs).

4. Does the model law meet the Model Law Criteria? ☒ Yes or ☐ No (Check one)

(If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

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

If yes, please explain why

The proposed new model would provide a consistent approach among the states for providing a regulatory scheme for these entities to address, for some states, a potential regulatory gap.

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

☒ Yes or ☐ No (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?

☒ 1 ☐ 2 ☐ 3 ☒ 4 ☐ 5 (Check one)

High Likelihood Low Likelihood

Explanation, if necessary: The current subgroup would target completion of a model within one year.
6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?

☐ 1  ☒ 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood               Low Likelihood

Explanation, if necessary: Some states have already implemented laws and/or regulations establishing a regulatory scheme for these entities, which may or may not be consistent with the provisions in the proposed new model. For those states with laws or regulations not consistent with the new model’s provisions, the issue will be whether these states will want to re-open those laws or regulations after adoption of the new model.

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

☐ 1  ☒ 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood               Low Likelihood

Explanation, if necessary: Some states have already implemented laws and/or regulations establishing a regulatory scheme for these entities, which may or may not be consistent with the provisions in the proposed new model. For those states with laws or regulations not consistent with the new model’s provisions, the issue will be whether these states will want to re-open those laws or regulations after adoption of the new model.

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

No

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

No. However, the U.S. Department of Health and Human Services (HHS) has proposed rules on rebating safe harbors. In addition, the HHS and/or other federal government agencies currently are considering proposing further federal policy guidance in the areas concerning PBMs and prescription drug pricing transparency and disclosure. In developing the new NAIC model, the Subgroup most likely will be discussing the same or similar issues.
[STATE] PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION MODEL ACT

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Section 1. Short Title

This Act shall be known and may be cited as the Pharmacy Benefit Manager Licensure and Regulation Act.

Section 2. Purpose

A. This Act establishes the standards and criteria for the licensure and regulation of pharmacy benefit managers providing claims processing services or other prescription drug or device services for health benefit plans.

B. The purpose of this Act is to:

(1) Promote, preserve, and protect the public health, safety and welfare through effective regulation and licensure of pharmacy benefit managers;

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

(3) Provide for powers and duties of the commissioner; and

(4) Prescribe penalties and fines for violations of this Act.

Section 3. Definitions

For purposes of this Act:

A. “Claims processing services” means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include:

(1) Receiving payments for pharmacist services;

(2) Making payments to pharmacists or pharmacies for pharmacist services; or

(3) Both paragraphs (1) and (2).

B. “Commissioner” means the insurance commissioner of this state.
C. “Covered person” means a member, policyholder, subscriber, enrollee, beneficiary, dependent or other individual participating in a health benefit plan.

D. “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of [physical, mental or behavioral] health care services.

E. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health insurance company, a health maintenance organization, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

F. “Other prescription drug or device services” means services other than claims processing services, provided directly or indirectly, whether in connection with or separate from claims processing services, including, but not limited to:

1. Negotiating rebates, discounts or other financial incentives and arrangements with drug companies;
2. Disbursing or distributing rebates;
3. Managing or participating in incentive programs or arrangements for pharmacist services;
4. Negotiating or entering into contractual arrangements with pharmacists or pharmacies, or both;
5. Developing and maintaining formularies;
6. Designing prescription benefit programs; or
7. Advertising or promoting services.

G. “Pharmacist” means an individual licensed as a pharmacist by the [state] Board of Pharmacy.

H. “Pharmacist services” means products, goods, and services or any combination of products, goods and services, provided as a part of the practice of pharmacy.

I. “Pharmacy” means the place licensed by the [state] Board of Pharmacy in which drugs, chemicals, medicines, prescriptions and poisons are compounded, dispensed or sold at retail.

J. (1) “Pharmacy benefit manager” means a person, business or entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefit manager, that provides claims processing services or other prescription drug or device services, or both, to covered persons who are residents of this state, for health benefit plans.

2. “Pharmacy benefit manager” does not include:
   (a) A health care facility licensed in this state;
   (b) A health care professional licensed in this state;
   (c) A consultant who only provides advice as to the selection or performance of a pharmacy benefit manager; or
A health carrier to the extent that it performs any claims processing and other prescription drug or device services exclusively for its enrollees.

**Section 4. Applicability**

A. This Act shall apply to a contract or health benefit plan issued, renewed, recredentialled, amended or extended on or after the effective date of this Act, including any health carrier that performs claims processing or other prescription drug or device services through a third party.

**Drafting Note:** States may want to consider adding language to Subsection A above or Section 10 of this Act providing additional time for pharmacy benefit managers to come into compliance with the requirements of this Act.

B. As a condition of licensure, any contract in existence on the date the pharmacy benefit manager receives its license to do business in this state shall comply with the requirements of this Act.

C. Nothing in this Act is intended or shall be construed to conflict with existing relevant federal law.

**Section 5. Licensing Requirement**

A. A person may not establish or operate as a pharmacy benefit manager in this state for health benefit plans without first obtaining a license from the commissioner under this Act.

B. The commissioner may adopt regulations establishing the licensing application, financial and reporting requirements for pharmacy benefit managers under this Act.

**Drafting Note:** States that are restricted in their rulemaking to only what is prescribed in statute may want to consider including in this section specific financial standards required for a person or organization to obtain a license to operate as a pharmacy benefit manager in this state.

C. A person applying for a pharmacy benefit manager license shall submit an application for licensure in the form and manner prescribed by the commissioner.

**Drafting Note:** States may want to consider reviewing their third-party administrator statute if a state wishes to specify what documents must be provided to the commissioner to obtain a pharmacy benefit manager license in the state.

D. A person submitting an application for a pharmacy benefit manager license shall include with the application a non-refundable application fee of $[X].

E. The commissioner may refuse to issue or renew a license if the commissioner determines that the applicant or any individual responsible for the conduct of affairs of the applicant is not competent, trustworthy, financially responsible or of good personal and business reputation or has been found to have violated the insurance laws of this state or any other jurisdiction, or has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction.

F. (1) Unless surrendered, suspended or revoked by the commissioner, a license issued under this section shall remain valid as long as the pharmacy benefit manager continues to do business in this state and remains in compliance with the provisions of this act and any applicable rules and regulations, including the payment of an annual license renewal fee of $[X] and completion of a renewal application on a form prescribed by the commissioner.

(2) Such renewal fee and application shall be received by the commissioner on or before [x] days prior to the anniversary of the effective date of the pharmacy benefit manager’s initial or most recent license.
Section 6. Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices

A. In any participation contracts between a pharmacy benefit manager and pharmacists or pharmacies providing prescription drug coverage for health benefit plans, no pharmacy or pharmacist may be prohibited, restricted or penalized in any way from disclosing to any covered person any healthcare information that the pharmacy or pharmacist deems appropriate regarding:

(1) The nature of treatment, risks or alternative thereto;
(2) The availability of alternate therapies, consultations, or tests;
(3) The decision of utilization reviewers or similar persons to authorize or deny services;
(4) The process that is used to authorize or deny healthcare services or benefits; or
(5) Information on financial incentives and structures used by the insurer.

B. A pharmacy benefit manager may not prohibit a pharmacy or pharmacist from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the covered person if a more affordable alternative is available.

C. A pharmacy benefit manager contract with a participating pharmacist or pharmacy may not prohibit, restrict, or limit disclosure of information to the commissioner, law enforcement or state and federal governmental officials, provided that:

(1) The recipient of the information represents it has the authority, to the extent provided by state or federal law, to maintain proprietary information as confidential; and
(2) Prior to disclosure of information designated as confidential the pharmacist or pharmacy:
   (a) Marks as confidential any document in which the information appears; or
   (b) Requests confidential treatment for any oral communication of the information.

D. A pharmacy benefit manager may not terminate the contract of or penalize a pharmacist or pharmacy due to pharmacist or pharmacy:

(1) Disclosing information about pharmacy benefit manager practices, except for information determined to be a trade secret, as determined by state law or the commissioner; or
(2) Sharing any portion of the pharmacy benefit manager contract with the commissioner pursuant to a complaint or a query regarding whether the contract is in compliance with this Act.

E. (1) A pharmacy benefit manager may not require a covered person purchasing a covered prescription drug to pay an amount greater than the lesser of the covered person’s cost-sharing amount under the terms of the health benefit plan or the amount the covered person would pay for the drug if the covered person were paying the cash price.

(2) Any amount paid by a covered person under paragraph (1) of this subsection shall be attributable toward any deductible or, to the extent consistent with section 2707 of the Public Health Service Act, the annual out-of-pocket maximums under the covered person’s health benefit plan.

Section 7. Enforcement

A. The commissioner shall enforce compliance with the requirements of this Act.

B. (1) The commissioner may examine or audit the books and records of a pharmacy benefit manager providing claims processing services or other prescription drug or device services for a health benefit plan to determine compliance with this Act.
Drafting Note: States may want to consider including a reference to the cost of examinations in the Model Law on Examinations (#390).

Drafting Note: States may want to consider incorporating their existing market conduct examination statutes into this Act rather than relying on the examination authority provided under this section.

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

(a) Considered proprietary and confidential;
(b) Not subject to the [Freedom of Information Act] of this state;
(c) Not subject to subpoena; and
(d) Not subject to discovery or admissible in evidence in any private civil action.

C. The commissioner may use any document or information provided pursuant to Section 6C of this Act or Section 6D of this Act in the performance of the commissioner’s duties to determine compliance with this Act.

D. The commissioner may impose a penalty on a pharmacy benefit manager or the health carrier with which it is contracted, or both, for a violation of this Act. The penalty may not exceed [insert appropriate state penalty] per entity for each violation of this Act.

Drafting Note: If an appeals process is not otherwise provided, a state should consider adding such a provision to this section.

Section 8. Regulations

The commissioner may promulgate regulations relating to pharmacy benefit managers that are not inconsistent with this Act.

Section 9. Severability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of this Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 10. Effective Date

This Act shall be effective [insert date]. A person doing business in this state as a pharmacy benefit manager on or before the effective date of this Act shall have six (6) months following [insert date that the Act is effective] to come into compliance with the requirements of this Act.
PROJECT HISTORY-2021

[STATE] PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION MODEL ACT

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

In 2018, after the full NAIC membership adopted the revisions to the Health Carrier Prescription Drug Benefit Management Model Act §22, there was consensus for the NAIC to explore whether to develop a new model regulating pharmacy benefit managers (PBMs). The Regulatory Framework (B) Task Force established the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup to discuss the issue. In 2019, the Subgroup decided to move forward with a 2019 charge to “[t]he Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.”

In March 2019, the Subgroup adopted a Request for NAIC Model Law Development to work on the proposed new PBM model. The Task Force and the Health Insurance and Managed Care (B) Committee both adopted the Request for NAIC Model Law Development at the 2019 Spring National Meeting. The Executive (EX) Committee adopted the request at the 2019 Summer National Meeting. Based on its work plan, the Subgroup met 12 times throughout the summer and early fall of 2019 to hear from various stakeholders on the issues the Subgroup wanted to hear more about, such as rebating, discounts, prescription drug pricing, and how PBMs are currently regulated. The Subgroup’s goal was to have its members all equally educated on these issues before it started drafting a model.

Following these informational meetings, the Subgroup determined that it had received sufficient information to move forward with drafting the proposed model. In November 2019, the Subgroup established an ad hoc technical drafting group to develop an initial draft for the full Subgroup’s review. The ad hoc technical drafting group met in December 2019 and January 2020. Due to the COVID-19 pandemic, the Subgroup was unable to meet to discuss the ad hoc technical drafting group’s draft until July 2020. During that meeting, the Subgroup discussed the initial draft and formally exposed the draft for public comment until Sept. 1, 2020. Following the end of the public comment deadline, the Subgroup met Oct. 22, 2020; Oct. 8, 2020; Oct. 1, 2020; Sept. 24, 2020; and Sept. 14, 2020, to discuss the Sept. 1, 2020, comments received on the proposed new model. During its Oct. 29, 2020, meeting, the Subgroup adopted the new model and forwarded it to the Task Force for its consideration.

As adopted by the Subgroup, at its core, the PBM model is a PBM licensing model. Sections 1–4 of the proposed PBM model set out the model’s purpose, scope, and definitions. Section 5 provides the PBM licensing provisions, including provisions related to approving initial PBM licenses and renewals. Section 6—Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices includes language related to gag clauses and information-sharing for the purposes of enforcement. Section 7 of the proposed PBM model provides enforcement language and penalties for any violations of the model act. Section 8—Regulations provides that the commissioner may promulgate regulations relating to PBMs that are not inconsistent with the model act. Section 8 also includes a drafting note to Section 8 to providing state statutory citations for 15 topic areas that some states might want to consider when developing their state legislation regulating PBMs. Section 9 and Section 10 provide, respectively, for the severability of the model act’s provisions and an effective date.

The Task Force met during the 2020 Fall National Meeting to consider the new PBM model. Given some issues with the proposed PBM model, particularly issues concerning a proposed drafting note for Section 8, the Task Force deferred acting on the PBM model and exposed it for an additional 30-day public comment period. Following the end of the public comment period, the Task Force met March 1 to discuss the comments received. During this meeting, the Task Force extensively discussed the comments received on the Section 8 drafting note and the potential impact of the U.S. Supreme Court’s decision in Rutledge vs. Pharmaceutical Care Management Association (PCMA) on the draft PBM model. The Task Force adopted the PBM model March 18 and forwarded it to the Health Insurance and Managed Care (B) Committee for its consideration. The Committee deferred acting on the proposed PBM model during its meeting at the Spring National Meeting. The Committee extensively discussed the proposed Section 8 drafting note during a meeting June 22. Following that discussion, the Committee adopted the PBM model without the Section 8 drafting note to address concerns about the precedent of including optional sections the states could consider in adopting an NAIC model. In addition, in making this decision, the Committee considered that the Task Force had adopted a new charge for the Subgroup to develop a white paper that would explore the PBM business practices highlighted in the drafting note, including current and emerging state laws on these practices.
2. **Name of Group Responsible for Drafting the Model and States Participating**

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force drafted the proposed new model. The members of the Subgroup were: Alabama, Alaska, Arkansas, California, District of Columbia, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, New Jersey, New Mexico, North Carolina, Oregon, Pennsylvania, Tennessee, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. Oregon chaired the Subgroup. Nebraska was vice chair of the Subgroup.

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

The Regulatory Framework (B) Task Force established the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup in 2018. In 2019, the Task Force adopted a charge for the Subgroup to, “[c]onsider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs). The Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.”

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

Beginning in March 2019 and ending in October 2020, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup reviewed and discussed all the comments received. Numerous interested parties participated in the drafting process. The interested parties represented all stakeholder groups, including consumers, insurers, providers, and PBM representatives. Each draft of proposed revisions was posted to the Subgroup’s web page on the NAIC website. All comment letters received were also posted. The Subgroup met in open meetings throughout the drafting process. In addition to the Subgroup’s drafting process, during its discussions of the PBM model, the Regulatory Framework (B) Task Force also held open meetings and posted all comment letters on its website.

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

Beginning in March 2019 and ending in October 2020, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup reviewed and discussed all the comments received. Numerous interested parties participated in the drafting process. The interested parties represented all stakeholder groups, including consumers, insurers, providers, and PBM representatives. Each draft of proposed revisions was posted to the Subgroup’s web page on the NAIC website. All comment letters received were also posted. The Subgroup met in open meetings throughout the drafting process. In addition to the Subgroup’s drafting process, during its discussions of the PBM model, the Regulatory Framework (B) Task Force also held open meetings and posted all comment letters on its website.

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

There was one significant item of controversy raised and ultimately resolved during the drafting process. The item of controversy concerned the proposed drafting note to Section 8. The proposed drafting note provided state statutory citations for 15 topic areas reflecting current PBM business practices that some states might want to consider when developing their state legislation regulating PBMs. The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup took this approach as a compromise between some states that wanted the PBM model to focus only on the licensing and registration by state departments of insurance (DOIs) and other states that wanted to go further to include substantive provisions related to these PBM business practices. The 15 topic areas are those areas where the Subgroup found, at this time, a lack of national consensus to include in the proposed PBM model. During the Regulatory Framework (B) Task Force and the Health Insurance and Managed Care (B) Committee discussion of the PBM model, concerns were raised about the potential of a lack of uniformity in adoption by the states, which is a key component of the NAIC model law development procedures, if states selected different provisions to include in their state law in implementing the PBM model. Given this concern, some stakeholders suggested that the options approach in the Section 8 drafting note was not the appropriate approach to take and instead suggested that the Task Force consider a charge to the Subgroup to develop a white paper that would examine current and emerging state laws related to the PBM business practices outlined in the drafting note. Following its adoption of the PBM model, during its June 15 meeting, the Task Force adopted such a charge for the Subgroup. During its June 22 meeting, the Committee decided to delete the Section 8 drafting note, given the adoption of the Subgroup charge to develop a white paper and the issues related to the drafting note.
Another issue that arose was whether to defer adoption of the PBM model because of the Rutledge decision, which upheld an Arkansas law regulating certain PBM business practices. Those suggesting deferring the PBM model adoption asserted that the Rutledge decision supported state efforts to enact laws regulating PBM business practices, and the PBM model should be revised to include substantive provisions related to these PBM business practices. The Task Force decided to move forward with the PBM model, as drafted by the Subgroup, because of the different interpretations of the Rutledge decision as it relates to Employee Retirement Income Security Act of 1974 (ERISA) preemption of state laws regulating PBM business practices. To address this issue, the Task Force included in its charge to the Subgroup to develop a white paper language requiring the Subgroup to also examine the impact of the Rutledge decision on states seeking to enact laws regulating certain PBM business practices. In its discussions related to this issue, the Committee supported addressing this issue through the white paper.

The Subgroup also received comments concerning Section 6. Some commenters suggested that the gag clause provision in this section should mirror the federal gag clause language. The Subgroup did not accept that suggestion.

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

None.

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GUIDELINE FOR DEFINITION OF RECIPROCAL STATE IN RECEIVERSHIP LAWS

Drafting Note: The receivership laws of most states address the coordination of receiverships involving multiple states. Typically, these laws provide that a domiciliary receiver appointed in another state has certain rights and protections, such as the following:

- The domiciliary receiver is vested with the title to the insurer’s assets in the state.
- Attachments, garnishments or levies against the insurer or its assets are prohibited.
- Actions against the insurer and its insureds are stayed for a specified period of time.

In many states’ laws, these provisions may apply only if the domiciliary state is a “reciprocal state.” Frequently, the definition of a reciprocal state is based on NAIC model laws adopted more than 20 years ago. These definitions may be inconsistent with laws in other states, and they may be more prescriptive than the Part A standards of the NAIC Financial Regulation Standards and Accreditation Program for state receivership laws. As a result, the assets of a receivership estate might not be protected outside of the domiciliary state, and the receiver may be forced to defend litigation in multiple forums.

The provisions described above are intended to promote judicial economy, which benefits all participants in the receivership process. This guideline provides a statutory definition that may be used by states with a reciprocity requirement to effectuate the purposes of these provisions. Under this definition, any state meeting the applicable NAIC Part A Accreditation standards for receivership laws will be treated as a reciprocal state. The definition recognizes the diversity of existing state receivership laws and should prevent unnecessary litigation regarding the recognition of a state as a reciprocal state.

Definition of Reciprocal State for Receivership

“Reciprocal state” means a state that has enacted a law that sets forth a scheme for the administration of an insurer in receivership by the state’s insurance commissioner or comparable insurance regulatory official.
PROJECT HISTORY-2021

GUIDELINE FOR DEFINITION OF RECIPROCAL STATE IN RECEIVERSHIP LAWS

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

The Receivership and Insolvency (E) Task Force has an active and ongoing charge, which was adopted in each year of this project by the Executive (EX) Committee and Plenary, that reads as follows:

Perform additional work as directed by the Financial Condition (E) Committee and/or received through referral by other groups.

In 2020, the Task Force finalized its Macroprudential Initiative (MPI) study, which began in 2019, and addressed the referral from the Financial Stability (EX) Task Force to evaluate receivership and guaranty fund laws and practices in the context of the MPI. The Task Force surveyed state insurance regulators and interested parties on each of the key provisions of receivership and guaranty fund laws that states should consider adopting into their laws, particularly with respect to receivership of insurers operating in multiple states. While a receivership of a multi-jurisdictional insurer would not likely have a material impact on financial stability or the broader financial markets, this project highlighted areas of the receivership process that may need attention, including laws related to full faith and credit of stays and injunctions.

The Task Force discussed the effect of whether a stay or injunction entered into a receivership court is honored in another state. This has been the subject of a lot of litigation, and receivers have expressed concern about this issue. The receivership laws of most states address the coordination of receiverships involving multiple states. However, in many states’ laws, these provisions may apply only if the domiciliary state is a “reciprocal state.” Frequently, the definition of a reciprocal state is based on NAIC model laws adopted more than 20 years ago.

The Task Force drafted this Guideline as an alternative to address how states define “reciprocal state.” This Guideline provides an optional statutory definition that may be used by states with a reciprocity requirement to effectuate the purposes of provisions regarding the coordination of receiverships involving multiple states.

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

The Receivership and Insolvency (E) Task Force was responsible for drafting the Guideline. The 2020 and 2021 members of the Task Force were:

2020: Texas (Chair); District of Columbia (Vice Chair); Alaska; American Samoa; Arkansas; California; Colorado; Connecticut; Florida; Illinois; Iowa; Kansas; Kentucky; Maine; Massachusetts; Michigan; Missouri; Montana; Nebraska; New Jersey; North Carolina; Oklahoma; Pennsylvania; Rhode Island; South Carolina; Tennessee; and Utah.

2021: Texas (Chair); Louisiana (Vice Chair); American Samoa; Arizona; Colorado; Connecticut; Florida; Hawaii; Illinois; Iowa; Kansas; Kentucky; Maine; Massachusetts; Michigan; Missouri; Montana; Nebraska; New Jersey; New Mexico; North Carolina; Northern Mariana Islands; Oklahoma; Pennsylvania; Rhode Island; South Carolina; and Utah.

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

As described in paragraph 1, on its Oct. 7, 2020, meeting, the Task Force agreed to draft a guideline to address this issue, which was identified through the results of the MPI study and the subsequent survey regarding key provisions of receivership and guaranty fund laws that states should consider adopting into their laws.

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

The Guideline was drafted by Task Force members: Florida; Maine; Texas; and Patrick Cantilo (Cantilo and Bennett LLP), an interested party. This drafting group met Oct. 19, 2020, and considered language contained in both the Florida and Maine laws. Rather than identifying a list of specific key provisions in law that would be required for a state to be defined as “reciprocal,” the drafting group agreed to use the same criteria used by the NAIC Financial Regulation Standards and Accreditation Program.
Under this definition, any state meeting the applicable NAIC Part A Accreditation standards for receivership laws, which requires a state to have a “receivership scheme,” will be treated as a reciprocal state. The definition recognizes the diversity of existing state receivership laws, and it should avoid unnecessary litigation regarding the recognition of a state as a reciprocal state.

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

On Nov. 19, 2020, the Task Force met to release the draft Guideline for a 42-day public comment period ending Dec. 31, 2020. The exposure was distributed by email to members, interested state insurance regulators, and interested parties of the Task Force; and it was posted to the NAIC website.

The Task Force did not receive any comments.

The Task Force adopted the Guideline on March 12, 2021.

The Financial Condition (E) Committee adopted the Guideline on April 13, 2021.

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

There were no issues of significance raised during the exposure periods or during meetings.

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

The Guideline provides the following definition, as well as an explanatory drafting note:

“Reciprocal state” means a state that has enacted a law that sets forth a scheme for the administration of an insurer in receivership by the state’s insurance commissioner or comparable insurance regulatory official.

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

The Guideline will not be considered for any accreditation standard.
MEMORANDUM

TO: NAIC Plenary

FROM: Scott White, Financial Condition (E) Committee

DATE: June 29

RE: Agenda item 2019-24: Levelized and Persistency Commission

This memorandum summarizes both 1) the adopted changes to SSAP No. 71—Policy Acquisition Costs and Commissions, and 2) an overview of the key points of the levelized commission agenda item 2019-24 which were adopted into the changes to SSAP No. 71.

The Statutory Accounting Principles (E) Working Group began discussion in August 2019 and on March 15, 2021, adopted revisions (see illustrated revisions page 5) which are effective Dec. 31, 2021. The Working Group vote was 13 states in favor and one state opposed. On March 23, 2021, the Accounting Practices and Procedures (E) Task Force adopted the revisions as adopted by the Working Group with a vote of 41 members in favor and two opposed (LA and OK). On April 13, 2021, the Financial Condition (E) Committee adopted theses same revisions to SSAP No. 71 with a vote of 11-3 (Mississippi, New Mexico and South Carolina dissenting).

Overview

• Acquisition Costs: Acquisition costs are expenses incurred in the acquisition of new and renewal insurance contracts. These are costs that vary with and are primarily related to the acquisition of insurance contracts (e.g., agent and broker commissions, certain underwriting and policy issue costs, and medical and inspection fees). It is a foundational concept for statutory accounting principles (SAP) that acquisition costs including commissions are expensed as incurred. This is because incurred costs are not available to pay policyholder claims. Both U.S. generally accepted accounting principles (GAAP) and SAP would calculate acquisition costs in a similar manner. GAAP treatment capitalizes acquisition costs and expenses them over time to match revenue and expenses. This is one of the major financial reporting differences between SAP and GAAP. These differences are intentional because SAP is measuring the ability to pay policyholder claims using the foundational principles of conservatism, consistency and recognition. GAAP, on the other hand, is focused on matching revenue to expenses.
• **Funding Agreement:** A funding agreement is using a third-party to pay commission costs on the insurer’s behalf, with the insurer repaying the third-party over time plus interest. To ensure consistent and conservative treatment, and appropriate recognition, SSAP No. 71 requires that the full amount of the funding agreement liability be recognized upfront by the insurer plus interest and fees owed to date. This is because the substance of the agreement is a LOAN. That is, the third-party is paying an insurer’s acquisition commission obligation and accepting repayment over time (e.g., over 3-8 years).

• **Persistency Commission Versus Loan with a Contingency Element:** A normal persistency commission is one in which additional commission is earned over time, when a policy is renewed or remains in force. A distinct difference is that persistency commission occurs subsequent to an initial sales commission. The triggering event is the continuation (or renewal) of a policy. An additional amount is owed if the policy persists overtime. A persistency commission is typically a much smaller payment than initial sales commission. For example, a small percentage if the policy is in force in years 2-10.

  Note: Although traditional persistency commission is not required to be recognized before the triggering event (e.g., renewal), earlier comments from industry noted that they could be inadvertently scoped in with the initially exposed revisions. The adopted edits addressed this concern and are clear that the recognition of commission is based on the triggering event, which is the policy action, such as initial issuance or renewal.

The practice under dispute represents initial sales commission that is not being recognized by a limited number of insurers. With these designs, the insurer has an agreement to reimburse a third-party in the future (who has paid the commission cost to the agent on the insurer’s behalf) plus interest and fees. The third-party agreement notes that the insurer does not have to pay the future installments if the policy lapses. *(The impacted insurers have noted that this practice inserts a “persistency” element into the initial sales commission already incurred. This is actually a LOAN with a contingency element.)* Note: Insurers are required to recognize the full initial commission cost when a policy is issued. If a policy is cancelled, at that time, an insurer can derecognize the liability to repay the third party.

**Disputed practice:** Those few insurers that are not recognizing the full liability under the funding agreement (to repay the parties who are paying acquisition costs on their behalf) are not following the long-standing guidance in SSAP No. 71. These limited companies are only recognizing a fraction of the acquisition commission expense, which results in misleading financial statements, and presents a better financial position than actually exists (as the company has unrecorded liabilities for commissions already paid on their behalf). SSAP No. 71 requires recognition of the full liability amount of such an
agreement, even if repayment is not guaranteed. The small number of insurers have asserted that their reporting is a decades-long practice. However the SSAP No. 71 guidance that requires full accrual of the liability was adopted in 1998 and is based on even earlier statutory accounting guidance which notes that, “The accounting treatment for certain transactions, characterized as levelized commissions, which results in enhancement of surplus, has been determined to be inappropriate for statutory reporting.” The Working Group discussions identified that not recognizing the full liability appears to have been practiced by only a small minority of companies, which supports that the majority of industry is reporting correctly.

- **Lapse** - Lapse risk is a risk identified in Model 791 Life and Health Reinsurance, as a significant insurance risk therefore it cannot be transferred to a non-insurance entity. However, some employing the disputed practice have tried to assert that it has been transferred to the funding agent.

- **Overview of Edits**: Revisions clarify that an insurance entity cannot use third-party structures to recharacterize and delay recognition of liabilities for initial sales commission owed, regardless of how a third-party arrangement is structured with regards to the timing of the payment from the insurers. This guidance clarifies that it is the writing of the insurance contract that obligates the insurer and recognition of expense shall occur consistently among insurers. SSAP No. 71 does not require advanced recognition for expected renewals or normal persistency metrics. When an insurance policy is issued, renewed or when metrics are met that require additional commission, then SSAP No. 71 consistently requires expense recognition for all insurers.

- **Substantive / Nonsubstantive** - The determination of a change as substantive or nonsubstantive is based on whether the edits reflect original intent (nonsubstantive) or incorporates new accounting concepts (substantive). Throughout the discussion process, it has been reiterated that the edits simply clarify the original intent of SSAP No. 71. As such, the change was classified as nonsubstantive. The impact to companies or the number of companies that have incorrectly applied accounting guidance is not a factor in determining whether a clarifying edit is substantive or nonsubstantive. However, the incorrect application only seems to involve a limited number of linked-companies, with other entities following the original intent of SSAP No. 71, which supports that the changes are nonsubstantive and consistent with original intent. The March 15 Working Group discussion affirmed the nonsubstantive classification of the revisions was consistent with the policy statement.

- **Correction of Error / Change in Accounting Principle**: An earlier comment from an impacted company identified that there is a process concern as the edits to SSAP No. 71 are classified as a change in accounting principle and not a correction of error. *(Under
SSAP No. 3—Accounting Changes and Correction of Errors, a mistake in the application of accounting principles is a correction of an error.) The edits proposed in July 2020 were to classify changes required from misapplication of SSAP No. 71 as a correction of error. However, in response to comments, the Working Group agreed to designate the impact as a change in accounting principle. This provision was provided to assist companies in reflecting the change. Both processes require the impact to be recognized to unassigned funds (surplus). If reported as a correction of an error, then an entity may be subject to filing amended financial statements for periods in which the error was reflected. As a change in accounting principle, then the entity calculates the change as a cumulative effect to the Jan. 1 balance in the current year financials.

- **Use of Funding Agreements:** SSAP No. 71 does not prohibit the use of funding agreements or the use of third parties to pay commission expense to selling agents. SSAP No. 71 simply requires consistent recognition of commission expense based on policy issuance or renewal. The involvement of third parties and funding agreements to front commission owed to selling agents is not a free service. These third-parties require fees and interest from these financing arrangements; which presumably exceeds the costs of commission only. The long-standing guidance in SSAP No. 71 requires recognition of the full amount of unpaid principal and interest accrued to date in these arrangements. One comment raised during the discussion was that the clarified guidance would hurt policyholders. This comment was never fully substantiated, but it was noted that failing to report expenses in line with SSAP No. 71 would result with inappropriate financial positions – which could hurt policyholders. Additionally, it was noted that if the process to defer expense recognition was sanctioned, then all insurers would have to engage in these arrangements to prevent competitive disadvantages with reporting.

- **Payments to the Direct Agent:** Some of the comments received from the impacted companies (or their representatives) have tried to indicate that the timing (and how) the initial sales commission is paid to the direct selling agent by the third-party should not impact the recognition of commission expense by the insurer. These comments were made because it has been highlighted that in the known situations, the third-party agents have already paid the direct selling agent the owed commission. Although the third-party payment to the direct selling agent substantiates that a commission was owed from policy issuance, the payment to the direct agent is not the triggering event. (Meaning, even if a third-party was to revise their agreements with direct agents to delay payment, this will not change that the insurer owes commission expense from policy issuance. The initial sales commission is triggered by policy issuance.)

- **Consistent Application Across Companies:** SSAP No. 71 is a “common area” SSAP and applies to all entities regardless of their line of business or product offerings. Some comments made to regulators have implied that certain large companies are permitted processes that are not in line with SSAP No. 71. It is speculated that these comments are
trying to compare commission expenses from renewals (which are not required until policy renewal occurs) to the process engaged by these companies in which they have not recognized commission expense from the initial issuance of policies. This goes back to these impacted companies mischaracterizing these financing arrangements as “persistency” commission. These timing arrangements do not alter the requirement to recognize commission expense with the issuance of a policy. Because many of these funding agreements were mischaracterized, it was noted that the disputed practice is difficult to identify on financial examinations and audits. One Working Group member shared that they had dealt with an issue like this previously when $16 million of off-balance sheet commission liabilities was identified after a third party funding agent applied to the liquidator for reimbursement.

- **Impacted Companies:** Throughout the discussion, key industry representatives continued to highlight that the impacted companies were less “than 10” and likely “5 or less.” The impacted companies were requested to reach out to domiciliary states to provide information. However the impact for these few companies is expected to be material. A consumer representative also voiced concerns about the illusory surplus and unlevel playing field such arrangements create. Because of the unfair competitive advantages that are perceived, the Working Group was not in favor of grandfathering the practices. However the Working Group did discuss that companies could have discussions with their domiciliary states regarding obtaining a permitted practice for phasing in the financial impact. A permitted practice approach was favored because the impact to the affected companies may vary.

**Effective Date:** Although nonsubstantive revisions are generally effective upon adoption, the Working Group ultimately determined to have a Dec. 31, 2021 effective date. Two of the industry commenters (Guggenheim and interested parties (Delaware Life)) stated support for an effective date no sooner than Dec. 31, 2021 at the March meeting. Annual 2020 effective dates were previously deferred. While some members of the Working Group supported an effective date earlier in 2021, it was discussed that a year end 2021 effective date would allow insurers, to assess the impact and review contracts, and additionally allow the issue to be fully through the NAIC committee process. During the March meeting, the National Council of Insurance Legislators (NCOIL) comments were supportive of a later effective date or an extended phase-in period. The Working Group determined that a year-end 2021 effective date was preferred because of the competitive issues and because the revisions were viewed as a clarification of long-standing guidance. The Working Group also reiterated its prior comments that the limited number of companies seeking phase in application could seek a permitted practice and that the permitted practices disclosures would provide regulatory transparency.
Adopted Revisions to SSAP No. 71 (new text from the prior exposure is shown as shaded):

2. Acquisition costs are those costs that are incurred in the acquisition of new and renewal insurance contracts and include those costs that vary with and are primarily related to the acquisition of insurance contracts (e.g., agent and broker commissions, certain underwriting and policy issue costs, and medical and inspection fees). Acquisition costs and commissions shall be expensed as incurred. Determination of when acquisition costs and commissions have been incurred shall be made in accordance with SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets.

3. Contingent commission liabilities shall be determined in accordance with the terms of each individual commission agreement. Commission liabilities determined on the basis of a formula that relates to loss experience shall be established for the earned portion. Assumptions used to calculate the contingent commission liability shall be consistent with the terms of the policy contract and with the assumptions made in recording other assets and liabilities necessary to reflect underwriting results of the reporting entity such as retrospective premium adjustments and loss reserves, including incurred but not reported.

4. Levelized commissions occur in situations where agents receive normal (non-level) commissions with payments made by a third party. It is intended, but not necessarily guaranteed, that the amounts paid to the agents by the third party would ultimately be repaid (with interest explicit or implied) to the third party by levelized payments (which are less than the normal first year commissions but exceed the normal renewal commissions) from the reporting entity. (Note: levelized repayments made by the reporting entity extend the repayment period but might not be a straight-line repayment.) These transactions are, in fact, funding agreements between a reporting entity and a third party, regardless of how the payment to the third party is characterized. The continuance of the stream of payments specified in the levelized commission contract is a mechanism which attempts to bypass recognition of those expenses which are ordinarily charged to expense in the first year of the contract. Consequently, the normal link between the persistency of the policy, the continuance of the premium payment or the maintenance of the agent’s license with the reporting entity is not maintained with respect to the payment stream.

5. The use of an arrangement such as a levelized commission arrangement where commission payments are not linked to traditional elements such as premium payments and policy persistency, but rather are linked to the repayment of an advance amount paid by a third party to the direct selling agents requires the establishment of a liability by the reporting entity for the full amount of the unpaid principal and accrued interest which is
payable to a third party related to levelized commissions. *Arrangements that use a third party to pay agents who write policies for the reporting entity and the insured can be an attempt to de-link the relationship between the insurer and those agents and defer or levelize the acquisition commissions.* The insurance reporting entity is required to recognize the full amount of earned commission costs to the direct policy writing agents even if those costs are paid indirectly to the agents by a third party through the use of levelized commission, or similar arrangement, which is in substance a funding arrangement. Having a third party pay commission costs to the selling agent is strong evidence of a potential funding arrangement which shall be recognized as a liability because the substance of the arrangement indicates that repayment is reasonable and probable, even if a contingency has been incorporated into the funding arrangement, until the underlying policy has been cancelled. A third-party structure cannot recharacterize (e.g. by referencing policy persistency) and delay recognition of liabilities for initial sales commission owed from the writing of policies regardless of how a third-party arrangement is structured with regards to the timing of payment from the insurer. The amount owed for full initial sales commission shall be recognized immediately as the writing of an insurance contract is the event that obligates the insurer, and such action shall occur consistently among insurers. As such, this recognition is required regardless of if the insurer owes a selling agent directly or if a third-party has been contracted to provide payment to the selling agent.

**Effective Date and Transition**

7. This statement is effective for years beginning January 1, 2001. A change resulting from the adoption of this statement shall be accounted for as a change in accounting principle in accordance with SSAP No. 3—Accounting Changes and Corrections of Errors. The nonsubstantive revisions adopted March 15, 2021 regarding levelized commission are to clarify the original intent of this statement and apply to existing contracts in effect as of December 31, 2021 and new contracts thereafter.
REQUEST FOR NAIC MODEL LAW DEVELOPMENT

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

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

1. Name of group to be responsible for drafting the model:

Receivership Law (E) Working Group

2. NAIC staff support contact information:

Jane Koenigsman
jkoenigsman@naic.org
816-783-8145

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

- **Insurance Holding Company System Regulatory Act (#440)**
- **Insurance Holding Company System Regulation with Reporting Forms and Instructions (#450)**

In 2018 the Financial Stability (EX) Task Force made a referral to the Receivership and Insolvency (E) Task Force as part of the Macro Prudential Initiative (MPI). At the 2019 Summer National Meeting, the Receivership and Insolvency (E) Task Force adopted a report including recommendations to address receivership powers that are implicit in state laws, rather than explicit. One such area is the power to ensure the continuity of essential services and functions within a holding company group once an insurer is placed into receivership.

The Financial Stability Board’s (FSB) Key Attributes (KAs) of Effective Resolution Regimes for Financial Institutions KA 3.2 states that a resolution authority should have the power to ensure the continuity of essential services and functions by requiring companies in the group to continue providing services. Under Common Framework for the supervision of Internationally Active Insurance Groups (ComFrame) (CF 12.7a), a resolution authority may take steps to provide continuity of essential services by requiring other entities within the IAIG (including non-regulated entities) to continue services. The Task Force identified the following authority and remedies available within the US regime related to these international standards:

- The **Insurance Holding Company System Model Act (#440)** requires approval of affiliated transactions, allowing a regulator to identify agreements that could create obstacles in a receivership. The **Insurance Holding Company System Model Regulation (#450)**, Section 19, provides that cost sharing and management agreements specify if the insurer is placed in receivership that an affiliate has no automatic right to terminate the agreement.
- The Receiver can take action against a provider that refuses to continue services under a contract, or seek an order requiring it to turn over records. If an affiliate providing services is inextricably intertwined with the insurer, the Receiver could also seek to place the affiliate into receivership.

However, it was noted that some of these authorities and remedies may not address the immediate need to continue services in some receiverships. Despite these available remedies, receivers continue to be challenged by this issue in receivership, often resulting in significant additional legal and administrative expenses to the receivership estate.

One potential solution is to revise the definition of “insurer” under state insurance holding company laws to encompass affiliated entities whose sole purpose is to provide services to the insurer.
The NAIC adopted 2020 charges for the Receivership Law (E) Working Group to: “Review and provide recommendations for remedies to ensure continuity of essential services and functions to an insurer in receivership by affiliated entities, including non-regulated entities. Consult with the Group Solvency Issues (E) Working Group as the topic relates to affiliated intercompany agreements.”

Scope of the Proposed Revisions to Models 440 and 450

The scope of the request is limited to addressing the issue of continuation of essential services through affiliated intercompany agreements that arise during the receivership of an insurance company. The Receivership Law (E) Working Group under the Receivership and Insolvency (E) Task Force would complete the review and recommend proposed revisions. Revisions may be necessary to the following sections of Models 440 and 450 including, but not limited to:

- Model 440 Section 1, Definitions
- Model 440 Section 5, Standards and Management of an Insurer Within an Insurance Holding Company System
- Model 440 Section 12, Receivership
- Model 450 Consistency with any revisions to Model 440

4. Does the model law meet the Model Law Criteria? ☒ Yes or ☐ No (Check one)

(If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

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

If yes, please explain why:

   While this change is being made in connection with the NAICs Macro Prudential Initiative, most important is that such changes are needed to address the challenges receivers continue to encounter in the area of continuation services which often result in significant additional legal and administrative expenses to the receivership estate and all members of the Task Force supported this request.

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

   ☒ Yes or ☐ No (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?

   ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood Low Likelihood

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

☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood  Low Likelihood

Explanation, if necessary: See previous discussion.

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

☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood  Low Likelihood

Explanation, if necessary:

At this juncture, the changes in concepts being considered are simple and because they have the potential to reduce expenses incurred by receivership estates, we believe such changes will be widely supported by all parties.

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

The Insurance Holding Company System Model Act (#440) is an Accreditation Standard but the task force has not yet considered whether this should become part of the required elements of that specific standard. However, given the potential the changes have in reducing the cost of regulation under receiverships, a national standard is likely appropriate.

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

No.
INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT

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Section 5. Standards and Management of an Insurer Within an Insurance Holding Company System

A. Transactions Within an Insurance Holding Company System

(1) Transactions within an insurance holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

(a) The terms shall be fair and reasonable;

(b) Agreements for cost sharing services and management shall include such provisions as required by rule and regulation issued by the commissioner;

(c) Charges or fees for services performed shall be reasonable;

(d) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(e) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties;

(f) The insurer’s surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer’s outstanding liabilities and adequate to meet its financial needs.
(g) If an insurer subject to this Act is deemed by the commissioner to be in a hazardous financial condition as defined by [insert citation for Model Regulation to Define Standards and Commissioner’s Authority for Companies Deemed to be in Hazardous Financial Condition] or a condition that would be grounds for supervision, conservation or a delinquency proceeding, then the commissioner may require the insurer to secure and maintain either a deposit, held by the commissioner, or a bond, as determined by the insurer at the insurer’s discretion, for the protection of the insurer for the duration of the contract(s) or agreement(s), or the existence of the condition for which the commissioner required the deposit or the bond.

In determining whether a deposit or a bond is required, the commissioner should consider whether concerns exist with respect to the affiliated person’s ability to fulfill the contract(s) or agreement(s) if the insurer were to be put into liquidation. Once the insurer is deemed to be in a hazardous financial condition or a condition that would be grounds for supervision, conservation or a delinquency proceeding, and a deposit or bond is necessary, the commissioner has discretion to determine the amount of the deposit or bond, not to exceed the value of the contract(s) or agreement(s) in any one year, and whether such deposit or bond should be required for a single contract, multiple contracts or a contract only with a specific person(s).

Drafting Note: This section is intended to apply to a broad range of affiliate managerial and support service contracts including, for example, general managerial services, financial accounting and actuarial services, data management, investment portfolio management and support and policy and policyholder services. (Performance collateralization for reinsurance and other risk transfer or financial contracts with affiliates is typically addressed in the underlying contractual agreements and is beyond the scope of these deposit/bond requirements). The intent of the deposit or bond is to ensure the affiliated services provided under the contract(s) are fulfilled. In determining appropriate circumstances when a commissioner may require a deposit or bond, (deposit vs. bond to be determined by the insurer) and in specifying an amount, the commissioner should evaluate and consider whether an insurer subject to this act is in a hazardous financial condition or a condition that would be grounds for substantial regulatory action, including supervision, conservation or a delinquency proceeding. If it is, the deposit or bond requirement would be available as an additional regulatory remedy at the discretion of the commissioner. Note, the commissioner should consider whether the affiliated person is already required to post a deposit or bond under applicable laws regulating third-party administrators.

(h) All records and data of the insurer held by an affiliate are and remain the property of the insurer, are subject to control of the insurer, are identifiable, and are segregated or readily capable of segregation, at no additional cost to the insurer, from all other persons’ records and data. This includes all records and data that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records or similar records within the possession, custody or control of the affiliate. At the request of the insurer, the affiliate shall provide that the receiver can obtain a complete set of all records of any type that pertain to the insurer’s business; obtain access to the operating systems on which the data is maintained; obtain the software that runs those systems either through assumption of licensing agreements or otherwise; and restrict the use of the data by the affiliate if it is not operating the insurer’s business. The affiliate shall provide a waiver of any landlord lien or other encumbrance to give the insurer access to all records and data in the event of the affiliate’s default under a lease or other agreement; and,

Drafting Note: The “at no additional cost to the insurer” language is not intended to prohibit recovery of the fair and reasonable cost associated with transferring records and data to the insurer. Since records and data of the insurer are the property of the insurer, the insurer should not pay a cost to segregate commingled records and data from other data of the affiliate.

(i) Premiums or other funds belonging to the insurer that are collected by or held by an affiliate are the exclusive property of the insurer and are subject to the control of the insurer. Any right of offset in the event an insurer is placed into receivership shall be subject to [the receivership act of the state].
The following transactions involving a domestic insurer and any person in its insurance holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, which are subject to any materiality standards contained in subparagraphs (a) through (g), may not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into the transaction at least thirty (30) days prior thereto, or such shorter period as the commissioner may permit, and the commissioner has not disapproved it within that period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported, within thirty (30) days after a termination of a previously filed agreement, to the commissioner for determination of the type of filing required, if any.

(a) Sales, purchases, exchanges, loans, extensions of credit, or investments, provided the transactions are equal to or exceed:

(i) With respect to nonlife insurers, the lesser of three percent (3%) of the insurer’s admitted assets or twenty-five percent (25%) of surplus as regards policyholders as of the 31st day of December next preceding;

(ii) With respect to life insurers, three percent (3%) of the insurer’s admitted assets as of the 31st day of December next preceding;

(b) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit provided the transactions are equal to or exceed:

(i) With respect to nonlife insurers, the lesser of three percent (3%) of the insurer’s admitted assets or twenty-five percent (25%) of surplus as regards policyholders as of the 31st day of December next preceding;

(ii) With respect to life insurers, three percent (3%) of the insurer’s admitted assets as of the 31st day of December next preceding;

(c) Reinsurance agreements or modifications thereto, including:

(i) All reinsurance pooling agreements;

(ii) Agreements in which the reinsurance premium or a change in the insurer’s liabilities, or the projected reinsurance premium or a change in the insurer’s liabilities in any of the next three years, equals or exceeds five percent (5%) of the insurer’s surplus as regards policyholders, as of the 31st day of December next preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a non-affiliate, if an agreement or understanding exists between the insurer and non-affiliate that any portion of the assets will be transferred to one or more affiliates of the insurer;

(d) All management agreements, service contracts, tax allocation agreements, guarantees and all cost-sharing arrangements;

(e) Guarantees when made by a domestic insurer; provided, however, that a guarantee which is quantifiable as to amount is not subject to the notice requirements of this paragraph unless it exceeds the lesser of one-half of one percent (.5%) of the insurer’s admitted assets or ten percent (10%) of surplus as regards policyholders as of the 31st day of December next preceding. Further, all guarantees which are not quantifiable as to amount are subject to the notice requirements of this paragraph;
(f) Direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount which, together with its present holdings in such investments, exceeds two and one-half percent (2.5%) of the insurer’s surplus to policyholders. Direct or indirect acquisitions or investments in subsidiaries acquired pursuant to Section 2 of this Act (or authorized under any other section of this Chapter), or in non-subsidiary insurance affiliates that are subject to the provisions of this Act, are exempt from this requirement; and

Drafting Note: When reviewing the notification required to be submitted pursuant to Section 5A(2)(f), the commissioner should examine prior and existing investments of this type to establish that these investments separately or together with other transactions, are not being made to contravene the dividend limitations set forth in Section 5B. However, an investment in a controlling person or in an affiliate shall not be considered a dividend or distribution to shareholders when applying Section 5B of this Act.

(g) Any material transactions, specified by regulation, which the commissioner determines may adversely affect the interests of the insurer’s policyholders.

Nothing in this paragraph shall be deemed to authorize or permit any transactions which, in the case of an insurer not a member of the same insurance holding company system, would be otherwise contrary to law.

(3) A domestic insurer may not enter into transactions which are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the commissioner determines that separate transactions were entered into over any twelve-month period for that purpose, the commissioner may exercise his or her authority under Section 11.

(4) The commissioner, in reviewing transactions pursuant to Subsection A(2), shall consider whether the transactions comply with the standards set forth in Subsection A(1) and whether they may adversely affect the interests of policyholders.

(5) The commissioner shall be notified within thirty (30) days of any investment of the domestic insurer in any one corporation if the total investment in the corporation by the insurance holding company system exceeds ten percent (10%) of the corporation’s voting securities.

(6) Supervision, seizure, conservatorship or receivership proceedings.

(a) Any affiliate that is party to an agreement or contract with a domestic insurer that is subject to Subsection 5A(2)(d) shall be subject to the jurisdiction of any supervision, seizure, conservatorship or receivership proceedings against the insurer and to the authority of any supervisor, conservator, rehabilitator or liquidator for the insurer appointed pursuant to [supervision and receivership acts] for the purpose of interpreting, enforcing and overseeing the affiliate’s obligations under the agreement or contract to perform services for the insurer that:

(i) Are an integral part of the insurer’s operations, including, but not limited to management, administrative, accounting, data processing, marketing, underwriting, claims handling, investment or any other similar functions; or

(ii) Are essential to the insurer’s ability to fulfill its obligations under insurance policies.

(b) The commissioner may require that an agreement or contract pursuant to Subsection 5A(2)(d) for the provision of services described in (i) and (ii) above specify that the affiliate consents to the jurisdiction as set forth in this Subsection 5A(6).

Drafting Note: Subsection 5A(6) is not intended to subject affiliates, in particular those that may be subject to regulation in other jurisdictions, to the general jurisdiction of pending supervision, seizure, conservation or receivership court proceedings in this state or the general authority of a supervisor, conservator or receiver for a domestic insurer. Rather, the jurisdiction and authority conferred by this provision is limited to ensuring that a domestic insurer continues to receive essential services from
an affiliate that it has contracted with to provide such services, in accordance with the terms of the contract and applicable law, during the aforementioned proceedings. Subsection 5A(6)(b) gives the commissioner discretion to require documentation of an affiliate’s consent to this jurisdiction in the agreement or contract. In determining appropriate circumstances when a commissioner may require such provision, the commissioner should consider the scope and materiality to the domestic insurer of the contract, the nature of the holding company system, and whether examination or investigation of the domestic insurer warrants requirement of such a provision.

B. Dividends and other Distributions

No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until thirty (30) days after the commissioner has received notice of the declaration thereof and has not within that period disapproved the payment, or until the commissioner has approved the payment within the thirty-day period.

For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding twelve (12) months exceeds the lesser of:

1. Ten percent (10%) of the insurer’s surplus as regards policyholders as of the 31st day of December next preceding; or
2. The net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the twelve-month period ending the 31st day of December next preceding, but shall not include pro rata distributions of any class of the insurer’s own securities.

In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two (2) calendar years that has not already been paid out as dividends. This carry-forward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the commissioner’s approval, and the declaration shall confer no rights upon shareholders until (1) the commissioner has approved the payment of the dividend or distribution or (2) the commissioner has not disapproved payment within the thirty-day period referred to above.

Drafting Note: The following Subsection C entitled “Management of Domestic Insurers Subject to Registration” is optional and is to be adopted according to the needs of the individual jurisdiction.

C. Management of Domestic Insurers Subject To Registration.

1. Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with this Act.

2. Nothing in this section shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property or services with one or more other persons under arrangements meeting the standards of Section 5A(1).

3. Not less than one-third of the directors of a domestic insurer, and not less than one-third of the members of each committee of the board of directors of any domestic insurer shall be persons who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or entity. At least one such person must be included in any quorum for the transaction of business at any meeting of the board of directors or any committee thereof.
(4) The board of directors of a domestic insurer shall establish one or more committees comprised solely of directors who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or any such entity. The committee or committees shall have responsibility for nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer and recommending to the board of directors the selection and compensation of the principal officers.

(5) The provisions of Paragraphs (3) and (4) shall not apply to a domestic insurer if the person controlling the insurer, such as an insurer, a mutual insurance holding company, or a publicly held corporation, has a board of directors and committees thereof that meet the requirements of Paragraphs (3) and (4) with respect to such controlling entity.

(6) An insurer may make application to the commissioner for a waiver from the requirements of this subsection, if the insurer’s annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, is less than $300,000,000. An insurer may also make application to the commissioner for a waiver from the requirements of this subsection based upon unique circumstances. The commissioner may consider various factors including, but not limited to, the type of business entity, volume of business written, availability of qualified board members, or the ownership or organizational structure of the entity.

D. Adequacy of Surplus. For purposes of this Act, in determining whether an insurer’s surplus as regards policyholders is reasonable in relation to the insurer’s outstanding liabilities and adequate to meet its financial needs, the following factors, among others, shall be considered:

(1) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria;

(2) The extent to which the insurer’s business is diversified among several lines of insurance;

(3) The number and size of risks insured in each line of business;

(4) The extent of the geographical dispersion of the insurer’s insured risks;

(5) The nature and extent of the insurer’s reinsurance program;

(6) The quality, diversification and liquidity of the insurer’s investment portfolio;

(7) The recent past and projected future trend in the size of the insurer’s investment portfolio;

(8) The surplus as regards policyholders maintained by other comparable insurers;

(9) The adequacy of the insurer’s reserves; and

(10) The quality and liquidity of investments in affiliates. The commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the judgment of the commissioner the investment so warrants.

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

In 2020, the NAIC Plenary adopted a new charge for the Receivership Law (E) Working Group. The charge is still active and reads as follows:

"Review and provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including nonregulated entities. Among other solutions, this will encompass a review of the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) to provide proposed revisions to address the continuation of essential services through affiliated intercompany agreements in a receivership."

Prior to, and prompting the need for, the adoption of this charge, the Receivership and Insolvency (E) Task Force performed a macroprudential analysis of the U.S. system of insurance regulation with respect to receivership laws compared to international standards under the Financial Stability Board (FSB) and under the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame). At the 2019 Summer National Meeting, the Receivership and Insolvency (E) Task Force adopted a report including recommendations to address receivership powers that are implicit in state laws, rather than explicit. One such area is the power to ensure the continuity of essential services and functions within a holding company group once an insurer is placed into receivership.

The Task Force identified the following authority and remedies available within the U.S. regime related to these international standards:

- Model #440 requires approval of affiliated transactions, allowing a state insurance regulator to identify agreements that could create obstacles in a receivership. Model #450, Section 19, provides that cost sharing and management agreements specify if the insurer is placed in receivership that an affiliate has no automatic right to terminate the agreement.
- The receiver can take action against a provider that refuses to continue services under a contract or seek an order requiring it to turn over records. If an affiliate providing services is inextricably intertwined with the insurer, the receiver could also seek to place the affiliate into receivership.

However, it was noted that some of these authorities and remedies may not address the immediate need to continue services in some receiverships. Despite these available remedies, receivers continue to be challenged by this issue in receivership, often resulting in significant additional legal and administrative expenses to the receivership estate.

In 2020, the Receivership Law (E) Working Group was given the charge to provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including nonregulated entities and specifically for agreements with affiliated entities whose sole business purpose is to provide services to the insurance company.

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

The Receivership Law (E) Working Group of the Receivership and Insolvency (E) Task Force drafted the initial revisions to Model #440 and Model #450. The 2020 and 2021 members of the Subgroup were: Illinois (Co-Chair); Pennsylvania (Co-Chair); Arkansas; California; Colorado; Connecticut; Florida; Iowa; Louisiana (2021); Maine; Massachusetts; Michigan; Missouri; Nebraska; Texas; and Washington.

A drafting group was formed to draft the revisions. Members included: Florida; Illinois; Maine; Michigan; Oklahoma; Pennsylvania; and Texas.
3. Project Authorized by What Charge and Date First Given to the Group.

As described in paragraph 1 above, the initial charge prompting a review of Model #440 and Model #450 was given to the Receivership Law (E) Working Group for 2020. The Request for NAIC Model Law Development to open Model #440 and Model #450 for revision was adopted by the Executive (EX) Committee at the 2020 Summer National Meeting.

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

In August 2020, the Receivership Law (E) Working Group began its work to address its charge by conducting a survey of state insurance regulators and interested parties to gather feedback on possible provisions to be addressed and goals of those revisions to Model #440 and Model #450. Survey responses were received from state insurance regulators and interested parties identifying specific sections of the models and topics to be considered.

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

On Dec. 17, 2020, the Receivership Law (E) Working Group met in open session to expose proposed amendments to Section 5A and Section 11 of Model #440 and Section 19 of #450 for a 42-day public comment period ending Jan. 29, 2021. Comments were received from Florida; the American Council of Life Insurers (ACLI); America’s Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA); Arbor Strategies LLC; Morgan, Lewis & Bockius LLP and the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA); and the National Conference of Insurance Guaranty Funds (NCIGF).

On Feb. 4, 2021, the Receivership Law (E) Working Group met in open session to discuss comments received. Subsequent edits were drafted by the drafting group as discussed during the meeting. The Working Group exposed proposed revised amendments to Section 5A and Section 11 of Model #440 and Section 19 of #450 for a 14-day public comment period ending Feb. 4, 2021. Comments were received from AHIP and the BCBSA; the American Property Casualty Insurance Association (APCIA); Arbor Strategies LLC; and NOLHGA and the NCIGF.

On March 4, 2021, the Receivership Law (E) Working Group met in open session to discuss comments received. Subsequent edits were drafted as discussed during the meeting by the drafting group in coordination with the interested parties that had provided comments. The Working Group co-chairs released proposed revised amendments to Section 5A(1)(g) of Model #440 for a 30-day public comment period ending April 9, 2021. One comment letter was received from the ACLI. The ACLI’s proposed edit was accepted.

All exposures were distributed by email to members, interested state insurance regulators and interested parties of both the Receivership Law (E) Working Group and the Receivership and Insolvency (E) Task Force and posted to the NAIC website.

All issues raised by members, interested state insurance regulators and interested parties were explained or addressed in the revisions to the original amendments.

The amendments were adopted by the Receivership Law (E) Working Group on May 4, 2021.

The amendments were adopted by the Receivership and Insolvency (E) Task Force on May 20, 2021.

The amendments were adopted by the Financial Condition (E) Committee on July 8, 2021.

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

There were no unresolved issues of real significance raised during the exposure periods. However, the following issue was considered and addressed by the Receivership Law (E) Working Group. Interested parties requested and provided draft revisions to the amendments in Section 5.A.(1)(g) regarding the requirement for a bond or deposit that limits the provision to insurers found to be in a condition of hazardous financial condition or a condition that would be grounds for supervision, conservation or a delinquency proceeding. Interested parties also provided revisions to the subsection and the accompanying drafting note that would further define and clarify the circumstances and the agreements to which the subsection could be applied. The Working Group was agreeable to these changes and accepted interested parties’ revisions.
7. **List the key provisions of the model (sections considered most essential to state adoption).**

The amendments to Model #440 are within Section 5, Standards and Management of an Insurer Within an Insurance Holding Company System, and within Model #450 Section 19, Transactions Subject to Prior Notice.

- **Section 5A(1) of Model #440**
  - Books and records of the insurer are updated to specifically include data of the insurer, being the property of the insurer. The data and records should be identifiable and capable of segregation. Essentially the data and records should be available to the receiver in the event of insolvency, including the systems necessary to access them.
  - If the commissioner deems the insurer to be in a statutorily defined hazardous financial condition, the commissioner may require a bond or deposit, limited in amount, after consideration of whether there are concerns about the affiliated party’s ability to fulfill the contract in the event of a liquidation.
  - Premiums are the property of the insurer, with any right of offset subject to receivership law.

- **Section 5A(6) of Model #440**
  - The affiliated entity is subject to jurisdiction of receivership court, and in certain circumstances the commissioner may require the affiliate to agree to this in writing.

- **Section 19 of Model #450**
  - Books and records of the insurer are updated to specifically include data of the insurer, being the property of the insurer. The data and records should be identifiable and capable of segregation. Essentially the data and records should be available to the receiver in the event of insolvency, including the systems necessary to access them. The data is specifically defined in Model #450.
  - Model #450 includes a provision relating to indemnification of the insurer in the event of gross negligence or willful misconduct by the affiliate.
  - In the event of receivership (now including supervision and conservatorship):
    - The rights of the insurer extend to the receiver or guaranty fund.
    - The affiliate will make available essential personnel.
    - The affiliate will continue the services for a minimum period of time as specified in the agreement with timely payment for post-receivership work.
    - The affiliate will maintain necessary systems, programs or infrastructure and make them available to the receiver or commissioner for as long as the affiliate receives timely post-receivership payment unless released by the receiver, commissioner or receivership court.

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

The Receivership and Insolvency (E) Task Force has not had formal discussions with respect to whether the current Insurance Holding Company Systems accreditation standard under the NAIC Financial Regulation Standards and Accreditation Program should be amended to include the current revisions to Model #440 and Model #450. The Task Force will consider this and make appropriate referrals prior to the 2022 Spring National Meeting.

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REQUEST FOR NAIC MODEL LAW DEVELOPMENT

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

Please check whether this is:  [ ] New Model Law  or  [x] Amendment to Existing Model

1. Name of group to be responsible for drafting the model:

Receivership Law (E) Working Group

2. NAIC staff support contact information:

Jane Koenigsman
jkoenigsman@naic.org
816-783-8145

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

- Insurance Holding Company System Regulatory Act (#440)
- Insurance Holding Company System Regulation with Reporting Forms and Instructions (#450)

In 2018 the Financial Stability (EX) Task Force made a referral to the Receivership and Insolvency (E) Task Force as part of the Macro Prudential Initiative (MPI). At the 2019 Summer National Meeting, the Receivership and Insolvency (E) Task Force adopted a report including recommendations to address receivership powers that are implicit in state laws, rather than explicit. One such area is the power to ensure the continuity of essential services and functions within a holding company group once an insurer is placed into receivership.

The Financial Stability Board’s (FSB) Key Attributes (KAs) of Effective Resolution Regimes for Financial Institutions KA 3.2 states that a resolution authority should have the power to ensure the continuity of essential services and functions by requiring companies in the group to continue providing services. Under Common Framework for the supervision of Internationally Active Insurance Groups (ComFrame) (CF 12.7a), a resolution authority may take steps to provide continuity of essential services by requiring other entities within the IAIG (including non-regulated entities) to continue services. The Task Force identified the following authority and remedies available within the US regime related to these international standards:

- The Insurance Holding Company System Model Act (#440) requires approval of affiliated transactions, allowing a regulator to identify agreements that could create obstacles in a receivership. The Insurance Holding Company System Model Regulation (#450), Section 19, provides that cost sharing and management agreements specify if the insurer is placed in receivership that an affiliate has no automatic right to terminate the agreement.
- The Receiver can take action against a provider that refuses to continue services under a contract, or seek an order requiring it to turn over records. If an affiliate providing services is inextricably intertwined with the insurer, the Receiver could also seek to place the affiliate into receivership.

However, it was noted that some of these authorities and remedies may not address the immediate need to continue services in some receiverships. Despite these available remedies, receivers continue to be challenged by this issue in receivership, often resulting in significant additional legal and administrative expenses to the receivership estate.

One potential solution is to revise the definition of “insurer” under state insurance holding company laws to encompass affiliated entities whose sole purpose is to provide services to the insurer.
The NAIC adopted 2020 charges for the Receivership Law (E) Working Group to: “Review and provide recommendations for remedies to ensure continuity of essential services and functions to an insurer in receivership by affiliated entities, including non-regulated entities. Consult with the Group Solvency Issues (E) Working Group as the topic relates to affiliated intercompany agreements.”

Scope of the Proposed Revisions to Models 440 and 450
The scope of the request is limited to addressing the issue of continuation of essential services through affiliated intercompany agreements that arise during the receivership of an insurance company. The Receivership Law (E) Working Group under the Receivership and Insolvency (E) Task Force would complete the review and recommend proposed revisions. Revisions may be necessary to the following sections of Models 440 and 450 including, but not limited to:

- Model 440 Section 1. Definitions
- Model 440 Section 5. Standards and Management of an Insurer Within an Insurance Holding Company System
- Model 440 Section 12. Receivership
- Model 450 Consistency with any revisions to Model 440

4. Does the model law meet the Model Law Criteria?  ☒ Yes  or  ☐ No  (Check one)

(If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

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

If yes, please explain why:

While this change is being made in connection with the NAICs Macro Prudential Initiative, most important is that such changes are needed to address the challenges receivers continue to encounter in the area of continuation services which often result in significant additional legal and administrative expenses to the receivership estate and all members of the Task Force supported this request.

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

☒ Yes  or  ☐ No  (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?

☒ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood  Low Likelihood

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

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood Low Likelihood

Explanation, if necessary: See previous discussion.

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

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood Low Likelihood

Explanation, if necessary:

At this juncture, the changes in concepts being considered are simple and because they have the potential to reduce expenses incurred by receivership estates, we believe such changes will be widely supported by all parties.

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

The Insurance Holding Company System Model Act (#440) is an Accreditation Standard but the task force has not yet considered whether this should become part of the required elements of that specific standard. However, given the potential the changes have in reducing the cost of regulation under receiverships, a national standard is likely appropriate.

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

No.
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**Form A** Statement Regarding the Acquisition of Control or Merger with a Domestic Insurer

**Form B** Insurance Holding Company System Annual Registration Statement

**Form C** Summary of Changes to Registration Statement

**Form D** Prior Notice of a Transaction

**Form E** Pre-Acquisition Notification Form

**Form F** Enterprise Risk Report

### Section 19. Transactions Subject to Prior Notice - Notice Filing

- **A.** An insurer required to give notice of a proposed transaction pursuant to Section 5 of the Act shall furnish the required information on Form D, hereby made a part of these regulations.

- **B.** Agreements for cost sharing services and management services shall at a minimum and as applicable:
  
  1. Identify the person providing services and the nature of such services;
  2. Set forth the methods to allocate costs;
  3. Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the Accounting Practices and Procedures Manual;
(4) Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement;

(5) State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance;

(6) Define books and records and data of the insurer to include all books and records and data developed or maintained under or related to the agreement that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records or similar records within the possession, custody or control of the affiliate;

(7) Specify that all books and records and data of the insurer are and remain the property of the insurer, and:
   
   (a) Are subject to control of the insurer;
   
   (b) Are identifiable; and
   
   (c) Are segregated from all other persons’ records and data or are readily capable of segregation at no additional cost to the insurer;

Drafting Note: The “at no additional cost to the insurer” language is not intended to prohibit recovery of the fair and reasonable cost associated with transferring records and data to the insurer. Since records and data of the insurer are the property of the insurer, the insurer should not pay a cost to segregate commingled records and data from other data of the affiliate.

(8) State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer;

(9) Include standards for termination of the agreement with and without cause;

(10) Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services and for any actions by the affiliate that violate provisions of the agreement required in Subsections 19B(11), 19B(12), 19B(13), 19B(14) and 19B(15) of this regulation;

(11) Specify that, if the insurer is placed in supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts] receivership or seized by the commissioner under the State Receivership Act:

   (a) All of the rights of the insurer under the agreement extend to the receiver or commissioner to the extent permitted by [law of the state]; and,

   (b) All records and data of the insurer shall be identifiable and segregated from all other persons’ records and data or readily capable of segregation at no additional cost to the receiver or the commissioner;

Drafting Note: The “at no additional cost to the receiver or the commissioner” language is not intended to prohibit recovery of the fair and reasonable cost associated with transferring records and data to the receiver or the commissioner. Since records and data of the insurer are the property of the insurer, the receiver or commissioner should not pay a cost to segregate commingled records and data from other data of the affiliate.

   (c) A complete set of all books and records and data of the insurer will immediately be made available to the receiver or the commissioner, shall be made available in a usable format, and shall be turned over to the receiver or commissioner immediately upon the receiver or the commissioner’s request, and the cost to transfer data to the receiver or the commissioner shall be fair and reasonable; and,
Drafting Note: The fair and reasonable cost to transfer data to the receiver or commissioner refers to the cost associated with physically or electronically transferring records and data files to the receiver or commissioner. This cost does not include costs to separate comingled data and records that should have been segregated or readily capable of segregation.

(d) The affiliated person(s) will make available all employees essential to the operations of the insurer and the services associated therewith for the immediate continued performance of the essential services ordered or directed by the receiver or commissioner;

(12) Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to the State Receivership Act; and

(13) Specify that the affiliate will provide the essential services for a minimum period of time [specified in the agreement] if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts], as ordered or directed by the receiver or commissioner. Performance of the essential services will continue to be provided without regard to pre-receivership unpaid fees, so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, commissioner or supervising court;

(14) Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure, notwithstanding supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts], for so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, commissioner or supervising court; and

(15) Specify that, in furtherance of the cooperation between the receiver and the affected guaranty association(s) and subject to the receiver’s authority over the insurer, if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts], and portions of the insurer’s policies or contracts are eligible for coverage by one or more guaranty associations, the affiliate's commitments under Subsections 19B(11), 19B(12), 19B(13) and 19B(14) of this regulation will extend to such guaranty association(s).
PROJECT HISTORY-2021

REVISIONS TO
INSURANCE HOLDING COMPANY SYSTEM MODEL ACT (#440)
AND INSURANCE HOLDING COMPANY SYSTEM MODEL REGULATION WITH REPORTING FORMS AND INSTRUCTIONS (#450)

RECEIVERSHIP

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

In 2020, the NAIC Plenary adopted a new charge for the Receivership Law (E) Working Group. The charge is still active and reads as follows:

"Review and provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including nonregulated entities. Among other solutions, this will encompass a review of the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) to provide proposed revisions to address the continuation of essential services through affiliated intercompany agreements in a receivership."

Prior to, and prompting the need for, the adoption of this charge, the Receivership and Insolvency (E) Task Force performed a macroprudential analysis of the U.S. system of insurance regulation with respect to receivership laws compared to international standards under the Financial Stability Board (FSB) and under the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame). At the 2019 Summer National Meeting, the Receivership and Insolvency (E) Task Force adopted a report including recommendations to address receivership powers that are implicit in state laws, rather than explicit. One such area is the power to ensure the continuity of essential services and functions within a holding company group once an insurer is placed into receivership.

The Task Force identified the following authority and remedies available within the U.S. regime related to these international standards:

- Model #440 requires approval of affiliated transactions, allowing a state insurance regulator to identify agreements that could create obstacles in a receivership. Model #450, Section 19, provides that cost sharing and management agreements specify if the insurer is placed in receivership that an affiliate has no automatic right to terminate the agreement.
- The receiver can take action against a provider that refuses to continue services under a contract or seek an order requiring it to turn over records. If an affiliate providing services is inextricably intertwined with the insurer, the receiver could also seek to place the affiliate into receivership.

However, it was noted that some of these authorities and remedies may not address the immediate need to continue services in some receiverships. Despite these available remedies, receivers continue to be challenged by this issue in receivership, often resulting in significant additional legal and administrative expenses to the receivership estate.

In 2020, the Receivership Law (E) Working Group was given the charge to provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including nonregulated entities and specifically for agreements with affiliated entities whose sole business purpose is to provide services to the insurance company.

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

The Receivership Law (E) Working Group of the Receivership and Insolvency (E) Task Force drafted the initial revisions to Model #440 and Model #450. The 2020 and 2021 members of the Subgroup were: Illinois (Co-Chair); Pennsylvania (Co-Chair); Arkansas; California; Colorado; Connecticut; Florida; Iowa; Louisiana (2021); Maine; Massachusetts; Michigan; Missouri; Nebraska; Texas; and Washington.

A drafting group was formed to draft the revisions. Members included: Florida; Illinois; Maine; Michigan; Oklahoma; Pennsylvania; and Texas.
3. **Project Authorized by What Charge and Date First Given to the Group.**

As described in paragraph 1 above, the initial charge prompting a review of Model #440 and Model #450 was given to the Receivership Law (E) Working Group for 2020. The Request for NAIC Model Law Development to open Model #440 and Model #450 for revision was adopted by the Executive (EX) Committee at the 2020 Summer National Meeting.

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

In August 2020, the Receivership Law (E) Working Group began its work to address its charge by conducting a survey of state insurance regulators and interested parties to gather feedback on possible provisions to be addressed and goals of those revisions to Model #440 and Model #450. Survey responses were received from state insurance regulators and interested parties identifying specific sections of the models and topics to be considered.

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

On Dec. 17, 2020, the Receivership Law (E) Working Group met in open session to expose proposed amendments to Section 5A and Section 11 of Model #440 and Section 19 of #450 for a 42-day public comment period ending Jan. 29, 2021. Comments were received from Florida; the American Council of Life Insurers (ACLI); America’s Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA); Arbor Strategies LLC; Morgan, Lewis & Bockius LLP and the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA); and the National Conference of Insurance Guaranty Funds (NCIGF).

On Feb. 4, 2021, the Receivership Law (E) Working Group met in open session to discuss comments received. Subsequent edits were drafted by the drafting group as discussed during the meeting. The Working Group exposed proposed revised amendments to Section 5A and Section 11 of Model #440 and Section 19 of #450 for a 14-day public comment period ending Feb. 4, 2021. Comments were received from AHIP and the BCBSA; the American Property Casualty Insurance Association (APCIA); Arbor Strategies LLC; and NOLHGA and the NCIGF.

On March 4, 2021, the Receivership Law (E) Working Group met in open session to discuss comments received. Subsequent edits were drafted as discussed during the meeting by the drafting group in coordination with the interested parties that had provided comments. The Working Group co-chairs released proposed revised amendments to Section 5A(1)(g) of Model #440 for a 30-day public comment period ending April 9, 2021. One comment letter was received from the ACLI. The ACLI’s proposed edit was accepted.

All exposures were distributed by email to members, interested state insurance regulators and interested parties of both the Receivership Law (E) Working Group and the Receivership and Insolvency (E) Task Force and posted to the NAIC website.

All issues raised by members, interested state insurance regulators and interested parties were explained or addressed in the revisions to the original amendments.

The amendments were adopted by the Receivership Law (E) Working Group on May 4, 2021.

The amendments were adopted by the Receivership and Insolvency (E) Task Force on May 20, 2021.

The amendments were adopted by the Financial Condition (E) Committee on July 8, 2021.

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

There were no unresolved issues of real significance raised during the exposure periods. However, the following issue was considered and addressed by the Receivership Law (E) Working Group. Interested parties requested and provided draft revisions to the amendments in Section 5A.1(1)(g) regarding the requirement for a bond or deposit that limits the provision to insurers found to be in a condition of hazardous financial condition or a condition that would be grounds for supervision, conservation or a delinquency proceeding. Interested parties also provided revisions to the subsection and the accompanying drafting note that would further define and clarify the circumstances and the agreements to which the subsection could be applied. The Working Group was agreeable to these changes and accepted interested parties’ revisions.
7. **List the key provisions of the model (sections considered most essential to state adoption).**

The amendments to Model #440 are within Section 5, Standards and Management of an Insurer Within an Insurance Holding Company System, and within Model #450 Section 19, Transactions Subject to Prior Notice.

- **Section 5A(1) of Model #440**
  - Books and records of the insurer are updated to specifically include data of the insurer, being the property of the insurer. The data and records should be identifiable and capable of segregation. Essentially the data and records should be available to the receiver in the event of insolvency, including the systems necessary to access them.
  - If the commissioner deems the insurer to be in a statutorily defined hazardous financial condition, the commissioner may require a bond or deposit, limited in amount, after consideration of whether there are concerns about the affiliated party’s ability to fulfill the contract in the event of a liquidation.
  - Premiums are the property of the insurer, with any right of offset subject to receivership law.

- **Section 5A(6) of Model #440**
  - The affiliated entity is subject to jurisdiction of receivership court, and in certain circumstances the commissioner may require the affiliate to agree to this in writing.

- **Section 19 of Model #450**
  - Books and records of the insurer are updated to specifically include data of the insurer, being the property of the insurer. The data and records should be identifiable and capable of segregation. Essentially the data and records should be available to the receiver in the event of insolvency, including the systems necessary to access them. The data is specifically defined in Model #450.
  - Model #450 includes a provision relating to indemnification of the insurer in the event of gross negligence or willful misconduct by the affiliate.
  - In the event of receivership (now including supervision and conservatorship):
    - The rights of the insurer extend to the receiver or guaranty fund.
    - The affiliate will make available essential personnel.
    - The affiliate will continue the services for a minimum period of time as specified in the agreement with timely payment for post-receivership work.
    - The affiliate will maintain necessary systems, programs or infrastructure and make them available to the receiver or commissioner for as long as the affiliate receives timely post-receivership payment unless released by the receiver, commissioner or receivership court.

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

The Receivership and Insolvency (E) Task Force has not had formal discussions with respect to whether the current Insurance Holding Company Systems accreditation standard under the NAIC Financial Regulation Standards and Accreditation Program should be amended to include the current revisions to Model #440 and Model #450. The Task Force will consider this and make appropriate referrals prior to the 2022 Spring National Meeting.

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Process for Evaluating Qualified and Reciprocal Jurisdictions
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I. Preamble

Purpose

The revised *Credit for Reinsurance Model Law (#785)* and *Credit for Reinsurance Model Regulation (#786)* (collectively, the Credit for Reinsurance Models) require an assuming insurer to be licensed and domiciled in a “Qualified Jurisdiction” in order to be eligible for certification by a state as a certified reinsurer for reinsurance collateral reduction purposes. In 2012, the NAIC Reinsurance (E) Task Force was charged to develop an NAIC process to evaluate the reinsurance supervisory systems of non-U.S. jurisdictions, for the purposes of developing and maintaining a list of jurisdictions recommended for recognition by the states as Qualified Jurisdictions. This charge was extended in 2019 to encompass the recognition of Reciprocal Jurisdictions in accordance with the 2019 amendments to the Credit for Reinsurance Models, including the maintenance of a list of recommended Reciprocal Jurisdictions. The purpose of the *Process for Evaluating Qualified and Reciprocal Jurisdictions* is to provide a documented evaluation process for creating and maintaining these NAIC lists.

Background

On November 6, 2011, the NAIC Executive (EX) Committee and Plenary adopted revisions to the Credit for Reinsurance Models. These revisions serve to reduce reinsurance collateral requirements for certified reinsurers that are licensed and domiciled in Qualified Jurisdictions. Under the previous version of the Credit for Reinsurance Models, in order for U.S. ceding insurers to receive reinsurance credit, the reinsurance was required to be ceded to U.S.-licensed reinsurers or secured by collateral representing 100% of U.S. liabilities for which the credit is recorded. When considering revisions to the Credit for Reinsurance Models, the Reinsurance (E) Task Force contemplated establishing an accreditation-like process, modeled on the current NAIC Financial Regulation Standards and Accreditation Program, to review the reinsurance supervisory systems of non-U.S. jurisdictions. Under the revised Credit for Reinsurance Models, the approval of Qualified Jurisdictions is left to the authority of the states; however, the models provide that a list of Qualified Jurisdictions will be created through the NAIC committee process, and that individual states must consider this list when approving jurisdictions.

The federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act), enacted in 2010, authorizes the U.S. Treasury Secretary and the U.S. Trade Representative (USTR), jointly, to negotiate and enter into “covered agreements” on behalf of the United States. These are bilateral or multilateral agreements with foreign governments, authorities or regulators relating to insurance prudential measures, which can preempt contrary state insurance laws or regulatory measures. The Dodd-Frank Act also created the Federal Insurance Office (FIO), which has the following authority: (1) coordinate federal efforts and develop federal policy on prudential aspects of international insurance matters; (2) assist the Secretary of the U.S. Department of the Treasury in negotiating covered agreements; (3) determine whether the states’ insurance measures are preempted by covered agreements; and (4) consult with the states (including state insurance regulators) regarding insurance matters of national importance and prudential insurance matters of international importance. It is the NAIC’s intention to communicate and coordinate with the FIO and related federal authorities as appropriate with respect to the evaluation of the reinsurance supervisory systems of non-U.S. jurisdictions.

On September 22, 2017, the United States and the European Union (EU) entered into the “*Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance.*” A similar agreement with the United Kingdom (UK) was signed on December 18, 2018. Both agreements (collectively referred to as the “Covered Agreements”) will require the states to eliminate reinsurance collateral requirements for reinsurers licensed and domiciled in these jurisdictions within 60 months (five years) after signing or face potential federal preemption by the Federal Insurance Office (FIO) under the Dodd-Frank Act.
Reciprocal Jurisdictions

On June 25, 2019, the NAIC Executive (EX) Committee and Plenary adopted revisions to the Credit for Reinsurance Models. These revisions were intended to conform the Models to the relevant provisions of the Covered Agreements. The Covered Agreements would eliminate reinsurance collateral requirements for EU and UK reinsurers that maintain a minimum amount of own funds equivalent to $250 million and a solvency capital requirement (SCR) of 100% under Solvency II, among other conditions. Conversely, U.S. reinsurers that maintain capital and surplus equivalent to 226 million euros with a risk-based capital (RBC) of 300% of authorized control level would not be required to maintain a local presence in order to do business in the EU or UK or post reinsurance collateral. Under the revised Credit for Reinsurance Models, jurisdictions that are subject to in-force covered agreements are considered to be Reciprocal Jurisdictions, and reinsurers that have their head office or are domiciled in a Reciprocal Jurisdiction are not required to post reinsurance collateral if they meet all of the requirements of the Credit for Reinsurance Models.

Under the revised Credit for Reinsurance Models, not only are jurisdictions that are subject to Covered Agreements treated as Reciprocal Jurisdictions for reinsurance collateral purposes, but any other Qualified Jurisdiction also has a pathway to qualify for collateral elimination as a Reciprocal Jurisdiction States that meet the requirements of the NAIC Financial Standards and Accreditation Program are also considered to be Reciprocal Jurisdictions.

The NAIC has updated and revised this Process for Evaluating Qualified and Reciprocal Jurisdictions to specify how Qualified Jurisdictions that recognize key NAIC solvency initiatives, including group supervision and group capital standards, and also meet the other requirements under the revised Credit for Reinsurance Models, will be recognized as Reciprocal Jurisdictions and receive similar treatment as that provided under the EU and UK Covered Agreements, including the elimination of reinsurance collateral and local presence requirements by the states.

1 The hypothetical possibility that a future covered agreement might not relate to reinsurance is addressed in Section 2F(1)(a)(i) of Model #785, which limits automatic Reciprocal Jurisdiction status to a covered agreement that “addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance.”
II. Principles for the Evaluation of Non-U.S. Jurisdictions

1. The NAIC model revisions applicable to certified reinsurers are intended to facilitate cross-border reinsurance transactions and enhance competition within the U.S. market, while ensuring that U.S. insurers and policyholders are adequately protected against the risk of insolvency. To be eligible for certification, a reinsurer must be domiciled and licensed in a Qualified Jurisdiction as determined by the domestic regulator of the ceding insurer. A Qualified Jurisdiction not subject to an in-force Covered Agreement under the Dodd-Frank Act may also be determined to be a Reciprocal Jurisdiction, and reinsurers that have their head office or are domiciled in any such Reciprocal Jurisdiction will not be required to post reinsurance collateral, provided they meet the minimum capital and financial strength requirements and comply with the other requirements of the Credit for Reinsurance Models.

2. The evaluation of non-U.S. jurisdictions as Qualified Jurisdictions and Reciprocal Jurisdictions will be conducted in accordance with the provisions of the Credit for Reinsurance Models and any other relevant guidance developed by the NAIC.

3. The evaluation of non-U.S. jurisdictions as Qualified Jurisdictions is intended as an outcomes-based comparison to financial solvency regulation under the NAIC Financial Regulation Standards and Accreditation Program (Accreditation Program), adherence to international supervisory standards, and relevant international guidance for recognition of reinsurance supervision. It is not intended as a prescriptive comparison to the NAIC Accreditation Program. In order for a Qualified Jurisdiction that is not subject to an in-force Covered Agreement to be evaluated as a Reciprocal Jurisdiction, that Qualified Jurisdiction must agree to recognize the states’ approach to group supervision, including group capital, and other such requirements as provided under the Credit for Reinsurance Models.

4. The states shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system within the Qualified Jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the jurisdiction to reinsurers licensed and domiciled in the U.S. The determination of Qualified Jurisdiction status is based on the effectiveness of the entire reinsurance supervisory system within the jurisdiction.

5. Each state may evaluate a non-U.S. jurisdiction to determine if it is a Qualified Jurisdiction. A list of Qualified Jurisdictions will be published through the NAIC committee process. A state must consider this list in its determination of Qualified Jurisdictions, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Qualified Jurisdictions contained in the Credit for Reinsurance Models. The creation of this list does not constitute a delegation of regulatory authority to the NAIC. The regulatory authority to recognize a Qualified Jurisdiction resides solely in each state and the NAIC List of Qualified Jurisdictions is not binding on the states.

6. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the List of Reciprocal Jurisdictions. A state must consider this list in its determination of Reciprocal Jurisdiction status, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Reciprocal Jurisdictions contained in the Credit for Reinsurance Models. Under the Credit for Reinsurance Model Law (as adopted by a state) the state must recognize the Reciprocal Jurisdiction status of jurisdictions subject to an in-force Covered Agreement.
7. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting,” as discussed more fully below in paragraph 15 of Section III.

8. Both Qualified Jurisdictions and Reciprocal Jurisdictions have agreed to share information and cooperate with the state with respect to all applicable reinsurers domiciled within that jurisdiction, in accordance with the Credit for Reinsurance Models, as adopted by the state. Critical factors in the evaluation process include but are not limited to the history of performance by assuming insurers in the applicant jurisdiction and any documented evidence of substantial problems with the enforcement of final U.S. judgments in the applicant jurisdiction. A jurisdiction will not be a Qualified Jurisdiction if the commissioner has determined that it does not adequately and promptly enforce final U.S. judgments or arbitration awards.

9. The determination of Qualified Jurisdiction status can only be made with respect to the reinsurance supervisory system in existence and applied by a non-U.S. jurisdiction at the time of the evaluation.

10. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to the evaluation of the reinsurance supervisory systems of non-U.S. jurisdictions.
III. Procedure for Evaluation of Non-U.S. Jurisdictions

   a. Priority will be given to requests from the states and from those jurisdictions specifically requesting an evaluation by the NAIC.
   b. Formal notification of the NAIC’s intent to initiate the evaluation process will be sent by the NAIC to the reinsurance supervisory authority in the jurisdiction selected, with copies to the FIO and other relevant federal authorities as appropriate. The NAIC will issue public notice on the NAIC website upon confirmation that the jurisdiction is willing to participate in the evaluation process. The NAIC will at this time request public comments with respect to consideration of the jurisdiction as a Qualified Jurisdiction. The process of evaluation and all related documentation are private and confidential matters between the NAIC and the applicant jurisdiction, unless otherwise provided in this document, subject to a preliminary confidentiality and information sharing agreement between the NAIC, relevant states and the applicant jurisdiction.
   c. Relevant U.S. state and federal authorities will be notified of the NAIC’s decision to evaluate a jurisdiction.

2. Evaluation of Jurisdiction
   a. Evaluation Materials. The Mutual Recognition of Jurisdictions (E) Working Group will initiate evaluation of a jurisdiction’s regulatory system by using the information identified in Section A through Section G of the Evaluation Methodology (Evaluation Materials). The Mutual Recognition of Jurisdictions (E) Working Group will begin by undertaking a review of the most recent Financial Sector Assessment Program (FSAP) Report prepared by the International Monetary Fund (IMF), including the Technical Note on Insurance Sector Supervision, and any other publicly available information regarding the laws, regulations, practices and procedures applicable to the reinsurance supervisory system. The Mutual Recognition of Jurisdictions (E) Working Group will also invite each jurisdiction or its designee to provide information relative to Section A through Section G of the Evaluation Methodology in order to update, complete or supplement publicly available information. The Mutual Recognition of Jurisdictions (E) Working Group may also request or accept relevant information from reinsurers domiciled in the jurisdiction under review.
   b. The Mutual Recognition of Jurisdictions (E) Working Group will notify the jurisdiction of any information upon which the Working Group is relying. In that communication, the NAIC will invite the supervisory authority to compare the materials identified by the NAIC to the materials described in Appendix A and Appendix B, and provide information required to update the identified public information or supplement the public information, as required, to address the topics identified in Section A through Section G of the Evaluation Methodology. The use of publicly available information (e.g., the FSAP Report and/or the Insurance Sector Technical Note) is intended to lessen the burden on applicant jurisdictions by requiring the production of information that is readily available, while still addressing substantive areas of inquiry detailed in the Evaluation Methodology. The Mutual Recognition of Jurisdictions (E) Working Group’s review at this stage will be focused on how the jurisdiction’s laws, regulations, administrative practices and procedures, and regulatory authorities regulate the financial solvency of its domestic reinsurers in comparison to key principles underlying the U.S. financial solvency framework and other factors set forth in the Evaluation Methodology.

2 The U.S. financial solvency framework is understood to refer to the key elements provided in the NAIC Financial Regulation Standards and Accreditation Program. Appendix A and Appendix B are derived from this framework.
c. After reviewing the Evaluation Materials, the Mutual Recognition of Jurisdictions (E) Working Group may request that the applicant jurisdiction submit supplemental information as necessary to determine whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. The Working Group will address specific questions directly with the jurisdiction related to items detailed in the Evaluation Methodology that are not otherwise addressed in the Evaluation Materials.

d. The NAIC will request that all responses from the jurisdiction being evaluated be provided in English. Any responses submitted with respect to a jurisdiction’s laws and regulations should be provided by a person qualified in that jurisdiction to provide such analyses and, in the case of statutory analysis, qualified to provide such legal interpretations, to ensure that the jurisdiction is providing an accurate description.

e. The NAIC does not intend to review confidential company-specific information in this process, and has focused the procedure on reviewing publicly available information. No confidential company-specific information shall be disclosed or disseminated during the course of the jurisdiction’s evaluation unless specifically requested, subject to appropriate confidentiality safeguards addressed in a preliminary confidentiality and information-sharing agreement. If no such agreement is executed or the jurisdiction is unable to enter into such an agreement under its regulatory authority, the NAIC will not accept any confidential company-specific information.

3. NAIC Review of Evaluation Materials

a. NAIC staff and/or outside consultants with the appropriate knowledge, experience and expertise will review the jurisdiction’s Evaluation Materials.

b. Expenses with respect to the evaluations will be absorbed within the NAIC budget. This will be periodically reviewed.

c. Timeline for review. A project management approach will be developed with respect to the overall timeline applicable to each evaluation.

d. Upon completing its review of the Evaluation Materials, the internal reviewer(s) will report initial findings to the Mutual Recognition of Jurisdictions (E) Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation. Copies of the initial findings may also be made available to FIO and other relevant federal authorities subject to appropriate confidentiality and information-sharing agreements being in place.

4. Discretionary On-site Review

a. The NAIC may ask the jurisdiction under consideration for the opportunity to perform an on-site review of the jurisdiction’s reinsurance supervisory system. Factors that the Mutual Recognition of Jurisdictions (E) Working Group will consider in determining whether an on-site review is appropriate include the completeness of the information provided by the jurisdiction under review, the general familiarity of the jurisdiction by the NAIC staff or other state regulators participating in the review based on prior conduct or dealings with the jurisdiction, and the results of other evaluations performed by other regulatory or supervisory organizations. If the review is performed, it will be coordinated through the NAIC, utilizing personnel with the appropriate knowledge, experience and expertise. Individual states may also request that representatives from their state be added to the review team.

b. The review team will communicate with the supervisory authority in advance of the on-site visit to clearly identify the objectives, expectations and procedures with respect to the review, as well as any significant
issues or concerns identified within the review of the Evaluation Materials. Information to be considered during the on-site review includes, but is not limited to, the following:

i. Interviews with supervisory authority personnel.

ii. Review of organizational and personnel practices.

iii. Any additional information beneficial to gaining an understanding of document and communication flows.

c. Upon completing the on-site review, the reviewer(s) will report initial findings to the Mutual Recognition of Jurisdictions (E) Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation.

5. **Standard of Review**

The evaluation is intended as an outcomes-based comparison to financial solvency regulation under the NAIC Accreditation Program, adherence to international supervisory standards and relevant international guidance for recognition of reinsurance supervision. The standard for qualification of a jurisdiction is that the NAIC must reasonably conclude that the jurisdiction’s reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction, that the jurisdiction’s demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system, and that the jurisdiction’s laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

6. **Additional Information to be Considered as Part of Evaluation**

The NAIC may also consider information from sources other than the jurisdiction under review. This information includes:

a. Documents, reports and information from appropriate international, U.S. federal and U.S. state authorities.

b. Public comments from interested parties.

c. Rating agency information.

d. Any other relevant information.

7. **Preliminary Evaluation Report**

a. NAIC staff and/or outside consultants will prepare a Preliminary Evaluation Report for review by the Mutual Recognition of Jurisdictions (E) Working Group. This preliminary report will be private and confidential (i.e., may only be reviewed by Working Group members, designated NAIC staff, consultants, the states, the FIO and other relevant federal authorities that specifically request to be kept apprised of this information, provided that such entities have entered into a preliminary confidentiality and information-sharing agreement with the foreign jurisdiction. Any outside consultants retained by the NAIC will be required to enter into a confidentiality and nondisclosure agreement.).

b. The report will be prepared in a consistent style and format to be developed by NAIC staff. It will contain detailed advisory information and recommendations with respect to the evaluation of the jurisdiction’s reinsurance supervisory system and the documented practices and procedures thereunder. The report will contain a recommendation as to whether the NAIC should recognize the jurisdiction as a Qualified Jurisdiction.

a. The Mutual Recognition of Jurisdictions (E) Working Group’s review of the Preliminary Evaluation Report will be held in regulator-to-regulator session in accordance with the NAIC Policy Statement on Open Meetings.

b. The Mutual Recognition of Jurisdictions (E) Working Group will make a preliminary determination as to whether the jurisdiction under consideration satisfies the Standard of Review and is deemed acceptable to be included on the NAIC List of Qualified Jurisdictions. If the preliminary determination is that the jurisdiction should not be included on the NAIC List of Qualified Jurisdictions, the Mutual Recognition of Jurisdictions (E) Working Group will set forth its specific findings and identify those areas of concern with respect to this determination.

c. The results of the Preliminary Evaluation Report will be immediately communicated in written form to the supervisory authority of the jurisdiction under review.


a. Upon receipt of the Preliminary Evaluation Report, the supervisory authority will have an opportunity to respond to the initial findings and determination. This is not intended to be a formal appeals process that would initiate U.S. state administrative due process requirements.

b. The Mutual Recognition of Jurisdictions (E) Working Group will consider any response, and will proceed to prepare its Final Evaluation Report. The Mutual Recognition of Jurisdictions (E) Working Group will consider the Final Evaluation Report for approval in regulator-to-regulator session in accordance with the NAIC Policy Statement on Open Meetings. This report will be approved upon an affirmative vote of a majority of the members in attendance at this meeting.

c. Upon approval of the Final Evaluation Report, the Mutual Recognition of Jurisdictions (E) Working Group will issue a public statement and a summary of its findings with respect to its determination. At this time, the Working Group will release the summary for public comment. The detailed report will be a confidential, regulator-only document. The report may be shared with any state indicating that it is considering relying on the NAIC List of Qualified Jurisdictions and has entered into a preliminary confidentiality and information-sharing agreement with the foreign jurisdiction.

10. NAIC Determination Regarding List of Qualified Jurisdictions

a. Once the Mutual Recognition of Jurisdictions (E) Working Group has adopted its Final Evaluation Report, it will submit the summary of its findings and its recommendation to the Reinsurance (E) Task Force at an open meeting. Upon approval by the Reinsurance (E) Task Force, the summary and recommendation will be submitted to the Executive (EX) Committee and Plenary, as well as to the FIO, USTR and other relevant federal authorities for consultation purposes. Upon approval as a Qualified Jurisdiction by the Executive (EX) Committee and Plenary, the jurisdiction will be added to the NAIC List of Qualified Jurisdictions. The NAIC will maintain the List of Qualified Jurisdictions on its public website and in other appropriate NAIC publications.
b. In the event that a jurisdiction is not approved as a Qualified Jurisdiction, the supervisory authority will be eligible for reapplication at the discretion of the NAIC.

c. Upon final adoption of the Mutual Recognition of Jurisdictions (E) Working Group’s determination with respect to a jurisdiction, the Final Evaluation Report will be made available to individual U.S. state insurance regulators upon request and confirmation that the information contained therein will remain confidential.

11. Memorandum of Understanding (MOU)

a. A Qualified Jurisdiction must agree to share information and cooperate on a confidential basis with the U.S. state insurance regulatory authority with respect to all certified reinsurers domiciled within that jurisdiction.

b. The International Association of Insurance Supervisors (IAIS) Multilateral Memorandum of Understanding (MMoU) is the recommended method under which a Qualified Jurisdiction will agree to share information and cooperate with U.S. state insurance regulatory authorities. However, until such time as a state has been approved as a signatory to the MMoU by the IAIS, the state may rely on an MOU entered into by a “Lead State” designated by the NAIC. This Lead State will act as a conduit for information between the Qualified Jurisdiction and other states that have certified a reinsurer domiciled and licensed in that jurisdiction, and will share information with these states consistent with the terms governing the further sharing of information included in the NAIC Master Information Sharing and Confidentiality Agreement, and, as applicable, in the IAIS MMoU, or in a bilateral MOU between the Lead State and the Qualified Jurisdiction. The jurisdiction must also confirm in writing that it is willing to permit this Lead State to act as the contact for purposes of obtaining information concerning its certified reinsurers, provided the that Lead State share that information with the other states requesting the information only in a manner consistent with the terms governing the further sharing of information included, as applicable, in the IAIS MMoU or bilateral MOU between the Lead State and the Qualified Jurisdiction.

c. If a Qualified Jurisdiction has not been approved by the IAIS as a party to the MMoU, it must enter into an MOU with a Lead State. The MOU must provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions.

d. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to this process.

12. Process for Evaluation after Initial Approval

a. The process for determining whether a non-U.S. jurisdiction is a Qualified Jurisdiction is ongoing and subject to periodic review. The Mutual Recognition of Jurisdictions (E) Working Group will perform a yearly review of Qualified Jurisdictions to determine whether there have been any significant changes over the prior year that might affect their status as Qualified Jurisdictions. This yearly review shall follow such abbreviated process as may be determined by the Mutual Recognition of Jurisdictions (E) Working Group to be appropriate. It shall include a review of the jurisdiction’s status as a Reciprocal Jurisdiction if the jurisdiction has been recognized by the NAIC as a Reciprocal Jurisdiction through the process established in paragraph 13.

b. Qualified Jurisdictions must provide the Mutual Recognition of Jurisdictions (E) Working Group with notice of any material change in the applicable reinsurance supervisory system that may affect the status of
the Qualified Jurisdiction. A U.S. jurisdiction should also notify the Mutual Recognition of Jurisdictions (E) Working Group if it receives notice of any material change in the applicable reinsurance supervisory system, or any adverse developments with respect to enforcement of final U.S. judgments, that may affect the status of the Qualified Jurisdiction. U.S. ceding insurers may also initiate notice to the Mutual Recognition of Jurisdictions (E) Working Group if they receive notice of any material change in the applicable reinsurance supervisory system or any adverse developments with respect to enforcement of final U.S. judgments. Upon receipt of any such notice, the Mutual Recognition of Jurisdictions (E) Working Group will consider whether it is necessary to re-evaluate the status of the Qualified Jurisdiction. Any review will be conducted in accordance with the procedure set forth in paragraph 14.

c. The Mutual Recognition of Jurisdictions (E) Working Group will monitor those jurisdictions that have been approved as Qualified or Reciprocal Jurisdictions by individual states, but are not included on the applicable NAIC List.

13. Review of Qualified Jurisdictions as Potential Reciprocal Jurisdictions

a. In evaluating whether to designate a Qualified Jurisdiction as a Reciprocal Jurisdiction, the Mutual Recognition of Jurisdictions (E) Working Group shall utilize such processes and procedures as outlined in the immediately-preceding paragraphs 1 – 12 of Section III. Procedure for Evaluation of Non-U.S. Jurisdictions such as the Mutual Recognition of Jurisdictions (E) Working Group deems is appropriate. Specifically, the Mutual Recognition of Jurisdictions (E) Working Group will use processes and procedures outlined in paragraph 1 (Initiation of Evaluation of the Reinsurance Supervisory System of an Individual Jurisdiction), paragraph 3 (NAIC Review of Evaluation Materials), paragraph 7 (Preliminary Evaluation Report), paragraph 8 (Review of Preliminary Evaluation Report), paragraph 9 (Opportunity to Respond to Preliminary Evaluation Report), paragraph 10 (NAIC Determination regarding List of Qualified Jurisdictions), paragraph 11 (Memorandum of Understanding) and paragraph 12 (Process for Evaluation after Initial Approval), as modified for use with applicants for Reciprocal Jurisdiction status.

b. A Qualified Jurisdiction may not be reviewed for inclusion on the NAIC List of Reciprocal Jurisdictions unless it has undergone the Evaluation Methodology outlined in Section IV, and remains in good standing with the NAIC as a Qualified Jurisdiction. The Mutual Recognition of Jurisdictions (E) Working Group may, if it determines an extended review period to be appropriate after its initial approval of a new Qualified Jurisdiction, defer consideration of that jurisdiction as a possible Reciprocal Jurisdiction until there has been sufficient United States experience with that jurisdiction and its Certified Reinsurers that the Working Group believes it is appropriate to progress from collateral reduction to collateral elimination. Nothing in this process requires a finding that a Qualified Jurisdiction meets the standards for recognition as a Reciprocal Jurisdiction, and the Mutual Recognition of Jurisdictions (E) Working Group may base its determination on all relevant information, which may include factors not specifically included in this Process for Evaluating Qualified and Reciprocal Jurisdictions.

c. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force covered agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the NAIC List of Reciprocal Jurisdictions. In making its recommendation with respect to whether a Qualified Jurisdiction that is not automatically designated as a Reciprocal Jurisdiction should be added to the NAIC List of Reciprocal
 Jurisdictions, the Mutual Recognition of Jurisdictions (E) Working Group shall undertake the following analysis in making its evaluation:

i. The Qualified Jurisdiction must confirm that an insurer which has its head office or is domiciled in that jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as the same insurer would receive credit for reinsurance assumed by an assuming insurer domiciled in that jurisdiction;

ii. The Qualified Jurisdiction must confirm that it does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by that jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

iii. The Qualified Jurisdiction must recognize the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by its competent regulatory authority that insurance groups that are domiciled or maintain their worldwide headquarters in a jurisdiction accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision, including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision by the Qualified Jurisdiction at the level of the worldwide parent undertaking of the insurance or reinsurance group;

iv. The Qualified Jurisdiction must provide written confirmation by its competent regulatory authority that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the Qualified Jurisdiction, including but not limited to the IAIS MMoU or other multilateral memoranda of understanding coordinated by the NAIC This requirement may be satisfied by an MOU with a Lead State, which shall provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions, similar to the MOU requirement outlined in paragraph 11 of this section III; and

v. The Qualified Jurisdiction must confirm that it will provide to the states on an annual basis confirmation that each eligible assuming insurer that is domiciled in the Qualified Jurisdiction continues to comply with the requirements set forth in in Section 9C(2) and (3) of Model #786; i.e., must maintain, on an ongoing basis, minimum capital and surplus of no less than $250,000,000, and the required minimum solvency or capital ratio, as applicable.

d. In order to satisfy the requirements of subsection (c) above, the chief insurance supervisor of the Qualified Jurisdiction being evaluated as a Reciprocal Jurisdiction may provide the NAIC with a written letter confirming, as follows:

[Jurisdiction] is a Qualified Jurisdiction under the NAIC Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786), and is currently in good standing on the NAIC List of Qualified Jurisdictions. As the lead insurance regulatory supervisor for [Jurisdiction], I hereby confirm to the National Association of Insurance Commissioners (NAIC) and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories the following:
An insurer which has its head office or is domiciled in [Jurisdiction] shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit would be granted for reinsurance assumed by insurers domiciled in [Jurisdiction]. [Jurisdiction] does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by [Jurisdiction] or as a condition to allow the ceding insurer to recognize credit for such reinsurance.

[Jurisdiction] recognizes the U.S. state regulatory approach to group supervision and group capital, and confirms that insurance groups that are domiciled or maintain their worldwide headquarters in jurisdictions accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the [Jurisdiction].

[Jurisdiction] confirms that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the [Jurisdiction].

[Jurisdiction] will annually provide to the states confirmation that applicable assuming insurers domiciled in [Jurisdiction] maintain minimum capital and surplus of no less than $250,000,000, and maintain on an ongoing basis the required minimum solvency or capital ratio, as applicable.

Finally, I confirm that [Jurisdiction] will immediately notify the NAIC upon any changes to the assurances provided in this letter.

e. The Mutual Recognition of Jurisdictions (E) Working Group will perform a due diligence review of available public and confidential documents to confirm that to the best of its determination, the representations in the letter are true and accurate, and will prepare for the review by the Reinsurance Task Force a Summary of Findings and Determination recommending that the Qualified Jurisdiction be recognized as a Reciprocal Jurisdiction. Upon approval by the Task Force, the Summary of Findings and Determination will be submitted for a vote of the NAIC Executive (EX) Committee and Plenary for inclusion on the List of Reciprocal Jurisdictions.

f. The Mutual Recognition of Jurisdictions (E) Working Group, working in coordination with the Qualified Jurisdiction and the Reinsurance Financial Analysis (E) Working Group, must make a determination on a minimum solvency or capital ratio under which reinsurers licensed and domiciled in the Qualified Jurisdiction may assume insurance from U.S. ceding companies without posting reinsurance collateral. The applicable minimum solvency or capital ratio must be an effective measure of solvency, comparable to either an NAIC risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, or one hundred percent (100%) of the solvency capital requirement (SCR) as calculated under the Solvency II Directive issued by the European Union, giving due consideration to any applicable
equivalency assessment conducted by the European Insurance and Occupational Pensions Authority (EIOPA) on the Qualified Jurisdiction with respect to Solvency II.

14. Termination of Status as Qualified and/or Reciprocal Jurisdiction

a. If the Mutual Recognition of Jurisdictions (E) Working Group finds a Qualified Jurisdiction to be out of compliance at any time with the requirements to be a Qualified Jurisdiction, the specific reasons will be documented in a report to the jurisdiction under review. The Mutual Recognition of Jurisdictions (E) Working Group would then report any concerns to the Reinsurance (E) Task Force for further discussion and communication with appropriate federal and/or international authorities. The status as a Qualified Jurisdiction may be placed on probation, suspended or revoked by the NAIC. If a Qualified Jurisdiction is also a Reciprocal Jurisdiction subject to a Covered Agreement, the Mutual Recognition of Jurisdictions (E) Working Group and the NAIC will initiate communications and consult with FIO, USTR and any other relevant federal and/or international authorities before any action is taken with respect to that Qualified Jurisdiction’s status.

b. Except for Reciprocal Jurisdictions entitled to automatic recognition, a jurisdiction’s status as a Reciprocal Jurisdiction may be placed on probation, suspended or revoked for good cause in the same manner as provided for Qualified Jurisdictions. If cause is found to question the fitness of a Reciprocal Jurisdiction that is subject to an in-force Covered Agreement, or its compliance with applicable requirements of the covered agreement, the Mutual Recognition of Jurisdictions (E) Working Group would report any concerns to the Reinsurance (E) Task Force for further discussion and communication with appropriate federal and/or international authorities. It is intended that compliance with the covered agreement will be addressed through the Joint Committee process established under the covered agreement, or through termination of the covered agreement by the parties to the covered agreement. The NAIC, individual state regulators and interested parties may raise these issues directly with FIO, USTR or other relevant federal authorities.

c. Both Qualified Jurisdictions and Reciprocal Jurisdictions that are not subject to a covered agreement are obligated to provide notice to the Mutual Recognition of Jurisdictions (E) Working Group of any applicable changes to their reinsurance supervisory system or changes to the assurances provided in the letter set forth in paragraph 13. States and U.S. ceding insurers may also provide notice of such changes to the Working Group. Upon notice of any such material changes, the Working Group will meet in regulator-only session to determine if these changes are in fact material to continuing recognition by the NAIC as either a Qualified or Reciprocal Jurisdiction. The Working Group will work directly with the jurisdiction to address any issues that have been identified. If these issues cannot be resolved through this regulator-only dialogue, then the Working Group will report its recommendation to the Reinsurance Task Force, which will consider a suspension of the jurisdiction’s status as a Qualified or Reciprocal Jurisdiction in open session. The Task Force will then make a recommendation to the NAIC Plenary on the action, if any, to be taken, which may include placing the Qualified or Reciprocal Jurisdiction’s status on probation, or suspending or revoking its status.

d. If a Qualified or Reciprocal Jurisdiction’s status is placed on probation by the NAIC, the material change will be noted in an update to its Summary of Finding and Determination in order to provide notice to the states and U.S. ceding insurers of this material change. If the NAIC decides to suspend or revoke its status, the jurisdiction may be given a reasonable time period, no more than 18 months, to rectify its noncompliance with the standards and return it to good standing. Once the NAIC’s suspension or revocation...
takes effect, it is expected that the same action will be taken by the respective states that have recognized
the jurisdiction as a Qualified or Reciprocal Jurisdiction.

e. There is no administrative right to appeal the decision of the NAIC with respect to the revocation of status
as a Qualified or Reciprocal Jurisdiction, but the jurisdiction can apply for reinstatement after a one-year
period.

f. During the period in which a Qualified or Reciprocal Jurisdiction’s status has been suspended by a state, any
new reinsurance assumed by a reinsurer domiciled in that jurisdiction from a ceding insurer domiciled in
that state will not be eligible for credit unless the transaction qualifies for credit on the basis of security
posted by the ceding insurer or some other basis that does not depend on recognition of the jurisdiction as
a Qualified or Reciprocal Jurisdiction. However, suspension does not affect credit for reinsurance that was
already in force.

g. If a Qualified or Reciprocal Jurisdiction’s status is revoked by a state, then those Certified Reinsurers and/or
Reciprocal Jurisdiction Reinsurers domiciled in that jurisdiction no longer qualify for that status, which
generally obligates them to post one hundred percent (100%) collateral on all their liabilities assumed from
ceding insurers domiciled in that state. The state has the option to suspend a reinsurer’s certification
indefinitely, in lieu of revocation, in which case the obligation to post collateral applies prospectively to all
new, renewed and amended reinsurance agreements. If the reinsurer’s eligibility is revoked, it must be
granted at least three months after the effective date of the revocation to cure any deficiency in collateral,
unless exceptional circumstances make a shorter period is necessary for policyholder and other consumer
protection.

h. The factors used in the evaluation of Reciprocal Jurisdictions are not the same as are utilized in the
evaluation of Qualified Jurisdictions. A Qualified Jurisdiction that has been approved by the NAIC as a
Reciprocal Jurisdiction may have its status as a Reciprocal Jurisdiction either suspended or revoked but still
meet the requirements to be a Qualified Jurisdiction. However, if a Reciprocal Jurisdiction that is not subject
to a covered agreement has its status as a Qualified Jurisdiction revoked, it cannot maintain its status as a
Reciprocal Jurisdiction, because it must be a Qualified Jurisdiction to meet the requirements of a Reciprocal
Jurisdiction.

15. Passporting Process for Certified and Reciprocal Jurisdiction Reinsurers

a. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the
states, the NAIC has initiated a process called “passporting” under which the commissioner has the
discretion to defer to another state’s determination with respect to the requirements for both Certified
Reinsurers and Reciprocal Jurisdiction Reinsurers. Passporting is based upon individual state regulatory
authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process.
States are also encouraged to utilize the passporting process to reduce the amount of documentation filed
with the states and reduce duplicate filings.

b. The passporting process is facilitated through the Reinsurance Financial Analysis (E) Working Group
(ReFAWG). It is intended that ReFAWG will help facilitate multi-state recognition of Certified Reinsurers
and Reciprocal Jurisdiction Reinsurers and address issues of uniformity among the states, both with respect
to initial application and subsequent changes in rating or status. The ReFAWG Review Process is set forth
in the ReFAWG Procedures Manual.
c. Section 9C(7) of the *Credit for Reinsurance Model Regulation* (#786) provides that the “assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis that the assuming insurer complies with the requirements set forth in Paragraphs (2) [i.e., minimum capital and surplus of no less than $250 million] and (3) [i.e., minimum solvency or capital ratio] of this subsection.” Section 9E(1) of Model #786 then provides that “The commissioner may accept financial documentation filed with another NAIC accredited jurisdiction or with the NAIC in satisfaction of the requirements of Subsection C.” A Reciprocal Jurisdiction may satisfy the requirements of Section 9C(7) of Model #786 either by providing the information required by Section 9C(7) itself, or by providing an assuming insurer domiciled in that Reciprocal Jurisdiction with a document confirming the required information, which the assuming insurer would file annually. With either filing method, in lieu of filing the required information directly with the domiciliary states of each of the reinsurer’s U.S. ceding companies, the information may be filed with either the Lead State or the NAIC, which will share this documentation with the other states through the ReFAWG Review Process in satisfaction of their respective filing requirements.
IV. Evaluation Methodology

The Evaluation Methodology was developed to be consistent with the provisions of the NAIC Credit for Reinsurance Models. It is intended to provide an outcomes-based comparison to financial solvency regulation under the NAIC Accreditation Program, adherence to international supervisory standards and relevant international guidance for recognition of reinsurance supervision. Although the methodology includes a comparison of the jurisdiction’s supervisory system to a number of key elements from the NAIC Accreditation Program, it is not intended as a prescriptive assessment under the NAIC Accreditation Program. Rather, the NAIC Accreditation Program simply provide the framework for the outcomes-based analysis. The NAIC will evaluate the appropriateness and effectiveness of the reinsurance supervisory system within the jurisdiction and consider the rights, benefits and the extent of reciprocal recognition afforded by the jurisdiction to reinsurers licensed and domiciled in the U.S. The determination of a Qualified Jurisdiction is based on the effectiveness of the entire reinsurance supervisory system within the jurisdiction.

The Evaluation Methodology consists of the following:

- Section A: Laws and Regulations
- Section B: Regulatory Practices and Procedures
- Section C: Jurisdiction’s Requirements Applicable to U.S.-Domiciled Reinsurers
- Section D: Regulatory Cooperation and Information Sharing
- Section E: History of Performance of Domestic Reinsurers
- Section F: Enforcement of Final U.S. Judgments
- Section G: Solvent Schemes of Arrangement

This information will be the basis for the Final Evaluation Report and the determination of whether the jurisdiction will be included on the NAIC List of Qualified Jurisdictions.
Section A: Laws and Regulations

The NAIC will review publicly available information, as well as information provided by an applicant jurisdiction with respect to its laws and regulations, in an effort to evaluate whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. This will include a review of elements believed to be basic building blocks for sound insurance/reinsurance regulation. A jurisdiction’s effectiveness under Section A may be demonstrated through law, regulation or established practice that implements the general authority granted to the jurisdiction, or any combination of laws, regulations or practices that meet the objective.

The Mutual Recognition of Jurisdictions (E) Working Group will initiate evaluation of a jurisdiction’s regulatory system by gathering and undertaking a review of the most recent FSAP Report, ROSC and any other publicly available information regarding the laws, regulations, practices and procedures applicable to the reinsurance supervisory system. The Mutual Recognition of Jurisdictions (E) Working Group will simultaneously invite each jurisdiction (or its designee) to provide information relative to Section A (and other sections, as relevant) to assist the NAIC in evaluating its laws and regulations. The NAIC will review this information in conjunction with Appendix A, which provides more detailed guidance with respect to elements the NAIC intends to consider on an outcomes basis in the evaluation under this section. Appendix A is not intended as a prescriptive checklist of requirements a jurisdiction must meet in order to be a Qualified Jurisdiction. Rather, it is provided in an effort to facilitate an outcomes-based comparison to financial solvency regulation under the NAIC Accreditation Program. An applicant jurisdiction is requested to address the following information, which the NAIC will consider, at a minimum, in determining whether the outcomes achieved by the jurisdiction’s laws and regulations meet an acceptable level of effectiveness for the jurisdiction to be included on the NAIC List of Qualified Jurisdictions:

1. Confirmation of the jurisdiction’s most recent FSAP Report, including relevant updates with respect to descriptions or elements of the FSAP Report in which changes have occurred since the assessment or where information might otherwise be outdated.
2. Confirmation of the jurisdiction’s ROSC, including relevant updates with respect to descriptions or elements of the ROSC in which changes have occurred since the report was completed or where information might otherwise be outdated.
3. If materials responsive to the topics under review have been provided in response to information exchanges between the jurisdiction under review and the NAIC, such prior responses may be cross-referenced provided updates are submitted, if required to address changes in laws or procedures.
4. Any other information, descriptions or responses the jurisdiction believes would be beneficial to the NAIC’s evaluation process in order to address, on an outcomes basis, the key elements described within Appendix A.

The NAIC will review the information provided by the applicant jurisdiction and determine whether it is adequate to reasonably conclude whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. After reviewing the initial submission, the NAIC may request that the applicant jurisdiction submit supplemental information as necessary in order to make this determination. An applicant jurisdiction is strongly encouraged to provide thorough, detailed and current information in its initial submission in order to

3 The basic considerations under this section are derived from Model #786, Section 8C(2), which include: (a) the framework under which the assuming reinsurer is regulated; (b) the structure and authority of the jurisdiction’s reinsurance supervisory authority with regard to solvency regulation requirements and financial surveillance; (c) the substance of financial and operating standards for reinsurers domiciled in the jurisdiction; and (d) the form and substance of financial reports required to be filed or made publicly available by reinsurers domiciled in the jurisdiction and the accounting principles used.
minimize the number and extent of supplemental information requests from the NAIC with respect to Section A of this Evaluation Methodology. The NAIC will provide a complete description in the Final Evaluation Report of the information provided in the Evaluation Materials, and any updates or other information that have been provided by the applicant jurisdiction.

**Section B: Regulatory Practices and Procedures**

Section B is intended to facilitate an evaluation of whether the jurisdiction effectively employs baseline regulatory practices and procedures to supplement and support enforcement of the jurisdiction’s financial solvency laws and regulations described in Section A. This evaluation methodology recognizes that variation may exist in practices and procedures across jurisdictions due to the unique situations each jurisdiction faces. Jurisdictions differ with respect to staff and technology resources that are available, as well as the characteristics of the domestic industry regulated. A determination of effectiveness may be achieved using various financial solvency oversight practices and procedures. This evaluation is not intended to be prescriptive in nature.

The NAIC will utilize the information provided by the jurisdiction as outlined under Section A in completing this section of the evaluation. The NAIC will review this information in conjunction with Appendix B, which provides more detailed guidance with respect to elements the NAIC intends to consider on an outcomes basis in the evaluation under this section. Appendix B is not intended as a prescriptive checklist of requirements a jurisdiction must meet in order to be a Qualified Jurisdiction. Rather, it is provided in an effort to facilitate an outcomes-based comparison to financial solvency regulation under the NAIC Accreditation Program. An applicant jurisdiction should also provide any other information, descriptions or responses the jurisdiction believes would be beneficial to the NAIC’s evaluation process in order to address, on an outcomes basis, the key elements described within Appendix B.

**Section C: Jurisdiction’s Requirements Applicable to U.S. Domiciled Reinsurers**

The jurisdiction is requested to describe and explain the rights, benefits and the extent of reciprocal recognition afforded by the non-U.S. supervisory authority to reinsurers licensed and domiciled in the U.S.

**Section D: Regulatory Cooperation and Information-Sharing**

The Credit for Reinsurance Models require the supervisory authority to share information and cooperate with the U.S. state insurance regulators with respect to all certified reinsurers domiciled within their jurisdiction. The jurisdiction is requested to provide an explanation of the supervisory authority’s ability to cooperate, share information and enter into an MOU with U.S. state insurance regulators and confirm that they are willing to enter into an MOU. This should include information with respect to any existing MOU with U.S. state and/or federal authorities that pertain to reinsurance. Both the jurisdiction and the states may rely on the IAIS MMoU to satisfy this requirement, and any states that have not yet been approved by the IAIS as a signatory to the MMoU may rely on an MOU entered into by a Lead State with the jurisdiction until such time that the state has been approved as a signatory to the IAIS MMoU. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to this process.

**Section E: History of Performance of Domestic Reinsurers**

The jurisdiction is requested to provide a general description with respect to the historical performance of reinsurers domiciled in the jurisdiction. The NAIC does not intend to review confidential company-specific information under this section. Rather, it is intended that any information provided would be publicly available, unless specifically addressed with the jurisdiction under review. This discussion should address, at a minimum, the following information:
a. Number of reinsurers domiciled in the jurisdiction, and a list of any reinsurers domiciled in the jurisdiction that have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, of no less than $250,000,000.

b. Up to a 10-year history of any regulatory actions taken against specific reinsurers.

c. Up to a 10-year history listing any reinsurers that have gone through insolvency proceedings, including the size of each insolvency and a description of the related outcomes (e.g., reinsurer rehabilitated or liquidated, payout percentage of claims to priority classes, payout percentage of claims to domestic and foreign claimants).

d. Up to a 10-year history of any significant industry-wide fluctuations in capital or profitability with respect to domestic reinsurers.

**Drafting Note:** The NAIC will determine the appropriate time period for review on a case-by-case basis with respect to this information.

**Section F: Enforcement of Final U.S. Judgments**

The NAIC has previously collected information from a number of jurisdictions with respect to enforcement of final U.S. judgments. The jurisdiction is also requested to provide a current description or explanation of any restrictions with respect to the enforcement of final foreign judgments in the jurisdiction. Based on the foregoing information, the NAIC will make an assessment of the effectiveness of the ability to enforce final U.S. judgments in the jurisdiction. This will include a review of the status, interpretations, application and enforcement of various treaties, conventions and international agreements with respect to final judgments, arbitration and choice of law. The Mutual Recognition of Jurisdictions (E) Working Group will monitor the enforcement of final U.S. judgments and the Qualified Jurisdiction is requested to notify the NAIC of any developments in this area.

**Section G: Solvent Schemes of Arrangement**

The jurisdiction is requested to provide a description of any legal framework that allows reinsurers domiciled in the jurisdiction to propose or participate in any solvent scheme of arrangement or similar procedure. In addition, the jurisdiction is requested to provide a description of any solvent scheme of arrangement or similar procedure that a domestic reinsurer has proposed or participated in and the outcome of such procedure.
V. Appendices: Specific Guidance with Respect to Section A and Section B

It is important to note that Part IV, Section A: Laws and Regulations, and Part IV, Section B: Regulatory Practices and Procedures, are derived from the NAIC Financial Regulation Standards and Accreditation Program, which is intended to establish and maintain standards to promote sound insurance company financial solvency regulation among the U.S. states. As such, the NAIC Accreditation Program requires the states to employ laws, regulations and administrative policies and procedures substantially similar to the NAIC accreditation standards in order to be considered an accredited state.

However, it is not the intent of the Evaluation Methodology to require applicant jurisdictions to meet the standards required by the NAIC for accreditation. Instead, Section A and Section B (and their corresponding appendices) are intended to provide a framework to facilitate an outcomes-based evaluation by the NAIC and state insurance regulators of the effectiveness of the jurisdiction’s supervisory authority. This framework consists of a description of the jurisdiction’s laws, regulations, practices and procedures applicable to the supervision of its domestic reinsurers. The amount of detail provided within these appendices should not be interpreted as specific requirements that must be met by the applicant jurisdiction. Rather, the information is intended to provide direction to the applicant jurisdiction in an effort to facilitate a complete response and increase the efficiency and timeliness of the evaluation process.
Appendix A: Laws and Regulations

1. Examination Authority
Does the jurisdiction have the authority to examine its domestic reinsurers? This description should address the following:
   a. Frequency and timing of examinations and reports.
   b. Guidelines for examination.
   c. Whether the jurisdiction has the authority to examine reinsurers whenever it is deemed necessary.
   d. Whether the jurisdiction has the authority to have complete access to the reinsurer’s books and records and, if necessary, the records of any affiliated company.
   e. Whether the jurisdiction has the authority to examine officers, employees and agents of the reinsurer when necessary with respect to transactions directly or indirectly related to the reinsurer under examination.
   f. Whether the jurisdiction has the authority to share confidential information with U.S. state insurance regulatory authorities, provided that the recipients are required, under their law, to maintain its confidentiality.

2. Capital and Surplus Requirement
Does the jurisdiction have the authority to require domestic reinsurers to maintain a minimum level of capital and surplus to transact business? This description should address the following:
   a. Whether the jurisdiction has the authority to require reinsurers to maintain minimum capital and surplus, including a description of such minimum amounts.
   b. Whether the jurisdiction has the authority to require additional capital and surplus based on the type, volume and nature of reinsurance business transacted.
   c. Capital requirements for reinsurers, including reports and a description of any specific levels of regulatory intervention.

3. Accounting Practices and Procedures
Does the jurisdiction have the authority to require domestic reinsurers to file appropriate financial statements and other financial information? This description should address the following:
   a. Description of the accounting and reporting practices and procedures.
   b. Description of any standard financial statement blank/reporting template, including description of content/disclosure requirements and corresponding instructions.

4. Corrective Action
Does the jurisdiction have the authority to order a reinsurer to take corrective action or cease and desist certain practices that, if not corrected or terminated, could place the reinsurer in a hazardous financial condition? This description should address the following:
   a. Identification of specific standards which may be considered to determine whether the continued operation of the reinsurer might be hazardous to the general public.
   b. Whether the jurisdiction has the authority to issue an order requiring the reinsurer to take corrective action when it has been determined to be in hazardous financial condition.
5. Regulation and Valuation of Investments

What authority does the jurisdiction have with respect to regulation and valuation of investments? This description should address the following:

a. Whether the jurisdiction has the authority to require a diversified investment portfolio for all domestic reinsurers as to type, issue and liquidity.

b. Whether the jurisdiction has the authority to establish acceptable practices and procedures under which investments owned by reinsurers must be valued, including standards under which reinsurers are required to value securities/investments.

6. Holding Company Systems

Does the jurisdiction have laws or regulations with respect to supervision of the group holding company systems of reinsurers? This description should address the following:

a. Whether the jurisdiction has access to information via the parent or other regulated group entities about activities or transactions within the group involving other regulated or non-regulated entities that could have a material impact on the operations of the reinsurer.

b. Whether the jurisdiction has access to consolidated financial information of a reinsurer’s ultimate controlling person.

c. Whether the jurisdiction has the authority to review integrity and competency of management.

d. Whether the jurisdiction has approval and intervention powers for material transactions and events involving reinsurers.

e. Whether the jurisdiction has authority to monitor, or has prior approval authority over:
   i. Change in control of domestic reinsurers.
   ii. Dividends and other distributions to shareholders of the reinsurer.
   iii. Material transactions with affiliates.

7. Risk Management

Does the jurisdiction have the authority to require its domestic reinsurers to maintain an effective risk-management function and practices? This description should address the following:

a. Whether the jurisdiction has Own Risk and Solvency Assessment (ORSA) requirements and reporting.

b. Any requirements regarding the maximum net amount of risk to be retained by a reinsurer for an individual risk based on the reinsurer’s capital and surplus.

c. Whether the jurisdiction has authority to monitor enterprise risk, including any activity, circumstance, event (or series of events) involving one or more affiliates of a reinsurer that, if not remedied promptly, is likely to have a material adverse effect on the financial condition or liquidity of the reinsurer or its insurance holding company system as a whole.

d. Whether the jurisdiction has corporate governance requirements for reinsurers.
8. Liabilities and Reserves

Does the jurisdiction have standards for the establishment of liabilities and reserves (technical provisions) resulting from reinsurance contracts? This description should address the following:

a. Liabilities incurred under reinsurance contracts for policy reserves, unearned premium, claims and losses unpaid, and incurred but not reported (IBNR) claims (including whether discounting is allowed for reserve calculation/reporting).

b. Liabilities related to catastrophic occurrences.

c. Whether the jurisdiction requires an opinion on reserves and loss and loss adjustment expense reserves by a qualified actuary or specialist for all domestic reinsurers, and the frequency of such reports.

9. Reinsurance Ceded

What are the jurisdiction’s requirements with respect to the financial statement credit allowed for reinsurance retroceded by its domestic reinsurers? This description should address the following:

a. Credit for reinsurance requirements applicable to reinsurance retroceded to domestic and non-domestic reinsurers.

b. Collateral requirements applicable to reinsurance contracts.

c. Whether the jurisdiction requires a reinsurance agreement to provide for insurance risk transfer (i.e., transfer of both underwriting and timing risk).

d. Requirements applicable to special purpose reinsurance vehicles and insurance securitizations.

e. Affiliated reinsurance transactions and concentration risk.

f. Disclosure requirements specific to reinsurance transactions, agreements and counterparties, if such information is not provided under another item.

10. Independent Audits

Does the jurisdiction require annual audits of domestic reinsurers by independent certified public accountants or similar accounting/auditing professional recognized in the applicant jurisdiction? This description should address the following:

a. Requirements for the filing of audited financial statements prepared in conformity with accounting practices prescribed or permitted by the supervisory authority.

b. Contents of annual audited financial reports.

c. Requirements for selection of auditor.

d. Allowance of audited consolidated or combined financial statements.

e. Notification of material misstatements of financial condition.

f. Supervisor’s access to auditor’s workpapers.

g. Audit committee requirements.

h. Requirements for reporting of internal control-related matters.

11. Receivership

Does the jurisdiction have a receivership scheme for the administration of reinsurers found to be insolvent? This should include a description of any liquidation priority afforded to policyholders and the liquidation priority of reinsurance obligations to domestic and non-domestic ceding insurers in the context of an insolvency proceeding of a reinsurer.
12. Filings with Supervisory Authority

Does the jurisdiction require the filing of annual and interim financial statements with the supervisory authority? This description should address the following:

a. The use of standardized financial reporting in the financial statements, and the frequency of relevant updates.

b. The use of supplemental data to address concerns with specific companies or issues.

c. Filing format (e.g., electronic data capture).

d. The extent to which financial reports and information are public records.

13. Reinsurance Intermediaries

Does the jurisdiction have a regulatory framework for the regulation of reinsurance intermediaries?

14. Other Regulatory Requirements with respect to Reinsurers

Any other information necessary to adequately describe the effectiveness of the jurisdiction’s laws and regulations with respect to its reinsurance supervisory system.
Appendix B: Regulatory Practices and Procedures

1. **Financial Analysis**

What are the jurisdiction’s practices and procedures with respect to the financial analysis of its domestic reinsurers? Such description should address the following:

   a. **Qualified Staff and Resources**
      The resources employed to effectively review the financial condition of all domestic reinsurers, including a description of the educational and experience requirements for staff responsible for financial analysis.

   b. **Communication of Relevant Information to/from Financial Analysis Staff**
      The process under which relevant information and data received by the supervisory authority are provided to the financial analysis staff and the process under which the findings of the financial analysis staff are communicated to the appropriate person(s).

   c. **Supervisory Review**
      How the jurisdiction’s internal financial analysis process provides for supervisory review and comment.

   d. **Priority-Based Analysis**
      How the jurisdiction’s financial analysis procedures are prioritized in order to ensure that potential problem reinsurers are reviewed promptly.

   e. **Depth of Review**
      How the jurisdiction’s financial analysis procedures ensure that domestic reinsurers receive an appropriate level or depth of review commensurate with their financial strength and position.

   f. **Analysis Procedures**
      How the jurisdiction has documented its financial analysis procedures and/or guidelines to provide for consistency and continuity in the process and to ensure that appropriate analysis procedures are being performed on each domestic reinsurer.

   g. **Reporting of Material Adverse Findings**
      The process for reporting material adverse indications, including the determination and implementation of appropriate regulatory action.

   h. **Early Warning System/Stress Testing**
      Whether the jurisdiction has an early warning system and/or stress testing methodology that is utilized with respect to its domestic reinsurers.
2. Financial Examinations

What are the jurisdiction’s practices and procedures with respect to the financial examinations of its domestic reinsurers? Such description should address the following:

a. **Qualified Staff and Resources**
   The resources employed to effectively examine all domestic reinsurers. This should include whether the jurisdiction prioritizes examination scheduling and resource allocation commensurate with the financial strength and position of each reinsurer, and a description of the educational and experience requirements for staff responsible for financial examinations.

b. **Communication of Relevant Information to/from Examination Staff**
   The process under which relevant information and data received by the supervisory authority are provided to the examination staff and the process under which the findings of the examination staff are communicated to the appropriate person(s).

c. **Use of Specialists**
   Whether the supervisory authority’s examination staff includes specialists with appropriate training and/or experience or whether the supervisory authority otherwise has available qualified specialists that will permit the supervisory authority to effectively examine any reinsurer.

d. **Supervisory Review**
   Whether the supervisory authority’s procedures for examinations provide for supervisory review.

e. **Examination Guidelines and Procedures**
   Description of the policies and procedures the supervisory authority employs for the conduct of examinations, including whether variations in methods and scope are commensurate with the financial strength and position of the reinsurer.

f. **Risk-Focused Examinations**
   Does the supervisory authority perform and document risk-focused examinations and, if so, what guidance is utilized in conducting the examinations? Are variations in method and scope commensurate with the financial strength and position of the reinsurer?

g. **Scheduling of Examinations**
   Whether the supervisory authority’s procedures provide for the periodic examination of all domestic reinsurers, including how the system prioritizes reinsurers that exhibit adverse financial trends or otherwise demonstrate a need for examination.

h. **Examination Reports**
   Description of the format in which the supervisory authority’s reports of examinations are prepared, and how the reports are shared with other jurisdictions under information-sharing agreements.

i. **Action on Material Adverse Findings**
   What are the jurisdiction’s procedures regarding supervisory action in response to the reporting of any material adverse findings.

3. Information Sharing

Does the jurisdiction have a process for the sharing of otherwise confidential documents, materials, information, administrative or judicial orders, or other actions with U.S. state regulatory officials, provided that the recipients are required, under their law, to maintain its confidentiality?
4. **Procedures for Troubled Reinsurers**

What procedures does the jurisdiction follow with respect to troubled reinsurers?

5. **Organization, Licensing and Change of Control of Reinsurers**

What processes does the supervisory authority use to identify unlicensed or fraudulent activities? The description should address the following:

   a. **Licensing Procedure**
      Whether the supervisory authority has documented licensing procedures that include a review and/or analysis of key pieces of information included in a primary licensure application.

   b. **Staff and Resources**
      The educational and experience requirements for staff responsible for evaluating company licensing.

   c. **Change in Control of a Domestic Reinsurer**
      Procedures for the review of key pieces of information included in filings with respect to a change in control of a domestic reinsurer.

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State Implementation Reporting of NAIC-Adopted Model Laws and Regulations

Executive (EX) Committee

- Amendments to the Unfair Trade Practices Act (#880)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2021 Spring National Meeting. One state has enacted this model.

Life Insurance and Annuities (A) Committee

- Amendments to the Suitability in Annuity Transactions Model Regulation (#275)—These revisions were adopted by the Executive (EX) Committee and Plenary during the February 13, 2020 conference call. Seven states have enacted these revisions to the model.

- Amendments to the Standard Nonforfeiture Law for Individual Deferred Annuities (#805)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

Health Insurance and Managed Care (B) Committee

- Amendments to the Accident and Sickness Insurance Minimum Standards Model Act (#170)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2019 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the Health Maintenance Organization Model Act (#430)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. One state has enacted this model.

- Amendments to the Insurance Holding Company System Regulatory Act (#440)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Adoption of the Limited Long-Term Care Insurance Model Act (#642)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. One state has enacted this model.

- Adoption of the Limited Long-Term Care Insurance Model Regulation (#643)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. One state has enacted this model.

Property and Casualty Insurance (C) Committee

- Adoption of the Real Property Lender-Placed Insurance Model Act (#631)—This model was adopted by the Executive (EX) Committee and Plenary at the 2021 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Adoption of the Travel Insurance Model Act (#632)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. Six states have enacted this model.
Financial Condition (E) Committee

- Amendments to the *Credit for Reinsurance Model Law (#785)*—These revisions were adopted by the Executive (EX) Committee and Plenary during the June 26, 2019 conference call. 38 states have enacted this model.

- Amendments to the *Credit for Reinsurance Model Regulation (#786)*—These revisions were adopted by the Executive (EX) Committee and Plenary during its June 26, 2019 conference call. Three states have enacted this model.

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EXECUTIVE (EX) COMMITTEE

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Executive (EX) Committee
Columbus, Ohio
August 15, 2021

The Executive (EX) Committee met in Columbus, OH, Aug. 15, 2021. The following Committee members participated: David Altmaier, Chair (FL); Dean L. Cameron, Vice Chair (ID); Chlora Lindley-Myers, Vice President (MO); Andrew N. Mais, Secretary-Treasurer (CT); Raymond G. Farmer, Most Recent Past President (SC); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Michael Conway (CO); Doug Ommen (IA); James J. Donelone (LA); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Mike Chaney (MS); Glen Mulready (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); and Larry D. Deiter (SD). Also participating were: Jon Godfread (ND); and Elizabeth Kelleher Dwyer (RI).

1. **Adopted the Aug. 13 Report of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee**

Commissioner Altmaier reported that the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee met Aug. 13 in joint session. The meeting was held in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC) and paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings.

During this meeting, the Committee and Subcommittee adopted its July 13, June 29, May 20, and Spring National Meeting minutes, which included the following action: 1) discussed elevating the Innovation and Technology (EX) Task Force to a standing committee; 2) received a mid-year financial update and overview of the preliminary 2022 budget; 3) approved the State Based Systems (SBS) Kansas Implementation 2021 Fiscal; 4) approved BlackRock as the commercial mortgage-backed securities (CMBS) and residential mortgage-backed securities (RMBS) financial modeling vendor; 5) approved the contribution of $670,000 to the NAIC Defined Benefit Pension Plan portfolio; 6) approved the Solvency Workpaper Software Modernization Project – Implementation Preparation Phase Fiscal; 7) approved the System for Electronic Rate and Form Filing (SERFF) Modernization – Mobilization and Pilot Phase Fiscal; 8) approved the SBS State Implementation 2021 Fiscal; and 9) approved the Property/Casualty (P/C) Rate Model Review Staffing Resources Fiscal.

The Committee and Subcommittee also adopted the report of the Audit Committee, which met Aug. 10 and took the following action: 1) received an overview of the June 30 financial statements; 2) reconfirmed RSM for the 2021 financial audit; 3) received an update on the 2021 Service Organization Control (SOC) 2 review for transaction processing in the Cloud; 4) received an update on Zone financials and the 2022 budget calendar; and 5) reaffirmed its 2022 proposed charter.

The Committee and Subcommittee also took the following action: 1) received the June 30 Long-Term Investment Portfolio and Defined Benefit Pension Plan Portfolio reports; 2) approved the Information Systems (EX1) Task Force’s 2022 proposed charges; and 3) approved its 2022 proposed charges.

The Committee and Subcommittee also: 1) approved the Enterprise Resource Planning (ERP) Solution Evaluation Fiscal; 2) heard the joint chief executive officer/chief operating officer (CEO/COO) report; 3) approved the request for an amicus brief in Gunn v. Continental Casualty Co.; and 4) heard a cybersecurity report.

Director Lindley-Myers made a motion, seconded by Commissioner Altmaier, to adopt the Aug. 13 report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee. The motion passed unanimously.

2. **Adopted its July 13, June 29, and May 20 Minutes**

Director Lindley-Myers, made a motion, seconded by Director Cameron, to adopt the Committee’s July 13, June 29, and May 20 interim meeting report (Attachment One). The motion passed unanimously.

3. **Adopted the Reports of its Task Forces**

The Committee received written reports from: 1) the Climate and Resiliency (EX) Task Force; 2) the Government Relations (EX) Leadership Council; 3) the Innovation and Technology (EX) Task Force; 4) the Long-Term Care Insurance (EX) Task Force; and 5) the Special (EX) Committee on Race and Insurance.
Commissioner Godfread added that the Innovation and Technology (EX) Task Force discussed the formation of a standing “H” committee on Innovation, Technology, and Cybersecurity. If approved, the purpose of the new standing committee will be to enhance coordination and provide a central forum for discussion on the many issues in the areas of innovation, technology, and cybersecurity. The Task Force will appoint an ad hoc group to take the lead on developing a draft mission statement and proposed charges. The goal is to have the decision on the standing committee and the accompanying bylaw amendment considered for adoption by Executive (EX) Committee and Plenary during the Fall National Meeting.

Director Cameron made a motion, seconded by Commissioner Donelon, to adopt the reports of: 1) the Climate and Resiliency (EX) Task Force; 2) the Government Relations (EX) Leadership Council; 3) the Innovation and Technology (EX) Task Force; 4) the Long-Term Care Insurance (EX) Task Force; and 5) the Special (EX) Committee on Race and Insurance (Attachment Two). The motion passed unanimously.

4. Received a Status Report on the NAIC State Ahead Strategic Plan Implementation

Commissioner Altmaier provided an update on NAIC State Ahead implementation efforts. State Ahead is a three-year strategic plan for the organization to further advance the products, services, and support the NAIC provides to state insurance regulators to better meet the changing regulatory landscape. NAIC staff continue to make good progress on the many State Ahead projects. (Attachment Three). In 2020, the NAIC paused on the development of State Ahead 2.0 to focus on COVID-19. The membership has now started the conversation on development of the next iteration of State Ahead. The NAIC will appoint a member steering committee to lead the effort along with the CEO, COO, and NAIC management.

5. Received a Report of Model Law Development Efforts

Commissioner Altmaier presented a written report on the progress of ongoing model law development efforts (Attachment Four).

6. Heard a Report from the NIPR Board of Directors

Director Deiter reported that the National Insurance Producer Registry (NIPR) Board of Directors had a busy and productive 2021. Through the end of June, NIPR’s revenues are 28% over budget with a total product revenue of $28.6 million through June 30. NIPR has experienced higher overall volume this year, with volumes and revenues outpacing 2019, which was NIPR’s highest revenue year before the pandemic.

Appointment transactions have been strong this year, as have other licensing and credentialling products. Non-resident licensing is particularly strong and continues to be NIPR’s largest revenue driver. NIPR is seeing a trend of individual producers obtaining more non-resident licenses and carrier appointments.

Due to the increased volume of transactions, the NIPR Board of Directors recently approved adding additional staff members to NIPR’s customer service center. These NIPR staff provide a valuable service to state insurance regulators by answering producer licensing-related questions for all states and territories, helping to reduce the administrative burden on individual state insurance departments.

After the completion of implementations scheduled for 2021 and 2022, there will only be two states—New York and Washington—that do not fully leverage the services of NIPR to provide cost-effective, streamlined, and uniform producer licensing services for state insurance regulators and industry.

7. Heard a Report from the Compact

Superintendent Dwyer reported that the Interstate Insurance Product Regulation Commission (Compact) met Aug. 12.

The Compact welcomed Delaware as its newest member. Gov. John Carney (D-DE) signed the Compact bill after bipartisan support in its General Assembly. Delaware is the 45th state to enact the Compact, bringing it to 47 Compact members, including Washington, DC and Puerto Rico.

The Compact considered changing the current 15% threshold for its approval authority of in-force rate increases on Compact-approved individual long-term care insurance (LTCD) products. The Compact held a public hearing and will be refining the options for what is hopefully final action at its next meeting.
The Compact heard an update from its Governance Committee, which is working on a proposed course of action in response to the recommendations from the Squire Patton Boggs governance review, which was received earlier this year, with respect to the next steps in addressing the Colorado Supreme Court opinion of April 2020.

The Compact put in place another emergency rule to apply the changes made to its individual deferred annuity standards to have the applicable minimum nonforfeiture law follow state law as states adopt Standard Nonforfeiture Law for Individual Deferred Annuities (#805) changes made by the NAIC at the end of 2020. The Compact adopted these changes on a permanent basis, and they will be effective in mid-October.

The Compact adopted amendments to two existing uniform standards for life benefit features: 1) waiver of premium and waiver of monthly deductions; and 2) a new standard for waiver of surrender charges for life policies.

The Compact also appointed Iowa to fill the opening of vice chair of the Product Standards Committee. Rhode Island stepped down as the vice chair this year, and the Compact’s designated representative, Sarah Neil (RI), is now a full-time employee of the Compact as its Communications and Outreach Coordinator.

The Compact continues to operate over-budgeted revenues this year, as it is seeing higher than anticipated life filings as companies update their interest rates in response to changes in federal law and the Valuation Manual.

Having no further business, the Executive (EX) Committee adjourned.
The Executive (EX) Committee met July 13, June 29, and May 20, 2021, in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. During these meetings, the Committee:

1. Discussed creating a new standing Committee on Innovation, Technology, and Cybersecurity.
2. Received a mid-year financial update and an overview of the preliminary 2022 budget.
3. Approved the State Based Systems (SBS) Kansas Implementation 2021 Fiscal.
4. Approved BlackRock Solutions as the commercial mortgage-backed securities (CMBS) and residential mortgage-backed securities (RMBS) modeling vendor.
5. Approved a contribution to the NAIC Defined Benefit Pension Plan Portfolio.
6. Adopted the Audit Committee report, including the 2020/2021 Service Organization Control (SOC) reports.
7. Adopted the Internal Administration (EX1) Subcommittee’s May 13 minutes.
REPORT OF THE EXECUTIVE (EX) COMMITTEE TASK FORCES

Climate and Resilience (EX) Task Force—The Climate and Resilience (EX) Task Force met on Aug. 15 and took the following action: 1) heard reports from its workstreams; 2) heard a presentation regarding the California Department of Insurance (DOI) Working Group recommendations report, Protecting Communities, Preserving Nature, and Building Resiliency: How First-of-its-Kind Climate Insurance Will Help Combat the Costs of Wildfires, Extreme Heat and Floods; and 3) heard a presentation from the Reinsurance Association of America (RAA) regarding its mapping and analysis tool for resiliency planning utilizing the Federal Emergency Management Agency’s (FEMA’s) Natural Risk Index for natural hazard data.

Government Relations (EX) Leadership Council—The Government Relations (EX) Leadership Council did not meet at the Summer National Meeting. The Leadership Council meets weekly in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss federal legislative and regulatory developments affecting insurance regulation.

Innovation and Technology (EX) Task Force—The Innovation and Technology (EX) Task Force met on Aug. 14 and took the following action: 1) adopted minutes from the Spring National Meeting and reports of the Big Data and Artificial Intelligence (EX) Working Group, the Speed to Market (EX) Working Group, and the E-Commerce (EX) Working Group. The Task Force will also hear a report on cybersecurity workstreams and international activity. The Task Force will discuss issues related to consumer data ownership and hear reports from various NAIC committees working on related or potentially overlapping workstreams, such as the Special (EX) Committee on Race and Insurance, the Accelerated Underwriting (A) Working Group, the Property and Casualty Insurance (C) Committee, and the Privacy Protections (D) Working Group. The Task Force will also hear an update on the predictive model review process and discussed the coordination of the various NAIC cybersecurity workstreams.

The Big Data and Artificial Intelligence (EX) Working Group met July 9 and took the following action: 1) adopted its March 29 minutes; 2) discussed a draft survey to conduct analysis on private passenger automobile insurers’ use and governance of big data, as used in an artificial intelligence (AI) and machine learning system. The survey is being conducted under the examination authority of Connecticut, Illinois, Iowa, Louisiana, Nevada, North Dakota, Pennsylvania, Rhode Island, and Wisconsin. This analysis will help inform the Working Group in completing its long-term goals of developing guidance and recommendations to update the existing regulatory framework for the use of big data and AI, including how to monitor and oversee the industry’s compliance with the NAIC’s AI principles. The survey work will be expanded to other lines of insurance as needed, such as life insurance and homeowners insurance.

The E-Commerce (EX) Working Group met June 30 and took the following action: 1) heard an introductory report, as well as additional background and other information explaining what led to its establishment; 2) discussed its 2021 charges, which include examining the states’ e-commerce laws and regulations, surveying the states regarding their various exceptions to the federal Uniform Electronic Transactions Act (UETA) while also examining whether a model bulletin may be appropriate; and 3) discussed its overall work plan and what sorts of efforts it can undertake moving forward in order to satisfy its charges, including: identifying key legislation; surveying the states; and working with state insurance regulators, industry, and consumer representatives to further evaluate what type of deliverable the Working Group will ultimately provide.

The Speed to Market (EX) Working Group met June 30 and June 29 and took the following action: 1) adopted its March 10 minutes; 2) heard an update from the Information Technology Group (ITG) regarding the implementation of last year’s changes to the product coding matrix (PCM); and 3) discussed and considered new suggested changes to the PCM and the uniform transmittal document (UTD). No new revisions were adopted.

Long-Term Care Insurance (EX) Task Force—The Long-Term Care Insurance (EX) Task Force met on Aug. 13 in joint session with the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup to: 1) adopted its July 6 minutes, which included adoption of its Spring National Meeting minutes; and 2) received the reports of the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup and the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup.

During the Aug. 13 meeting, the Task Force received the reports of its subgroups: 1) the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup which met June 22 to hear comments from state insurance regulators and interested parties on
the operational section of the long-term care insurance (LTCI) multistate actuarial (MSA) rate review framework exposure draft; 2) the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup, which met July 28, July 22, and May 4 where it heard presentations on current innovative long-term care (LTC) wellness pilot programs, exposed a document titled “Issues Related to LTC Wellness Benefits” for a public comment period ending Sept. 5, and began making revisions to the draft “RBO Consumer Notices Checklist” based on comments received; and 3) the Long-Term Care Insurance Financial Solvency (EX) Subgroup, which reported on industry trends and factors affecting reserve levels.

During the Aug. 13 meeting, the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup discussed the status of revisions to the operational section of the LTCI MSA rate review framework. The drafting group continues to work through issues identified in the comments received. A second draft is expected to be released for comment in the fall. The Subgroup heard comments on the actuarial section of the LTCI MSA rate review framework from state insurance regulators and interested parties. The drafting group will begin work addressing the issues identified in the comments received.

Special (EX) Committee on Race and Insurance—The Special (EX) Committee on Race and Insurance met Aug. 15 and took the following action: 1) adopted its July 21, July 1, and Spring National Meeting Minutes; 2) heard reports from its five workstreams; and 3) heard presentations from interested parties. The Special Committee met on July 21 and July 1 to hear comments on its proposed charges and adopt those charges for 2021–2022.

- Workstream One of the Special Committee is focused on researching and analyzing the level of diversity and inclusion within the insurance sector. The Workstream submitted an initial report to the Special Committee in February outlining its findings, as well as its recommendations to the Executive (EX) Committee and membership on next steps.

- Workstream Two of the Special Committee has not met since the Spring National Meeting. The Workstream recently emailed to commissioners a survey intended to examine, at the zone level, best practices and initiatives state insurance departments can consider to promote diversity, equity, and inclusion (DE&I) in their offices. Once responses have been gathered, the Workstream will meet to discuss and develop a method and forum to share diversity and inclusion information among state insurance regulators.

- Workstream Three of the Special Committee is focused on property/casualty (P/C) insurance issues. The Workstream has met four times to develop a list of issues that it wishes to focus on. The Workstream leveraged the issues list to create a final report in January that it submitted to the Special Committee for its consideration. The report included potential charges related to affordability; availability and access; producer issues; education and outreach; and unfair discrimination. The Workstream expects to take the adopted charges and begin to draft a work plan to complete its tasks.

- Workstream Four of the Special Committee drafted and adopted an initial report and recommendations via e-vote ending Feb. 5 and forwarded it to the Special Committee for its consideration. The Workstream expects to meet in September to discuss the charges adopted by the Special Committee and draft a work plan to complete its tasks.

- Workstream Five of the Special Committee met July 8 and June 10 to discuss issues related to data collection and provider networks, provider directories, and cultural competency. During these meetings, the Workstream heard responses and testimony from stakeholders on a specified set of questions related to these issues. The Workstream recently exposed a draft Principles for Data Collection document for a public comment period ending Aug. 19. The Workstream plans to discuss the comments received by the Aug. 19 public comment deadline during a meeting on Aug. 26. The Workstream anticipates developing a similar document for issues related to provider networks, provider directories, and cultural competency. After its Aug. 26 meeting, the Workstream plans to finalize a work plan to complete its work on both documents by the end of 2021.
Amendments to the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)—Amendments to Model #171 are required for consistency with the federal Affordable Care Act (ACA). Therefore, they did not require approval of a Request for NAIC Model Law Development by the Executive (EX) Committee. At the 2015 Fall National Meeting, the Regulatory Framework (B) Task Force discussed the proposed revisions to this model. The Task Force met Feb. 11, 2016, and appointed the Accident and Sickness Insurance Minimum Standards (B) Subcommittee to work on revisions to this model. The Subcommittee has been meeting on a regular basis since the 2016 Spring National Meeting, and it plans to continue meeting until it completes its work. During its meetings, the Subcommittee has discussed several issues, including its approach for revising the model’s disability income insurance coverage provisions, and it decided preliminarily to review the Interstate Insurance Product Regulation Commission’s (Compact’s) approach. After pausing its work due to the ACA’s potential repeal, replacement, or modification—and the possible impact on the provisions of this model, as well as the Subcommittee’s preliminary proposed revisions to the model—the Subcommittee began meeting again in May 2018. Revisions to the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170) were adopted by the full NAIC membership at the 2019 Spring National Meeting. The Subcommittee has been meeting to consider revisions to Model #171 for consistency with the revised Model #170 since the 2019 Summer National Meeting discussion on comments received on Sections 1–5 of Model #171. In December 2019, the Subcommittee set a public comment period ending Feb. 7, 2020, to receive comments on Section 6 and Section 7 of Model #171. Due to the COVID-19 health emergency, the Subcommittee has not scheduled any meetings. Any future meetings will depend on when a new co-chair is appointed and the duration of the COVID-19 health emergency. As requested, the Subcommittee received comments from stakeholders on Section 6 and Section 7 of Model #171. A new Subcommittee co-chair has been appointed. The Subcommittee met June 7, 2021, to discuss the status of the proposed revisions to Model #171 and its next steps. The Subcommittee decided to establish a new public comment period ending July 2, 2021, to receive comments on Section 1 through Section 7 of Model #171. The Subcommittee met July 26 and July 12, 2021, to discuss revisions to Model #171 based on the comments received by the July 2, 2021, public comment deadline. The Subcommittee does not plan to meet at the Summer National Meeting. It plans to meet Aug. 9, 2021, to continue its discussion of possible revisions to Model #171.

Amendments to the Annuity Disclosure Model Regulation (#245)—The Executive (EX) Committee met June 19, 2017, and approved a Request for NAIC Model Law Development to amend Model #245. The amendments will revise Section 6—Standards for Illustrations. The purpose of the revision is to address issues identified by the Annuity Disclosure (A) Working Group of the Life Insurance and Annuities (A) Committee related to innovations in annuity products that are not addressed, or not addressed adequately, in the current standards. Revisions addressing participating income annuities were adopted by the Life Insurance and Annuities (A) Committee during its July 19, 2018, meeting and held pending the resolution of the Working Group’s discussions regarding illustrating indexes in existence for less than 10 years. The Working Group is no longer considering the index issue, and the 2018 revisions are being considered for adoption by the Executive (EX) Committee and Plenary at the Summer National Meeting.

Amendments to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)—The Executive (EX) Committee approved a Request for NAIC Model Law Development for amendments to Model #440 and Model #450 at the 2020 Summer National Meeting. The Receivership Law (E) Working Group met six times in 2020 and 2021 to develop revisions to Section 5 of Model #440 and Section 19 of Model #450 that address the issue of continuation of essential services by affiliates in receivership. The Working Group adopted the amendments following the exposure period ending April 9, 2021. The Receivership and Insolvency (E) Task Force adopted the amendments on May 20, 2021. The Financial Condition (E) Committee adopted the amendments on July 8, 2021.

Amendments to the Life Insurance Disclosure Model Regulation (#580)—The Executive (EX) Committee met June 19, 2017, and approved a Request for NAIC Model Law Development to incorporate a policy overview document requirement into Model #580 and the Life Insurance Illustrations Model Regulation (#582) in order to improve the understandability of the life insurance policy summary and narrative summary already required by Section 5A(2) of Model #580 and Section 7B of Model #582. While the Life Insurance Illustration Issues (A) Working Group of the Life Insurance and Annuities (A) Committee was originally planning to revise both Model #580 and Model #582, it will now revise only Model #580. The Working Group has been meeting to develop language to add a requirement for a one- to two-page consumer-oriented policy overview. The Working Group continued to make progress during meetings in late 2019 and early 2020, and it received an extension from the Life Insurance and Annuities (A) Committee at the 2021 Spring National Meeting to continue its work. The
Working Group completed alternative draft versions of model law revisions and a sample policy overview document for term life policies. One version shows the model and sample pre-underwriting, and the other shows the model and sample under existing model law timing requirements. The Working Group developed these alternative versions to aid the Committee in providing guidance to the Working Group with respect to the timing of the delivery of the policy overview document. Discussion of this issue is on the Committee’s agenda at the 2021 Summer National Meeting.

**Amendments to the Nonadmitted Insurance Model Act (#870)**—The Executive (EX) Committee approved a Request for NAIC Model Law Development for amendments to Model #870 at the 2021 Spring National Meeting. The amendments will modernize the model and bring it into alignment with the federal Nonadmitted and Reinsurance Reform Act. The Surplus Lines (C) Task Force met on Aug. 5, 2021, and appointed a drafting group to work on the revisions to Model #870.

**New Model: Pet Insurance Model Law**—The Executive (EX) Committee approved a Request for NAIC Model Law Development at the 2019 Summer National Meeting. The Pet Insurance (C) Working Group held numerous meetings to draft the model law to define a regulatory structure for pet insurance and address issues such as: producer licensing; policy terms; coverages; claims handling; premium taxes; disclosures; arbitration; and preexisting conditions. The Working Group adopted the Model Law on Aug. 4, 2021.

**New Model: Pharmacy Benefit Manager (PBM) Model Law**—The Executive (EX) Committee approved a Request for NAIC Model Law Development at the 2019 Summer National Meeting to draft a new model law addressing the licensure or registration of PBMs. The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force is drafting the model as a result of discussions that began during the Health Insurance and Managed Care (B) Committee’s work to revise the *Health Carrier Prescription Drug Benefit Management Model Act* (#22). Following the 2019 Summer National Meeting, the Working Group held several information-gathering sessions to assist it in working on its charge. The Working Group met in regulator-to-regulator session to discuss its next steps. The Working Group formed an ad hoc drafting group to develop an initial draft regulating PBMs. The Subgroup met July 16, 2020, to discuss a draft of establishing a PBM licensing requirement and other PBM provisions, including a gag clause provision. The Subgroup exposed the draft for a public comment period ending Sept. 1, 2020. The Subgroup discussed the comments received on the proposed new model during a series of meetings in September and October. The Subgroup adopted the proposed new model on Oct. 29, 2020, and forwarded it to the Regulatory Framework (B) Task Force for consideration of adoption. The Regulatory Framework (B) Task Force discussed the proposed new model during its Nov. 19, 2020, meeting. The Task Force deferred adopting the proposed new model and exposed it for an additional 30-day public comment period. The Task Force discussed the comments received on the proposed new model on March 1, 2021, and adopted it on March 18, 2021. The Health Insurance and Managed Care (B) Committee adopted the model law during its meeting on June 22, 2021. The Executive (EX) Committee and Plenary will consider adoption of the model law during the Summer National Meeting.
CLIMATE AND RESILIENCY (EX) TASK FORCE

Climate and Resiliency (EX) Task Force Aug. 15, 2021, Minutes

4-12
The Climate and Resiliency (EX) Task Force met in Columbus, OH, August 15, 2021. The following Task Force members participated: Ricardo Lara, Co-Chair, represented by Mike Peterson (CA); Raymond G. Farmer, Co-Chair, Michael Wise and Michelle Proctor (SC); Colin M. Hayashida, Co-Vice Chair (HI); James J. Donelon, Co-Vice Chair, and Warren Byrd (LA); Kathleen A. Birrane, Co-Vice Chair, and Kory Boone (MD); Mark Afable, Co-Vice Chair, (WI); Andrew R. Stolfi, Co-Vice Chair (OR); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling and Jimmy Gunn (AL); Michael Conway and Peg Brown (CO); Andrew N. Mais and George Bradner (CT); Karima M. Woods (DC); Trinidad Navarro (DE); David Altmaier and Susanne Murphy (FL); Gary D. Anderson (MA); Eric A. Cioppa and Robert Wake (ME); Anita G. Fox represented by Chad Arnold (MI); Grace Arnold (MN); Jon Godfread, John Arnold, and Chris Aufenthie (ND); Eric Dunning represented by Justin Schrader (NE); Russel Toal represented by Jennifer Catechis (NM); Barbara D. Richardson (NV); Linda A. Lacewell represented by My Chi To (NY); Judith L. French (OH); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer, Matthew Gendron, and Jack Broccoli (RI); Scott A. White, Rebecca Nichols and Don Beatty (VA); Michael S. Pieciak represented by Rosemary Raszka (VT); Mike Kreidler and Jay Bruns (WA); James A. Dodrill (WV); and Jeff Rude (WY). Also participating were: Kathy Schmidt and Barb Rankin (KS); Doug Ommen and Travis Grassel (IA); Glen Mulready (OK); Jim L. Ridling and Jimmy Gunn (AL); Michael Conway and Peg Brown (CO); Kathleen A. Birrane, Co-Vice Chair, and Kory Boone (MD); Mark Afable, Co-Vice Chair, (WI); Andrew R. Stolfi, Co-Vice Chair (OR); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling and Jimmy Gunn (AL); Michael Conway and Peg Brown (CO); Andrew N. Mais and George Bradner (CT); Karima M. Woods (DC); Trinidad Navarro (DE); David Altmaier and Susanne Murphy (FL); Gary D. Anderson (MA); Eric A. Cioppa and Robert Wake (ME); Anita G. Fox represented by Chad Arnold (MI); Grace Arnold (MN); Jon Godfread, John Arnold, and Chris Aufenthie (ND); Eric Dunning represented by Justin Schrader (NE); Russel Toal represented by Jennifer Catechis (NM); Barbara D. Richardson (NV); Linda A. Lacewell represented by My Chi To (NY); Judith L. French (OH); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer, Matthew Gendron, and Jack Broccoli (RI); Scott A. White, Rebecca Nichols and Don Beatty (VA); Michael S. Pieciak represented by Rosemary Raszka (VT); Mike Kreidler and Jay Bruns (WA); James A. Dodrill (WV); and Jeff Rude (WY). Also participating were: Kathy Schmidt and Barb Rankin (KS); Doug Ommen and Travis Grassel (IA); Mike Chaney (MS); Lisa Cota-Robles and David Bettencourt (NH); Glen Mulready (OK); Mark Worman and J'ne Byckovski (TX) and Tracy Klausmeier (UT).

1. Adopted its 2021 Spring National Meeting Minutes

Commissioner Altmaier made a motion, seconded by Commissioner Dodrill, to adopt the Task Force’s April 9, 2021, minutes (see NAIC Proceedings – Spring 2021, Climate and Resiliency (EX) Task Force). The motion passed unanimously.

2. Received Reports from its Workstreams

   a. Pre-Disaster Mitigation Workstream

Commissioner Afable said the Pre-Disaster Mitigation Workstream met May 12 to discuss its goals and deliverables. He said the first goal was to compile a list of mitigation actions. The list has been compiled using reputable sources, such as the Insurance Institute for Building & Home Safety (IBHS), the Federal Emergency Management Agency (FEMA), the National Institute of Building Sciences (NIBS), and state departments. The list of mitigation actions has been exposed for a public comment period, and the Workstream is gathering comments on the mitigation actions as well as input on risk-based factors for insurance coverage. The initial focus is on wind mitigation, and the list of actions will help with production of consumer education and outreach, working with community stakeholders.

Commissioner Afable said the NAIC’s Center for Insurance Policy and Research (CIPR) hosted a meeting for state departments in late July to facilitate discussion with Hagerty Consulting to explore the use of federal funding options for state resiliency projects. He said the Biden administration has increased funding levels for resiliency projects, raising the Building Resilient Infrastructure and Communities (BRIC) fund from $500 million to $1 billion for fiscal year 2021. President Joe Biden also announced that $3.46 billion in mitigation funding would be made available through the Hazard Mitigation Grant Program (HMGP). HMGP is available in 59 states, territories, and tribes following disaster declarations due to the COVID-19 pandemic. Additionally, the U.S. Senate recently approved a $1.2 trillion infrastructure package, which includes substantial funding for pre-disaster mitigation and flood mitigation assistance.

   b. Solvency Workstream

Commissioner Birrane said the Solvency Workstream is focused on the regulatory oversight of climate-related financial risks faced by U.S. insurers. Specifically, the Workstream will identify and recommend enhancements to existing financial surveillance and reporting tools, such as the Own Risk and Solvency Assessment (ORSA) and the Financial Condition Examiners Handbook (Handbook), to ensure that climate-related risks are appropriately addressed. She said the Workstream expects to deliver its recommendations to the Climate and Resiliency (EX) Task Force in the fourth quarter of this year. The recommendations will include proposed referrals to the substantive committees that oversee the content of the applicable tools. The Workstream held public meetings in May, June, and August. Each meeting consisted of presentations regarding critical foundational knowledge and context to guide its recommendations to the Task Force.
During its May 5 meeting, the Workstream provided a baseline of the state of climate-related financial surveillance by state insurance regulators and insurer responses. Deloitte provided a presentation on the evolution of regulator reaction to climate-related financial risks that insurers face. DLA Piper Global Law Firm provided an in-depth analysis of the history and current state of regulatory directives internationally. The Workstream also heard a presentation from FTI Consulting regarding insurer development of strategic and institutional responses to climate-related financial risks, as well as existing and anticipated governmental actions related to those risks. Furthermore, the Workstream held discussions with international organizations affecting the insurance sector, including the United Nations Environmental Programme’s (UNEP’s) finance initiatives, the UN Principles of Responsible Investment (PRI), and the Sustainable Insurance Forum (SIF).

During its June 1 meeting, the Workstream identified and defined the kinds of financial risk experienced by insurers and identified frameworks for evaluating and managing the risk. The Insurance Information Institute (III) described current industry practices for identifying risks, particularly related to physical risks in underwriting. AM Best and Moody’s described how they account for climate-related risks in their assessment of credit worthiness and the impact on corporate credit. They described frameworks developed to determine the economic impact of climate risks on insurers.

During its Aug. 6 meeting, the Workstream explored risks on both sides of the balance sheet, asset, and liability risks. It considered transition risk to investments, as well as underwriting and liability. The Workstream heard presentations from the UN-Convened Net Zero Asset Owner Alliance, Transamerica, Allstate, and the UNEP Principles for Sustainable Insurance (PSI). Each presenter had an opportunity to describe their recommendation for revisions to U.S. financial solvency tools concerning climate-related risks. The Asset Owner Alliance shared its member-driven approach to shifting investments to both mitigate transition risk and prove good corporate citizenship and environmental stewardship. Transamerica shared tools for measuring and quantifying climate-exposure risk for investment portfolios and addressed the systemic nature of climate-risks. Transamerica shared viewpoints on financial surveillance tools, such as the ORSA’s adaptability to address climate-related risk. PSI described its assessment frameworks for addressing physical, transition, and liability risks to insurers and its approach to portfolio assessment of such risks. Allstate described its coordinated top-down approach to integrating climate-related risk into its overall risk management strategy and demonstrated tracking of weather-related losses and the impact to underwriting.

Commissioner Birrane said the Workstream plans to meet on Sept. 20 to summarize the key takeaways from its earlier meetings, hear a presentation from the New York Department of Financial Services regarding its recently released guidelines and expectations for insurers related to climate risk, and hear a federal update. The Workstream will also invite comments regarding the need for enhancements to U.S. regulatory financial surveillance tools to better address climate-related risks and then shift its focus from information gathering to drafting its recommendations.

c. Climate Risk Disclosure Workstream

Commissioner Stolfi said the Climate Risk Disclosure Workstream met June 9 to hear a presentation from Morgan Stanley Capital International (MSCI) regarding environmental, social, and corporate governance (ESG) investment policies and climate solutions. The Workstream also reviewed comments received on its guiding questions to determine objectives of the NAIC Climate Risk Disclosure Survey. The Workstream then met in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy on Open Meetings, to discuss comments received and prioritize the recommendations to be made by the Workstream. The Workstream determined that the purpose of the tool is to be a regulator resource to assess the risk management processes of insurers. It also determined that the results should continue to be publicly available, and the questions will be redesigned to align with the framework developed by the Financial Stability Board’s (FSB) Task Force on Climate-Related Financial Disclosures (TCFD). Commissioner Stolfi said a drafting group was formed including California, New York, Oregon, and Washington. A draft of the new survey will be exposed for a public comment period before a recommendation is made to the Climate and Resiliency (EX) Task Force.

Commissioner Stolfi said Gary Gensler (U.S. Securities and Exchange Commission—SEC) remarked in an online seminar that while it is good to learn from external standard-setters like the TCFD, he believes in moving forward with writing rules and establishing the appropriate climate-risk disclosure regime for U.S. markets. Commissioner Stolfi said Mr. Gensler also indicated that he asked the SEC to develop a mandatory climate risk disclosure proposal for the SEC’s consideration by the end of the year and consider metrics for specific industries, such as banking and insurance.

Commissioner Stolfi said the FSB is considering new metrics to capture quantitative information on climate risks. The FSB’s TCFD is on a timeline to submit recommended updates to the FSB by Sept. 15 and publish guidance and implementation guidelines with the new metrics in October 2021. He said 15 states are participating in the NAIC Climate Risk Disclosure Survey in 2021. Six states have been participating for several years: California, Connecticut, Minnesota, New Mexico, New
York, and Washington. Nine states were added in 2021: Delaware, District of Columbia, Maine, Massachusetts, Maryland, Oregon, Pennsylvania, Rhode Island, and Vermont.

d. **Innovation Workstream**

Commissioner Hayashida said the Innovation Workstream met May 10 to hear a presentation from the First Insurance Company of Hawaii regarding its parametric product FirstTrack. FirstTrack offers coverage for pre- and post-hurricane expenses like emergency supplies, groceries, debris removal, and minor repairs. The Workstream also met June 3 to hear a presentation from Jerry Skees (Global Parametrics). Mr. Skees described parametric products created for developing countries, including a risk pooling arrangement for 16 governmental organizations through the Caribbean Catastrophe Risk Insurance Facility Segregated Portfolio Company (CCRIF SPC) and the African Risk Capacity (ARC), a specialized agency of the African Union established to help African governments improve their capacity to plan, prepare and respond to extreme weather events. The Workstream also met July 21 to hear presentations from the Bermuda Monetary Authority (BMA), Nephila Capital, and Renaissance Re. The BMA described its supervisory approach, working with capital solution providers to tailor products for alternative capital climate risk solutions. Nephila Capital described products for agriculture, utilities, governments, and school districts. Renaissance Re described how basis risk (the risk of losses incurred being higher or lower than the actual payout) is reduced when parametric products are used for communities or businesses instead of individual insureds. It also shared the history of the market for parametric products in alternative capital markets. The MetroCat Catastrophe Bond for the New York City subway is triggered by coastal surge. The Penn Union Catastrophe Bond for Amtrak is triggered by tidal and wind measurements using U.S. Geological Survey (USGS) data. The Workstream will continue hearing from parametric solutions for climate-related risk and summarize the design features integrated to close coverage gaps from extreme weather events.

e. **Technology Workstream**

Commissioner Donelon said the Technology Workstream met May 7 to discuss the need for a referral to the Catastrophe Insurance (C) Working Group to consider revisions to the Catastrophe Computer Modeling Handbook (Catastrophe Handbook). The Catastrophe Handbook was developed in 2010 to explore the use of catastrophe models and discuss issues arising from their use. The Workstream discussed the need for updates to include more perils and future looking climate models. The referral was delivered to the Catastrophe Insurance (C) Working Group and discussed during its public meeting on July 22. The Technology Workstream also met June 7 and Aug. 6 in regulator-to-regulator session, pursuant paragraph 6 (technical guidance from NAIC staff) of the NAIC Policy Statement on Open Meetings, to hear about the Center for Insurance Policy and Research (CIPR) study of wildfire risk in California, Colorado, and Washington in conjunction with the Risk Management Agency (RMA), as well as to discuss the wildfire model review taking place under the Catastrophe Risk (E) Subgroup.

3. **Heard a Presentation on the California Department of Insurance Climate Working Group Recommendations Report**

Mr. Peterson said Senate Bill 30, passed by the legislature and signed by the California Governor in September 2018, required the California Insurance Commissioner to convene a working group to identify, assess, and recommend risk transfer market mechanisms that, among other things, promote investment in natural infrastructure to reduce the risks of climate change related to catastrophic events, create incentives for investment in natural infrastructure to reduce risks to communities, and provide mitigation incentives for private investment in natural lands to lessen exposure and reduce climate. The California Climate Insurance Working Group is comprised of 18 members, including the Natural Resource Defense Council (NRDC), The Greenlining Institute, the Environmental Defense Fund (EDF), The Nature Conservancy, the Audobon Society, Los Angeles County, Swiss Re, and Munich Re. The Working Group developed a report, Protecting Communities, Preserving Nature and Building Resiliency, which shows that the best long-term strategy is to drastically reduce greenhouse gas emissions. Mr. Peterson said the report includes impacts from extreme heat, wildfire, and flood—the most pressing perils affecting California right now. The report stresses community resilience, especially for the most vulnerable communities. Mr. Peterson said without greater investment in risk reduction and improved tools for financial resilience, communities are likely to enter a damaging feedback loop where escalating risks lead to increased losses, financial consequences, fewer insurance options, and a diminishing capacity for future resilience. The report recommends improved hazard mapping and disclosures, land and building codes, closing the protection gap, nature-based solutions, and innovation with mitigation.

Alice Hill (Council on Foreign Relations—CFR), chair of the Working Group, said insurance gaps are not only seen in developing economies, coverage gaps exist in California and states across the U.S. Construction standards through building codes and retrofitting properties improve resilience.

Raghavreer Vinukollu (Munich Re) said the report explores combining risk reduction with risk transfer, promoting policy development that recognizes nature-based solutions, and making insurance more affordable and recovery faster.
Katelyn Roedner Sutter (Environmental Defense Fund—EDF) said California is experiencing extreme drought and heat. People with lower incomes, older adults, and people with chronic health conditions are more vulnerable to suffering the effects. Nature-based solutions such as investments in wetlands, urban forests, and ecological forest strategies can reduce damages to health and infrastructure. The EDF has been working to design environmental impact bonds and other market-based financing concepts for investing in wetlands along the coast of the Gulf of Mexico. The Restoration Insurance Services Company (RISCO), with funding by Climate Finance Lab, uses insurance and blue carbon as revenue streams to protect and restore mangroves that reduce flood risk. The Working Group report includes the following nature-based solutions: prioritizing nature-based solutions in city planning, initiating pilot projects on nature-based insurance solutions, linking business investments to nature-based solutions to support resilience, and coordinating with state and federal agencies to develop strategies promoting urban greening, prescribed burning, and sand dune restoration. Engaging local communities and educating residents is critical to the success of these projects. Ms. Sutter said it is important for insurers to get involved and find ways to incentivize risk reduction and resilience.

Serena Sowers (Swiss Re) said the Working Group made recommendations to rank and name heat waves to better communicate the deadly risks to consumers, help communities prepare, and create pilot projects for extreme heat. Ms. Sowers said many of the recommendations are general and adaptable and could apply to all states and multiple climate perils.

4. Heard a Presentation from the RAA on its Resiliency Mapping Tool and Analysis

Dennis Burke (Reinsurance Association of America—RAA) said the RAA is an advocate for using data to identify and communicate risk and plan for mitigation. FEMA published the National Risk Index (NRI) data in late 2020 to help identify communities most at risk to natural hazards. FEMA evaluated natural hazards of 18 perils and combined risk assessment data with social vulnerability and community resilience metrics. Mr. Burke said Scott Williamson (RAA) combined FEMA’s NRI data with U.S. Census Bureau data to analyze the economic impact of perils in each state and identify disaster-prone communities that lack the resources to recover from disasters without state or federal assistance. Many disaster-prone communities lack the ability to use federal funding due to the cost-share provisions and FEMA disaster co-payments required. The RAA’s tool helps identify resource-constrained communities that would benefit from additional legislative provisions to improve their resiliency. Mr. Burke said President Biden’s proposed infrastructure bill includes funding that could be combined with public and private funding to address the needs of these communities which the RAA has termed Community Disaster Resilience Zones (CDRZ). While not formally defined, CDRZ are the most socially and economically at-risk populations of the U.S. The tool could be used by state departments to conduct benefit-cost analysis necessary for federal grant applications because the underlying data was provided by FEMA.

The RAA is promoting the CDRZ Act to improve America’s infrastructure, focusing on public and private infrastructure funding to protect America’s communities from the increasing threat of natural disasters. The RAA is advocating for direct pay bonds such as Build America Bonds (BABs), private activity bonds, transferrable tax credits for community-level projects and individual homeowner retrofits, and corporate and individual charitable contribution tax credits. Finally, the RAA is advocating to waive the required matching funds for FEMA’s BRIC fund due to resource constraints for many communities most in need of the support. The RAA welcomes the support of the NAIC and state insurance regulators in advocating for legislation to improve the resilience of America’s communities.

Having no further business, the Climate and Resiliency (EX) Task Force adjourned.
GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL

The Government Relations (EX) Leadership Council did not meet at the Summer National Meeting.
INNOVATION AND TECHNOLOGY (EX) TASK FORCE

Innovation and Technology (EX) Task Force Aug. 14, 2021, Minutes........................................................................................................4-18
   Big Data and Artificial Intelligence (EX) Working Group July 9, 2021, Minutes (Attachment One) .................................4-26
   Speed to Market (EX) Working Group June 30 and June 29, 2021, Minutes (Attachment Two) ...............................4-29
   E-Commerce (EX) Working Group June 30, 2021, Minutes (Attachment Three).........................................................4-34
The Innovation and Technology (EX) Task Force met in Columbus, OH, Aug. 14, 2021. The following Task Force members participated: Jon Godfread, Chair, and Chris Aufenthie (ND); Elizabeth Kelleher Dwyer, Vice Chair, and Matt Gendron (RI); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling (AL); Alan McClain (AR); Evan G. Daniels (AZ); Ricardo Lara represented by Lucy Jabourian (CA); Michael Conway and Peg Brown (CO); Andrew N. Mais and George Bradner (CT); Karima M. Woods (DC); Trinidad Navarro (DE); David Altmairer represented by John Reilly (FL); Colin M. Hayashida (HI); Doug Ommen and Johanna Nagel (IA); Dean L. Cameron (ID); Dana Popish Severinghaus represented by C.J. Metcalf (IL); Vicki Schmidt (KS); Sharon P. Clark represented by Rob Roberts (KY); James J. Donelon represented by Tom Travis (LA); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Eric A. Cioppa (ME); Anita G. Fox represented by Chlora Lindley-Myers represented by Cynthia Amann (MO); Mike Chaney (MS); Troy Downing (MT); Mike Causey represented by Tracy Beihn (NC); Eric Dunning (NE); Chris Nicolopoulos represented by David Bettencourt (NH); Russell Toal (NM); Barbara D. Richardson (NV); Judith L. French (OH); Glen Mulready (OK); Andrew R. Stolfi and TK Keen (OR); Jessica K. Altman and Michael McKenney (PA); Raymond G Farmer (SC); Larry D. Deiter (SD); Carter Lawrence (TN); Doug Slape (TX); Jonathan T. Pike and Tanji J. Northrup (UT); Scott A. White represented by Eric Lowe and Rebecca Nichols (VA); Michael S. Pieciak represented by Chris Rouleau (VT); Mike Kreidler and Molly Nollette (WA); Mark Aafable and Nathan Houdek (WI); and James A. Dodrill represented by Joylynn Fix (WV).

1. **Adopted its Spring National Meeting Minutes**

Superintendent Toal made a motion, seconded by Ms. Biehn, to adopt the Task Force’s April 9 minutes (see NAIC Proceedings – Spring 2021, Innovation and Technology (EX) Task Force) with one revision to add Connecticut to the list of states on page 1 participating in the artificial intelligence (AI)/machine learning (ML) survey drafting group. The motion passed unanimously.

2. **Adopted its Working Group Reports**

   a. **Big Data and Artificial Intelligence (EX) Working Group**

   Commissioner Ommen gave the report of the Big Data and Artificial Intelligence (EX) Working Group. He said the Working Group met July 9 and discussed a draft survey to conduct analysis on private passenger automobile (PPA) insurers’ use and governance of big data, as used in an AI and ML system. He said as part of that discussion, the Working Group received comments from Working Group members and interested parties. He reviewed the components of the survey and noted that it is being conducted under the examination authority of Connecticut, Illinois, Iowa, Louisiana, Nevada, North Dakota, Pennsylvania, Rhode Island, and Wisconsin and is being sent to insurers writing PPA insurance in at least one of these nine states. He reviewed the timeline, including completing the work by the NAIC Fall National Meeting and what content is and will be available on the associated web page, and he reminded the Task Force members that the Working Group will likely expand the survey work to other lines of insurance in the future.

   b. **Speed to Market (EX) Working Group**

   Ms. Nichols gave the report of the Speed to Market (EX) Working Group. She said the Working Group met June 30 and June 29 and took the following action: 1) adopted its March 10 minutes; and 2) heard an update from the Information Technology Group (ITG). She said part of that update included discussion regarding the low adoption rate for changes to the Product Coding Matrix (PCM) over the last couple of years and the reason why. She said the requests for changes are more specific to a particular state, so solutions for those states are usually provided using filing labels when needed, rather than creating new categories that would not apply to most states. Ms. Nichols said the ITG update also explained that when the System for Electronic Rate and Form Filing (SERFF) redesign begins, the intent is to have one set of types of insurance (TOIs), sub-TOIs, and filing types; but submission requirements that vary for states would be reflected. She said states are encouraged to be sure to respond to any correspondence received regarding the PCM, so that a clear understanding of their needs can be documented and accounted for in the redesign. She reviewed other suggestions that the Working Group members chose not to adopt and the reasons why. The details are documented in the minutes from the meeting.
c. E-Commerce (EX) Working Group

Commissioner Birrane gave the report of the E-Commerce (EX) Working Group. She said the Working Group met June 30 and took the following action: 1) discussed the establishment of the Working Group and the background that led to its formation; 2) reviewed the Working Group’s 2021 charges; and 3) began outlining and discussing the work to be accomplished. She said the Working Group discussed and agreed that understanding the current legal landscape and identifying any key legislation should come first, and the first step in that process is to examine the states’ adoption of the Uniform Electronic Transactions Act (UETA) and review any gaps there may be or exceptions they may have in place. She said to do so, the Working Group discussed surveying the states in this regard and asking what laws, rules, regulations, and bulletins were put in place during the pandemic that temporarily suspended or waived state law by allowing for the electronic exchange of information. She said the Working Group also anticipates asking the states of those provisions that were put in place which ones remain, which ones have expired or been rescinded, and for an explanation as to why the state took the action it did.

Commissioner Birrane said the Working Group learned through this discussion that some states have already started this process on their own, and they would be willing to share their results, which will serve as a good starting point for the Working Group. She said the Working Group also discussed what type of deliverable its work will result in, and the options of both a model bulletin and a white paper were explored; however, before the Working Group can decide on how best to move forward in this regard, the Working Group is now focused on gathering this information from the states then determining how best to move forward, as well as what the timeframe for a deliverable may be. She said the Working Group intends to meet in September 2021 to continue its work.

Commissioner Godfread asked if there were any questions regarding any of the working group reports. Hearing none, Superintendent Dwyer made a motion, seconded by Commissioner Mulready, to adopt the following reports: 1) the Big Data and Artificial Intelligence (EX) Working Group, including its July 9 minutes (Attachment One); 2) the Speed to Market (EX) Working Group, including its June 30 and June 29 minutes (Attachment Two); and 3) the E-Commerce (EX) Working Group, including its June 30 minutes (Attachment Three). The motion passed unanimously.

3. Received an Update on NAIC Cybersecurity Workstreams and Priority

Commissioner Godfread said one of the charges to the Task Force is to serve as a coordinating body for workstreams related to cybersecurity. He said the workstreams currently being tracked total 12 and include work being done related to tracking the Insurance Data Security Model Law (#668), updating NAIC handbooks, working with industry on tabletop exercises and incident response, international work, and domestic work related to data privacy and the cybersecurity insurance market. He said Model #668 has been adopted by 18 states who have either already implemented it or are in the process of doing so, and two more states have action under consideration.

Commissioner Godfread said tools associated with the Financial Condition Examiners Handbook continue to be updated, and in 2021, the Information Technology (IT) Examination (E) Working Group is developing new guidance and procedures for state insurance regulators to use in evaluating an insurer’s response to vulnerabilities. The Market Regulation Handbook, providing guidance and checklists, was updated in 2019.

Commissioner Godfread said while cybersecurity tabletop exercises experienced a bit of a slowdown because of COVID-19, they are getting rolling again, and Connecticut will be hosting one in November 2021. He said the Center for Insurance Policy and Research (CIPR) developed a survey related to insurer cybersecurity preparedness, and it was implemented in Connecticut and will help inform the tabletop. He said due to the rise in ransomware events, that tabletop will focus on that issue. He said through tabletops and work with the Financial and Banking Information Infrastructure Committee (FBII) and others, incident best practices guidelines are being developed, and NAIC staff have already collected best practices from the U.S. Securities and Exchange Commission (SEC), the Commodity Futures Trading Commission (CFTC), the FBIIC, and state insurance departments to see where updates to the Market Regulation Handbook and the Financial Condition Examiners Handbook might be helpful.

Director Farmer noted the importance of getting Model #668 passed in each of the states. He said getting back to the tabletop exercises, he would encourage each state to consider doing a tabletop exercise, and he said the NAIC has participated with the U.S. Department of the Treasury (Treasury Department) on two tabletop exercises, including one in South Carolina in 2019 that was extremely helpful to its local industry. He said that template is now available to other states to use to host their own.
Commissioner Godfread asked Commissioner Mais if other states could join the Connecticut tabletop to observe. Commissioner Mais said yes, and all state insurance regulators are welcome to participate. He said that should be relatively easy to do since it will be virtual.

Commissioner Godfread said regarding the cybersecurity insurance market, the NAIC began capturing data from insurers via the Cybersecurity Annual Statement Supplement back in 2018, and each year produces a report based on that data and includes data collected from the surplus lines market. He said that work is under the purview of the Property and Casualty Insurance (C) Committee and will be discussed during a cybersecurity “mini-series” session at the NAIC’s September Hybrid Insurance Summit: Part 2, and there will be two other cybersecurity sessions that will be part of that series.

Commissioner Godfread said the Task Force members would hear an update later in the agenda related to the Privacy Protections (D) Working Group, and he said state insurance regulators, through the NAIC, are also tracking closely with international colleagues on cyber issues, including work with the European Union (EU), European Insurance and Occupational Pensions Authority (EIOPA), and the International Association of Insurance Supervisors (IAIS) Operational Resilience Task Force (ORTF). He said the ORTF is working on gathering existing materials that will inform a paper on how standard setters and jurisdictional supervisors are approaching risks associated with operational resilience for IT third-party outsourcing, cyber risk, and related lessons learned from the COVID-19 pandemic on business continuity planning over the long term, and that paper is scheduled for public consultation in the second quarter of 2022.

Commissioner Godfread said the NAIC continues to stay diligent in terms of internal cybersecurity and data security, privacy and field work on the first cloud System and Organization Controls (SOC) 2 review has been completed, and follow-up work is underway. He said the NAIC maintains a security posture communication using the Shared Information Gathering (SIG) questionnaire.

4. Discussed Consumer Data Ownership Issues and Potential Guidance

Superintendent Dwyer reviewed the presentations received by the Task Force during the Spring National Meeting from Daniel Demetri, the founder and chief executive officer (CEO) of Trellis Connect, and Ali Safavi, the co-founder and CEO of Vero. She said Trellis Connect helps consumers navigate insurance as they move online using apps to allow their information to be shared with the advisor app they have selected and provides consumers the ability to rely on and share data, allowing them to share their insurance information for many different purposes. She said Mr. Demetri suggested that state insurance regulators should determine what the parameters around this should be and what rights consumers should have to their insurance data in terms of who owns it and how they can access it. She said he also noted that many insurers elect to block consumer access for security or competitive purposes, and he urged state insurance regulators to consider what the data access rights are in each of our states and how they translate to the online environment.

Superintendent Dwyer noted these as examples of begging the question of how to address the questions of who owns consumer data and who owns access to consumer data. She said the Privacy Protections (D) Working Group is investigating consumer rights, so that may be where this matter should be addressed, possibly in its Privacy Policy Statement.

In addition, Superintendent Dwyer said there is the question of what rights independent agents have compared to what they consider to be data that belongs to them regarding their customer’s data and access to that data, particularly if they are to assist their customer/policyholder in determining the best and appropriate coverages or products to consider. She said these are not the only scenarios under the heading of “consumer data ownership and access,” and she asked if there truly are significant security issues with allowing a consumer to give their credentials to a third party to offer services to them and analyze information on their behalf. She asked what the other scenarios are regarding ownership and access to this data.

Superintendent Dwyer noted this seems like an area to dig into. She said questions should be asked like whether consumers should be able to allow access to that information to a third party, who “owns” the data, and what the associated risks might be.
Superintendent Dwyer said the question to the members of the Task Force is whether it should take this on and if so, what the best approach is. She asked if the best approach is to study it more at the Task Force level or refer it to another committee. She said it makes sense to coordinate with the Working Group, but she would like to hear what the will of the Task Force members is.

Commissioner Godfread said when North Dakota picked up this issue, he was interested to learn that it was not so much about who owned the data as much as it was about how and what format a consumer could get it if requested. He said the consumer may ask for it digitally, but the insurer gets to decide how the data gets transmitted. He said that was a bit troubling to him. He said their work in this area was met with heavy resistance, and understandably so, as it is a new issue; and everyone is still working through it and associated security issues, but it is a solvable problem, as the banking industry seems to have done so, as there are a number of different applications that can analyze multiple accounts that include consumers giving credentials to a third party in order to see the full picture. He said some antiquated laws potentially need to be reviewed in this area, and that is the kind of thing the Task Force looks at.

Ms. Amann said this is becoming an underlying issue that the Working Group is identifying in consumer rights that it is trying to address. She said if given the direction from the Market Regulation and Consumer Affairs (D) Committee, this could be an issue that the Working Group could take on. She said the Working Group is starting to see more issues around health apps where a consumer may want to share information from multiple online sources, allowing it to analyze the data in aggregate, but there is no accountability regarding the advice given based on that data. She said the app could tell someone to do something that may not be appropriate. She said there seems to be no regulatory authority to oversee this area, but the Working Group is starting to work on recommendations regarding where states might improve their laws and regulations.

Commissioner Lawrence noted that data ownership issues are a large macro issue when considering a look across all parts of our society, and this topic is worthy of taking up for review.

Director Daniels asked for clarification regarding what the deliverable might be in addition to continuing the work that is already underway in the Working Group, asking if it would be a model law, guidance, or something else. He said it would be helpful to understand the scope of that work.

Commissioner Godfread said he really does not know just yet, and it is a matter of looking to see where the gaps are and then seeing what the best way would be to address it. He said he does not prefer the model law approach generally, because that can be difficult to get adopted everywhere. He said with some of these issues, bringing it to light helps to sometimes start the process of getting the issue solved. He said every state should look where their laws are and where they might be causing an impediment, but at this point, everything is on the table. He said in North Dakota, antiquated laws likely need to be updated. Superintendent Dw yer said she does not think it would be good to start with a specific direction, and she suggested that the first step is to determine the status and get an overall understanding of laws that currently exist. She said they likely exist regarding the agents versus the companies, but no one has moved forward on these in a long time, so step one is to do the research, see where they stand, and then decide the best approach.

Ms. Amann said the Working Group has reviewed the NAIC Insurance Information and Privacy Protection Model Act (#670) and the Privacy of Consumer Financial and Health Information Regulation (#672), and she redlined edits to make it more technologically correct, made some other recommended changes, and did a gap analysis to the other data privacy laws in place today, such as the General Data Protection Regulation (GDPR), the Gramm-Leach-Bliley Act (GLBA), the California Consumer Privacy Act (CCPA), the Fair Credit Reporting Act (FCRA), Virginia and Colorado’s laws, and others. She said after all of that they have concluded they need to either draft a new model law or go back to Model #672 and make updates to it, which would likely be a complete rewrite.

Commissioner Godfread asked that work be distributed to the Task Force members. Commissioner Birrane noted support for this as well and pointed out that data ownership, use, and access is often one of the most complicated contract negotiations with third parties regarding consumer facing apps. She said it is important to determine what pieces of this, within what context, are being taken up at what point in time. Mr. McKenney said he would encourage whatever group that looks at this to also consider the tying of eligibility to use of a third-party app because that is a part of this conversation as well. Superintendent Toal echoed Commissioner Godfread’s comment about preferring not to take the approach of drafting a model law, and he said he believes this would be better done through regulation.

Angela Gleason (American Property Casualty Insurance Association—APCIA) said the proprietary nature of the information and the associated data security and privacy issues are critical. She said the Working Group has already started this conversation and is looking at gaps, but there are definitely issues in the privacy and cyber world, and choosing the format for transmitting
data to a consumer can pose significant challenges for data security in terms of how to ensure systems can accommodate that and protect the data at the same time. She said these are important and complex issues.

Birny Birnbaum (Center for Economic Justice—CEJ) said before selecting tools, it is important to examine the values they will need to represent. He said along those lines, he would suggest characterizing this slightly different from data ownership and characterize it as defining what consumer-generated data an insurance or producer collects, for what purpose, how it is used, what access a consumer has to their data, and how a consumer can take their data from one vendor to another. He said he concurred with focusing on data ownership and several of the issues raised about existing laws, but stating what data is being collected from consumers, what it can be sued for, and how it must be made available to a consumer is a more straightforward approach as opposed to just addressing it as issues of ownership. He said that is really a proxy for all the other issues that might be better addressed more directly.

Chris Petersen (Arbor Strategies LLC), speaking on behalf of a collation of health insurers, said the group should consider state laws that have data retention requirements during which the data are not portable, as it must be kept by the insurer, as required by state law, and consider the Health Information Portability and Accountability Act of 1996 (HIPAA) that has severe restrictions on what health insurers can and cannot do. He said that law preempts state laws that have less favorable privacy protections. He said because of these other laws being in place, including the GLBA, the portability issue is different in health insurance than the tech company arena.

Following discussion of the topic, Commissioner Godfread asked the Task Force members if it would make sense to refer this item to the Committee to consider and possibly add it to the charges of the Working Group. Hearing no objection from the Task Force members, he said it would be referred to the Committee.

5. Heard Updates from Other Committees and Working Groups on Related Activities

Commissioner Godfread asked representatives from other committees whose charges involve related workstreams to those the Task Force is addressing to provide updates.

a. Special (EX) Committee on Race and Insurance

Commissioner Mais said there are several charges under the Special (EX) Committee on Race and Insurance that relate closely to what the Task Force is working on, and it will be paramount to communicate and engage with one another as these workstreams develop. He said the charges for the Special Committee specifically note that it should coordinate with groups such as the Big Data and Artificial Intelligence (EX) Working Group and encourage groups to continue their work on issues that affect people of color and historically underrepresented groups, particularly in predictive modeling, price algorithms, and AI. He said Charge F spreads across the lines of business and calls for continuing research and analysis of insurance, legal, and regulatory approaches to addressing unfair discrimination, disparate treatment, proxy discrimination, and disparate impact. He said a subset of Charge F, F2 is specific to Workstream Three and calls for the development of analytical and regulatory tools to assist state insurance regulators in defining, identifying, and addressing unfair discrimination in property/casualty (P/C) insurance.

Commissioner Mais said the Special Committee and its workstreams will look to define those terms, but as it turns to developing analytical and regulatory tools, ensuring that the line of business workstreams are communicating and working closely with the Task Force and groups like the Accelerated Underwriting (A) Working Group who have researched these sorts of tools already will be imperative.

Commissioner Mais said with the adoption of charges, the workstreams will look to create workplans to develop priorities and timelines and ensure continued communication with the Task Force.

b. Accelerated Underwriting (A) Working Group

Commissioner Arnold said she is the vice chair of the Accelerated Underwriting (A) Working Group and the chair of an informal state insurance regulator drafting group that is drafting the educational report that is the Working Group’s work product. She said the drafting group is made up of state insurance regulators from approximately six states and has been meeting on a weekly basis.

Commissioner Arnold said to date, two parts of what is intended to be a five-part paper have been exposed for comment. She said the Working Group have employed an iterative process and been drafting and releasing sections of the draft for comment...
as the drafting group finishes them, and comments on the entire draft are welcome with each release of a new part. She said the drafting group intends to collect and review comments throughout the process, and it anticipates revisions to earlier sections as new sections are developed.

Commissioner Arnold highlighted some of the issues and feedback encountered so far, including:

- Receiving quite a few comments on the definition of accelerated underwriting after the release of the first part of the paper.
- Spending a lot of time on the definition and considering definitions from a number of sources, in addition to the comments.
- Concluding that the definition proposed for use in the educational paper was largely in the middle of all the options offered and deciding not to make any changes at this point.

Commissioner Arnold said the drafting group acknowledges that once the rest of the paper is drafted, there may be a need to reconsider the definition, and consideration of the issue of tone needs to be discussed. She said the drafting group tried to keep the tone of the paper neutral, but during presentations, the Working Group heard a lot about the advantages and disadvantages of accelerated underwriting. She said the drafting group tried to stay away from that in the report and stay focused on what accelerated underwriting is, what accelerated underwriting does, and what the regulatory structure is or should be in the context of current laws.

Commissioner Arnold said the matter of a glossary was also discussed, and the Working Group received several suggestions to create one but decided not to at this point for a few reasons, but largely because some terms are defined differently in different contexts and in different states.

Commissioner Arnold said another issue is ensuring the educational report builds on existing NAIC work products and the drafting group has tried to use terminology that builds on and is consistent with other NAIC documents, like the AI Principles and the Casualty Actuarial and Statistical (C) Task Force white paper. She said the drafting group specifically requests comments on the parts of the paper addressing, from a legal and practical perspective, the data used in accelerated underwriting programs and feedback on how the paper might achieve clarity describing the kinds of data being used, whether data sources or the scores that come from the sources, what those terms mean, what kinds of obligations flow from them, and what a consumer sees or should see.

Lastly, Commissioner Arnold said another area where the drafting group is requesting feedback are the sections discussing the distinctions between the types of data, including data covered under the FCRA, and what that means for state insurance regulators, companies, and consumers.

c. Property and Casualty Insurance (C) Committee

Commissioner Schmidt said one of the main issues relevant to the Task Force that the Property and Casualty Insurance (C) Committee is working on is cybersecurity. She said the charge to study the cyberinsurance market and report on cyberinsurance data collected in the Annual Statement moved from the Task Force to the Committee this year, and the Committee will be hearing a report on the cyberinsurance data and a later update once the alien surplus lines data has been reviewed.

Commissioner Schmidt said there will be several sessions dealing with various aspects of cyber risk, security, and insurance in September at the NAIC Insurance Summit. She said another topic the Committee and the Task Force should be sure to communicate on relates to parametric insurance. She said the Climate and Resiliency (EX) Task Force has received several presentations related to parametric products and has more scheduled in the future. She said the Committee’s interest in this topic goes beyond the focus of either the Climate and Resiliency (EX) Task Force, which would focus on covering specific coverage gaps, and the Innovation and Technology (EX) Task Force, which would probably be focused more on data and technology. She said it might make sense for the Committee to take a broad look at parametric insurance and produce some type of work product related to that type of innovative product.

d. Privacy Protections (D) Working Group

Ms. Amann said the Privacy Protections (D) Working Group reviewed the 2021 NAIC member-adopted strategy for consumer data privacy protections and discussed the 2020 Fall National Meeting verbal gap analysis of consumer issues. She said it also discussed the draft of the initial privacy policy statement. She reviewed the six areas covered by the policy statement and said the Working Group requested comments in the form of parameters and examples on the initial privacy policy statement for
discussion during the Working Group meeting. She said this issue of consumer data ownership may possibly be a seventh, but it also underlies the others. She said during the June meeting of the Working Group, it discussed the initial draft of the privacy policy statement and requested comments in the form of parameters and examples on the initial privacy policy statement. She said the Working Group is also talking about how far the reach of this will be regarding whether it will pertain to a vendor, supply chain or third parties such as third-party administrators (TPAs), adjusters, and others.

Ms. Amann said the Privacy Policy Statement template is on the Working Group’s website and is being combined with comment received into a draft for exposure and accelerated review by the Working Group.

Harry Ting (Consumer Advocate Volunteer) said another privacy issue, somewhat peripheral but relevant for consumers, is research that indicates in some cases, sales of health insurance plans online involve using outside entities to collect data to market health plans and collecting private information the entity is later selling to other entities; in most cases, they are not insurance entities. He said this involves quite a bit of personal contact and health status information. He said that seems to be a privacy issue that should be addressed somewhere within the NAIC.

6. Received NAIC Reports on the Model Review Process and International Initiatives Relative to AI and Big Data

a. Received the NAIC Report on the Model Review Process

Kris DeFrain (NAIC) said the NAIC model review project officially began in April 2018 when the Executive (EX) Committee adopted the recommendation of the Big Data (EX) Working Group to “conduct research on the appropriate skills and potential number of resources for the organization to help NAIC members in coordinating their reviews of predictive models.” She said NAIC senior management conducted the research and recommended gradual build-up of expertise at the NAIC to aid state insurance regulators’ review of P/C rate models. She said in 2019, with existing actuarial, legal, and IT staff, the NAIC did three things:

- Drafted a contractual agreement called the Rate Review Support Services Agreement to be used so a state can gain access to the shared model database and request a rate model technical review from the NAIC.
- Developed the initial NAIC rate model technical review process with a consulting actuary.
- Created a shared model database for confidential regulatory communication.

Ms. DeFrain said as of today, there are 31 states who have a Rate Review Support Services Agreement with the NAIC, and the NAIC has worked with 10 of the 31 states to produce 60 NAIC reports. She said most of the rate models reviewed have been the most common type of model, a generalized linear model (GLM). She said the GLM reviews are aligned with the Casualty Actuarial and Statistical (C) Task Force’s white paper on the Regulatory Review of Predictive Models. She said other types of models have also been reviewed, adapting the white paper recommendations to fit the different models. She said the Task Force was asked to consider reviewing the approaches on these other types of models and offer guidance regarding the technical review reports to ensure that they help state insurance regulators.

Ms. DeFrain said as the database of model reviews at the NAIC grows, it is expected that there will be an expanding number of second state requests, or requests for review of a company’s model the NAIC has already reviewed for another state. She said there is a substantive amount of analysis required to compare the models between the states and track the NAIC-identified issues to objections to state approval or disapproval and sometimes to company withdrawal. She said the NAIC will assist the second and subsequent states to use the first state’s NAIC technical review and determine its next steps to take with its filing, and that may mean that sometimes the second state is satisfied with the objections and answers from the first state filing, yet other times that might mean the second state wants to pursue a different course of action. She said that may increase speed to market in the second and subsequent states.

Ms. DeFrain pointed out that the group continues to abide by the principles created by the Working Group, and the NAIC does not:

- Assume any regulatory authority.
- Create objections to be sent to the company.
- Recommend acceptance or rejection of the model or any specific rating variable.
- Do separate modeling to determine any correlation with unlawful characteristics or assess disparate impact.

Ms. DeFrain said the NAIC approved the addition of two new actuaries to join the rate review team, while simultaneously eliminating the assistance of the part-time consultant.
b. Received an Update on International Initiatives Relative to AI and Big Data

Ryan Workman (NAIC) provided a briefing on international initiatives relative to AI and Big Data. He said these initiatives are relevant for the Task Force to track and monitor. He said the IAIS FinTech Forum is currently focusing on AI, ML, and data analytics, application programming interfaces (APIs), open data, and distributed ledger technologies (DLTs). He said at the end of 2020, the FinTech Forum set up individual subgroups to consider each of these applications, respectively, and Commissioner Godfread represents the NAIC as a member of the FinTech Forum and the subgroup on AI and ML.

Mr. Workman also discussed the work on big data/AI of the U.S. EU Insurance Dialogue Project. He said the U.S. EU Insurance Dialogue Project started in 2012, when the NAIC, the Federal Insurance Office (FIO), the European Commission (EC), and the EIOPA agreed to participate in a deeper dialogue project with the objective of enhancing the mutual understanding and cooperation between the EU and the U.S. for the benefit of insurance consumers, business opportunity, and effective supervision. He said as part of this project and for the last few years, there has been a working group on big data and AI, which included NAIC staff and state insurance regulators from the U.S., along with federal and European counterparts. He said the Working Group has:

- Focused on aspects of the relationship between innovation, technology, and insurance, specifically: 1) the increased use of big data by insurers; and 2) the use of advanced data analytics in the insurance sector.
- Published a paper in 2018 providing the reader with a better understanding of what data is collected, how data is collected, data portability, data quality, and how data is made available and used by both insurers and third parties.
- Focused, in 2019, on regulatory oversight of insurers’ use of third-party vendors, the ability of insurance supervisors to monitor new vendors operating in the insurance marketplace, disclosures to applicants and policyholders about how rating factors and third-party vendor data are being used, and insurers’ use of AI models that increasingly rely on the use of big data.
- Provided a summary of this work in a February 2020 paper that is available on the NAIC website under EU-U.S. Insurance Dialogue Project.
- Worked on another published report providing a summary of the Big Data and Artificial Intelligence (EX) Working Group exchanges of supervisory experiences and regulatory environments since publication of the February 2020 paper in October 2021. He said this report will include: 1) further development of AI principles in the U.S. and EU, respectively, including ethical aspects; 2) regulatory review of predictive models, including but not limited to, assessing transparency and explainability issues arising from the use of AI, including ML algorithms; 3) industry use of big data for fraud detection and claims settlement; and 4) new developments on third-party vendors and consumer disclosure issues since the discussions in 2019.

Mr. Workman said the U.S. EU Insurance Dialogue Project will host a public virtual webinar Oct. 19 on its continued progress and future priorities, and representatives of the NAIC, including Commissioner Birrane and Commissioner Ommen; the FIO; and the EIOPA, will lead the webinar.

7. Discussed Other Matters

Commissioner Godfread discussed the conversation that NAIC members have had concerning the creation of a new letter committee dedicated to Innovation, Technology, and Cybersecurity. He said based on today’s meeting and the ongoing work of the Task Force and its working groups, as well as many other NAIC workstreams, the NAIC has and will continue to be involved in several workstreams regarding innovation, technology, and cybersecurity. He said coordination among these workstreams is critical and, in addition to the ongoing activities, there are any number of open questions as technology continues to advance, as cyber breaches continue to occur, and as state and federal entities continue to develop legislative and regulatory guidance to address these issues. He said the mission of the new committee will be to: 1) provide a forum for state insurance regulators to learn and have discussions regarding innovation, technology, and cybersecurity issues; 2) monitor developments in these areas that affect the state insurance regulatory framework; and 3) develop regulatory guidance, as appropriate. He said in terms of process, the Task Force will play an important role in finalizing a draft mission statement and set of charges for this new committee. He said he planned to appoint an ad hoc group to begin that work and seek input from interested parties. He said the charges will require Executive (EX) Committee and Plenary approval and an amendment to the NAIC bylaws to officially add the new committee. He said the goal is to take those actions at the Fall National Meeting in San Diego, CA, and more information about the next steps will be available via the Task Force in the coming weeks.

Having no further business, the Innovation and Technology (EX) Task Force adjourned.
Big Data and Artificial Intelligence (EX) Working Group
Virtual Meeting
July 9, 2021

The Big Data and Artificial Intelligence (EX) Working Group of the Innovation and Technology (EX) Task Force met July 9, 2021. The following Working Group members participated: Doug Ommen, Chair (IA); Elizabeth Keller Dwyer, Co-Vice Chair (RI); Mark Afable, Co-Vice Chair (WI); Daniel Davis (AL); Ken Allen (CA); Mitchell Bronson (CO); Wanchin Chou and Andrew N. Mais (CT); Rebecca Smid (FL); Judy Mottar (IL); Amy L. Beard (IN); Ron Kreiter (KY); Tom Travis (LA); Ron Coleman (MD); Karen Dennis (MI); Phil Vigliaturo (MN); Cynthia Amann (MO); Chris Aufenthie (ND); Christian Citarella (NH); Randall Currier (NJ); Gennady Stolyarov (NV); Lori Barron (OH); Shannen Logue (PA); Michael Wise (SC); Rachel Cloyd (TX); Eric Lowe (VA); Christina Rouleau (VT); John Haworth (WA); and James A. Dodrill (WV).

1. **Adopted its March 29 Minutes**

Superintendent Dwyer made a motion, seconded by Commissioner Richardson, to adopt the Working Group’s March 29 minutes (see NAIC Proceedings – Spring 2021, Innovation and Technology (EX) Task Force, Attachment One). The motion passed unanimously.

2. **Discussed a Draft Survey and Definitions on Industry’s Use of Big Data, AI, and ML**

Commissioner Ommen said the Working Group is developing a survey to obtain a more accurate and objective measure of how insurers are using data variables, artificial intelligence (AI), and machine learning (ML) while also protecting the trade secrets and intellectual property of insurers. Commissioner Ommen said the work is being completed to fulfill the Working Group’s charge to “research the use of big data and artificial intelligence (AI) in the business of insurance and evaluate existing regulatory frameworks for overseeing and monitoring their use. Present findings and recommend next steps, if any, to the Innovation and Technology (EX) Task Force, which may include model governance for the use of big data and AI for the insurance industry.” He said the Working Group is focusing on private passenger auto (PPA) insurance. He said the Working Group is not trying to scrutinize any individual company’s practices, but rather it is trying to understand broader market practices. Because of this, the survey is not designed to collect information on a state-specific basis.

Superintendent Dwyer said a small number of subject matter experts (SMEs) were asked to work with NAIC staff to create the draft survey. Iowa, Rhode Island, and Wisconsin led these discussions, and representatives from Connecticut, Illinois, Louisiana, Nevada, North Dakota, and Pennsylvania served as SMEs. Superintendent Dwyer said the SMEs met throughout April and spent a considerable amount of time to ensure the survey instrument makes sense for the stated purpose and, more specifically, the questions, terms, flow, and general content is understandable, intuitive, and will produce the information needed to get a more objective understanding of the current status of AI/ML for PPA insurance.

Superintendent Dwyer said the drafting group circulated the draft survey to five pilot companies in early May. During May, NAIC staff held independent calls with those companies to receive feedback and improve the survey. The SMEs then picked up their work again in early June with the work culminating in the draft survey being circulated to the Working Group, interested state insurance regulators, and interested parties on June 24. Superintendent Dwyer said the SMEs who are attorneys drafted an examination call letter during May and June, and they began working with NAIC staff on how to collect the survey responses, with assistance from the NAIC. She said the lead states collecting the survey information clearly understand the need to have a centralized method of collecting survey responses, while maintaining individual company confidentiality. She said the SMEs believe the concerns related to confidentiality protections are being addressed.

Superintendent Dwyer said the survey begins with the threshold question of whether an insurer is using AI/ML. The SMEs spent a significant amount of time refining and clarifying the scope of the survey and ultimately defined AI/ML for the purposes of the survey as, “an automated process in which a system begins recognizing patterns without being specifically programmed to achieve a pre-determined result.” Superintendent Dwyer said this is different from a standard algorithm that consists of a process or set of rules executed to solve an equation or problem in a pre-determined fashion, and evolving algorithms are considered a subset of AI/ML. She said the SMEs understand there are many different interpretations regarding the meaning of AI and ML. She said she wants to be very clear the Working Group is not trying to develop a unilaterally agreed upon or standard definition beyond this survey.
Superintendent Dwyer said the survey then asks how AI/ML is being used in the following areas of rating, underwriting, claims, fraud detection, marketing, and loss prevention. For each of these operational areas, the survey seeks information on the level of deployment, the use of third-party vendors, and whether model governance is in place. In addition, Superintendent Dwyer said the survey includes questions about whether insurers have contracts with third-party vendors that might limit transparency to state insurance regulators and how insurers voluntarily provide transparency to consumers regarding data being used. She said the third aspect of the survey relates to data elements being used in AI/ML. This includes seeking information on the use of consumer “scores” that may be used. Superintendent Dwyer said the survey intentionally excludes questions about traditional and well understood uses of data, and the Working Group wants to learn more about what it does not already know.

Mr. Stolyarov said the data definitions include examples of AI/ML to clarify what insurer practices are in and out of the scope of the survey. He said the survey is not intended to collect information for general linear models, static algorithms, or table algorithms, no matter how complex. He said the survey is not intended to collect information on company practices that were used prior to 2000, and most of the practices the Working Group is trying to address began in the last decade.

Mr. Vigliaturo asked how the listing of data variables, such as education and occupation, would be viewed if the data is used, but not in AI/ML. Mr. Stolyarov said the purpose of this survey exhibit is to obtain information on data input into AI/ML, and it is not designed to obtain information on the use of data outside AI/ML.

Frank O’Brien (American Property Casualty Insurance Association—APCIA) said he appreciates the comments regarding the confidentiality concerns, and he looks forward to receiving more information on how these concerns are being addressed. He said the survey will require a significant amount of work for companies, and he urged the Working Group to provide companies sufficient time to respond to the survey.

Chris Petersen (Arbor Strategies LLC) said he understands the survey is limited to PPA insurance, but he also understands the template may be used for additional lines of insurance. He said it will be difficult for insurers to list all vendors because health insurers may have hundreds of vendors. He suggested that the survey focus on collecting the categories of vendors used. He said there is a difference between AI and ML, and there are various types of ML. He said the survey should reflect these nuances.

Birny Birnbaum (Center for Economic Justice—CEJ) said the survey asks companies to identify the areas in which AI/ML is used but does not ask what different types of data insurers use. He suggested that the survey asked whether data being used is compliant with the Fair Credit Reporting Act (FCRA), which is a broader focus than whether consumers can correct data being used. He said some of the survey questions require interpretation by insurers. Regarding the questions on model governance, he said one company may respond that it wants its model governance to be fair and ethical, while another company may be testing to verify that its model governance is fair and ethical. He said a better approach to determine insurers’ compliance with the NAIC AI Principles would be to have the insurers submit their model governance policies. Finally, he asked if the survey report would be made public.

Commissioner Ommen said the survey is informed by individual state work and will not be able to identify everything regarding how companies are adhering to the NAIC AI Principles. Superintendent Dwyer said the Working Group will issue a public report, but it will not disclose individual company information.

Superintendent Dwyer said the SMEs will consider the comments received today, and she asked interested parties to send the exact language they would propose for the survey. She said the Working Group understands the importance of having clarity in the survey questions to obtain consistent responses from insurers. She requested that all comments be submitted by July 16.

Superintendent Dwyer said the SMEs will finalize the survey and definitions and distribute a final version of the survey to the Working Group. In addition, she said an informational version of the survey will be distributed by the end of July to the insurers who will be asked to respond to the survey. She said NAIC staff will develop the survey tool, instructions, frequently asked questions (FAQ), and the web page, and they will follow the same process used for other coordinated data requests, such as those used for the COVID-19 Property/Casualty (P/C) data request.

Superintendent Dwyer said NAIC staff need three weeks to set up the survey, but they urged insurers to begin collecting their responses upon receiving the informational version of the survey at the end of July. She said the online portal for submitting the survey will be available in mid-August, and this will be communicated to insurers.
Superintendent Dwyer said the survey responses will be collected under the exam authority of Connecticut, Illinois, Iowa, Louisiana, Nevada, North Dakota, Pennsylvania, Rhode Island, and Wisconsin, and they will be collected through the NAIC’s Regulatory Data Collection (RDC) system. She said the following schedule is anticipated for the remainder of 2021:

- August: Issuance of the survey to PPA insurers. The number of insurers to receive the survey is still to be determined.
- September: Companies respond to the survey via the NAIC portal.
- October: Lead states for the survey issue a draft report of its findings to the Working Group.
- December: The Working Group issues a final report on industry practices, while maintaining the confidentiality of individual company responses. Will take comments on the draft report October–December.

Superintendent Dwyer said the Working Group will focus on its long-term goals of developing guidance and recommendations to update the existing regulatory framework for the use of big data and AI, including how to monitor and oversee the industry’s compliance with the NAIC’s AI principles, after the Working Group has a better understanding of how insurers use big data and AI in PPA insurance. She said the results will also inform the development of governance and risk management controls over these activities. She said the survey work will also be expanded to other lines of insurance as needed, such as life insurance and homeowners insurance.

Having no further business, the Big Data and Artificial Intelligence (EX) Working Group adjourned.

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The Speed to Market (EX) Working Group met June 30, 2021. The following Working Group members participated: Maureen Motter, Vice Chair (OH); Katie Hegland (AK); Jimmy Gunn (AL); Jimmy Harris (AR); Susan Buth (CO); Michele Mackenzie (ID); Marcia Kramer (KS); Tammy Lohmann (MN); LeAnn Cox (MO); Ted Hamby and Timothy Johnson (NC); Chrystal Bartuska (ND); Leatrice Geckler (NM); Cuc Nguyen (OK); Heidi Clausen, Tanji J. Northrup, and Tracy Klausmeier (UT); Elsie Andy (VA); Lichiou Lee (WA); and Barry Haney (WI).

1. Discussed and Considered Suggestions Received on the Uniform Life, Accident & Health, Annuity, and Credit PCM

Ms. Motter stated that discussions began during the June 29 call regarding the suggestion received to add two additional sub-types of insurance (TOIs) for the Medicare Supplement plans on the Life and Health side in the Uniform Life, Accident & Health, Annuity, and Credit Product Coding Matrix (PCM). She stated that what was noted in the suggestion is that there are instances where an insurer wants to report some rate information, and occasionally some form information, on Medicare Supplement plans that are not only applicable to 2010 products, but also to 2020 products. She stated that this requires the need for the company to file two separate submissions with almost identical information since there is not currently an option to select multiple sub-TOIs, which also creates additional work for the state insurance regulator reviewing the information submitted.

Ms. Motter stated that written communication was provided by Camille Anderson-Weddle (MO), as she was unable to attend the call, which stated the following: “Missouri does not have a preference with regard to the creation of MS10 and MS11 TOIs but would appreciate the ability to elect whether or not to turn these TOIs on. While Missouri currently accepts some combined rate filings where combined experience is used, it is not always appropriate, and we may request rates to be separated into two filings. Historically, carriers have used the existing TOIs including MS09-Other for such filings. In those instances where a combined filing is not appropriate, the company has not been asked to withdraw the filing in question, but to remove and revise documents where necessary and submit a second filing, as opposed to the alternative (where MS10 or 11 is used) of withdrawing an existing MS10 or 11 filing and having to submit two new filings. It should also be noted that we encourage filing rates under the same TOI as the forms, where possible. We would not expect to see forms combined and I do not believe we have.” Ms. Cox confirmed there was nothing additional to add for Missouri, and she reiterated the desire to be able to turn the new TOIs on or off if they are added.

Ms. Motter reminded the Working Group that another possible solution is changing the description to indicate or direct companies to use the “Other” categories to file combined data. She stated that the description could also be updated in such a way to direct companies away from using certain sub-TOIs.

Ms. Lee stated that the way Washington addresses this issue is that under MS06 Medicare Supplement – Other, it traditionally uses it for something where the action is not approved, and not for rate filings. She stated that Washington uses MS06 for the Medicare Supplement Experience Rating Refund Report, Medicare Supplement Advertisement, and those other actions filed and not approved because Medicare Supplement Forms and Rates are considered prior approvals. She stated that MS06 is used for everything above it, other than MS04 and MS05, and MS09 Medicare Supplement – Other is used for MS07 and MS08. She stated that Washington was the state that proposed the new MS10 and MS11 Medicare Supplement TOIs, because of their identical/duplicate two rate filings. She stated that Washington has never used MS06 as part of the rate filing because it wanted to separate out the prior approvals.

Ms. Nguyen stated that it would be helpful if additional explanation was provided for MS06 so that when companies file, they have a better understanding of what to choose. Ms. Motter asked if Ms. Nguyen would want to receive filings the same way Ms. Lee explained, and if they would not want companies using the “Other” category to do some of those combined rate filings. Ms. Nguyen said yes, that would be her preference. Ms. Motter asked if Ms. Nguyen would still want two filings, but just using the existing TOIs, and Ms. Nguyen confirmed that was correct.

Ms. Mackenzie made a motion, seconded by Ms. Lohmann, not to adopt the suggestion to add MS10 Individual Medicare Supplement-Standard and 2010 Standard Plans, as well as MS11 Group Medicare Supplement-Standard and 2010 Standard Plans TOIs. The motion passed unanimously.
Ms. Motter stated that there was a suggestion made on the June 29 call to edit the H13 – Short-Term Care TOI description. Currently, the description states, “[c]overage that provides medical and other services to insured’s who need constant care in their own home or in a nursing facility for periods less than one year.” The suggestion is to add the following sentence to that description, “also considered limited long-term care.”

Ms. Lee stated that Washington has never turned on the H13 TOIs because the product is illegal there. She stated that the reason it is illegal in Washington is because a plan providing health care services like that is either a health plan that is part of the H15 or H16 TOIs, or it is a long-term care (LTC) product.

Ms. Andy stated that Virginia uses the H13 TOI. She stated that LTC cannot be written if it provides coverage for less than 12 months; and in certain circumstances, policies are allowed that provide home health care unrelated to LTC, such as loss related to accident and sickness rather than mimicking LTC, and the coverage provides less than 12 months of coverage.

Ms. Clausen stated that she made this suggestion to edit the H13 description because a couple of states indicated that they are receiving filings under H13 for limited long-term products. Ms. Motter asked if it would be appropriate to add a sub-TOI instead of editing the overall H13 description. Ms. Bartuska stated that North Dakota has a law that allows for short-term care policies, in that they are basically LTC policies less than a year old, or less than a year worth of care, and North Dakota uses the H13 TOI for individual health; i.e., short-term care, utilizing the sub-TOI for Nursing Home. Ms. Lohmann stated that Minnesota is also utilizing the H13 TOI and sub-TOIs.

Ms. Motter asked if changing the suggested wording would be helpful, such as adding “where permissible” or “where applicable.” Mr. Hamby said maybe the wording could state, “[m]ay include Limited Long-Term care.” Ms. Bartuska stated that when North Dakota adopted its short-term care law, it took the language from its LTC law and just changed some of the provisions around the time frame of the contract. She stated that these types of policies are referred to as short-term care in North Dakota, and since they are technically health policies, she would be apprehensive of putting any indication of LTC in the description since it is not LTC, and not a traditional LTC policy, rather it is a short-term care nursing home product.

Ms. Lohmann made a motion, seconded by Ms. Bartuska, not to implement the suggestion to edit the H13 TOI description. The motion passed unanimously.

Having no further business, the Speed to Market (EX) Working Group adjourned.
The Speed to Market (EX) Working Group of the Innovation and Technology (EX) Task Force met June 29, 2021. The following Working Group members participated: Rebecca Nichols, Chair (VA); Maureen Motter, Vice Chair (OH); Katie Hegland (AK); Jimmy Gunn (AL); Jimmy Harris (AR); Susan Buth (CO); Frank Pyle (DE); Michele Mackenzie (ID); Heather Droge (KS); Tammy Lohmann (MN); Camille Anderson-Weddle (MO); Timothy Johnson (NC); Chrystal Bartuska (ND); Leatrice Geckler (NM); Cuc Nugyen (OK); Mark Worman (TX); Heidi Clausen, Tanji J. Northrup, and Tracy Klausmeier (UT); Gail Jones and Lichiou Lee (WA); and Barry Haney (WI). Also participating were: Alan Gore (NY) and Bob Grissom (VA).

1. **Adopted its March 10, 2021, Minutes**

The Working Group met March 10, 2021, and took the following action: 1) adopted its Nov. 10, 2020, minutes; 2) received an update from the Interstate Insurance Product Regulation Commission (Compact); 3) discussed the results of the Product Requirements Locator (PRL) tool survey and next steps; 3) received an update on the System for Electronic Rate and Form Filing (SERFF); and 4) discussed the annual review of the product coding matrix (PCM) and uniform transmittal document (UTD).

Ms. Geckler made a motion, seconded by Mr. Gunn, to adopt the Working Group’s March 10, 2021, minutes (Attachment). The motion passed unanimously.

2. **Received an Update from the ITG on the 2021 PCM**

Alex Rogers (Information Technology Group—ITG) stated his team works to implement newly adopted changes to the PCM. He said that each year, they begin their annual outreach efforts in October into November, and then they follow up biweekly through the end of the year to get needed changes implemented by January. He stated his team continues regular follow-up throughout the first quarter of the year. Mr. Rogers advised that there has been a low adoption rate for changes to the PCM over the past two years. He stated that in 2020, one sub-type of insurance (TOI) was introduced to the PCM; there were 12 states that adopted that sub-TOI and 21 states that declined it. He stated that in 2021, 11 states implemented the new H15G and H15I TOIs, 11 states declined, and 30 states did not respond.

Joy E. Morrison (ITG) stated the reason mentioning the low adoption rate is important, is that statistics for adoption have declined in the last two years and that variations from a uniform PCM make it more difficult for industry users to create a multistate filing in the SERFF application. She asked for feedback from the Working Group in determining the best way to implement proposed changes in a consistent manner.

Ms. Motter stated she has noticed that in the last couple of years, the PCM covers nearly every product and that nearly every TOI is there, but occasionally there is something new. She stated a couple years back, for example, there was a need to address stand-alone cyber insurance policies for property/casualty (P/C). Ms. Motter advised some of the requests and suggestions received are more specific to a particular state and a state’s need for granularity for reporting purposes, so there is hesitation to add products to the PCM that most states will not adopt. She explained that part of these discussions is suggesting other ways states can capture specific information they need, such as through the use of filing labels, in those instances where most states do not share the same needs.

Ms Morrison stated that insight was helpful to understanding these discussions. She stated that when the SERFF redesign begins, the intent is to have one set of TOIs, sub-TOIs, and filing types, but that submission requirements that vary for states would be reflected. She stated it would be helpful for all states to be sure they are responding to the correspondence received regarding the PCM so that a good understanding of their needs is documented.

3. **Discussed and Considered Suggestions Received on the PCM and UTD**

Ms. Motter stated the first suggestion to discuss was regarding the uniform P/C transmittal documents that continue to be used on paper filings. She stated they are kept updated to stay consistent between what is currently available as fields in SERFF and
also keep what is available for life and health submissions to be comparable to P/C submissions when appropriate. Ms. Motter stated that NAIC staff have noted that the document for P/C is missing some rating information, so a recommendation has been made by NAIC staff to update the rate/rule schedule to show the rate action information with all of the applicable information as shown in life and health information. She stated this would also line up with what is currently shared in SERFF when submitting a filing that way as well.

Ms. Lee stated she consulted with her P/C peers, and they do not feel this suggestion is needed for Washington because they already have a previous rate filing for each schedule item. The other reason she provided is that they already have the company rate information that shows the proposed change as whole. Ms. Motter stated this suggested change would not change SERFF but would bring it in line with SERFF to bring consistency to the paper filing document that already exists. Ms. Lee stated it looks good for life and health, but on the P/C side, this suggested change would change the rate schedule item because it would add in an item for each plan’s separate rate change, which may not be consistent with the way the carrier rates. She explained they usually see the average rate change as a whole, and it does not go down to each claim’s rate change.

Brandy Woltkamp (NAIC) clarified that the intent of this suggestion was to update both SERFF and the uniform transmittal paper document, but she stated it could be changed to diverge between the two if preferred. Ms. Motter asked which fields would be new. Ms. Woltkamp stated that in SERFF, currently for P/C, it is that very first item which is the rate action and then the field for “previous state filing number.” The suggestion is to change the field for “previous state filing number” to “rate action information” and move the previous state filing number or the tracking number down into it, in a second column. Ms. Motter asked if these fields could be updated via post submission update. Ms. Woltkamp stated these items would be under change schedule items, so they would come in via amendment or response letters. Ms. Motter stated she could see how adding more fields could cause confusion to the user as to what information is wanted in those fields, such as understanding the difference between a previous filing number and the previous filing that had a rate action and what a rate action is. Ms. Lee stated she believes adding more fields would make things more confusing and that companies and state insurance regulators would be spending more time trying to make sure the right fields were filled in with the right information.

Ms. Lee made a motion, seconded by Mr. Johnson, not to adopt the suggestion to update the rate/rule schedule in the uniform P/C transmittal document to show rate action information with all applicable information as shown on life and health information.

Ms. Motter stated the next suggestion to discuss is related to the uniform life, accident and health (A&H), annuity, and credit PCM. The suggestion is to create two additional sub-TOIs under Medicare Supplement plans of MS10I and MS10G—one for individual plans and one for group plans—with a description for a package filing containing Medicare standard plans issued before June 1, 2010, and 2010 Medicare standard plans issued June 1, 2010, and later. The reason provided for this suggestion stated: “Plans issued before June 1, 2020 (1990 plans) have similar benefits to those plans with the same letter issued after June 1, 2010, and 2010 Medicare standard plans issued June 1, 2010, and later. The reason provided for this suggestion stated: “Plans issued before June 1, 2020 (1990 plans) have similar benefits to those plans with the same letter issued after June 1, 2010, and 2010 Medicare standard plans issued June 1, 2010, and later. The reason provided for this suggestion stated: “Plans issued before June 1, 2020 (1990 plans) have similar benefits to those plans with the same letter issued after June 1, 2010, and 2010 Medicare standard plans issued June 1, 2010, and later. The reason provided for this suggestion stated: “Plans issued before June 1, 2020 (1990 plans) have similar benefits to those plans with the same letter issued after June 1, 2010, and 2010 Medicare standard plans issued June 1, 2010, and later. The reason provided for this suggestion stated: “Plans issued before June 1, 2020 (1990 plans) have similar benefits to those plans with the same letter issued after June 1, 2010, and 2010 Medicare standard plans issued June 1, 2010, and later. Therefore, the suggestion is to create two additional sub-TOIs under Medicare Supplement plans of MS10I and MS10G—one for individual plans and one for group plans—with a description for a package filing containing Medicare standard plans issued before June 1, 2010, and 2010 Medicare standard plans issued June 1, 2010, and later.

Ms. Motter asked if these fields could be updated via post submission update. Ms. Woltkamp stated these items would be under change schedule items, so they would come in via amendment or response letters. Ms. Motter stated she could see how adding more fields could cause confusion to the user as to what information is wanted in those fields, such as understanding the difference between a previous filing number and the previous filing that had a rate action and what a rate action is. Ms. Lee stated she believes adding more fields would make things more confusing and that companies and state insurance regulators would be spending more time trying to make sure the right fields were filled in with the right information.

Ms. Lee stated that currently, Medicare Supplement plans end at MS09 in the PCM. She stated occasionally, there are filings received that may combine the experience of older and newer plans, and that right now it seems to be very bifurcated that you use certain TOIs for the older plans and other sub-TOIs for the newer plans. She stated the suggestion is that additional TOIs are needed for when there is information coming in about both plans together. Ms. Motter asked if filing submissions are being received, or should be being received, that combine older plans in the newer plans. Ms. Lee stated that Washington considers the 1990 and 2010 plans similar from a rating standpoint, but that because of the current TOI requirement, they have the carriers submit two identical filings. She explained if a carrier filed for an individual 1990 and 2010 plan, for example, they would need to submit one rate filing under MS051 and one under MS081, which creates a lot of work as two filings must then be reviewed. Ms. Motter stated one thought to consider is that there is a TOI for MS06 labeled as “Medicare Supplement – Other,” so it is possible that states could do combined filings under MS06. Currently, the description states, “Not specifically described above,” so this may need to be changed to: “Not specifically described,” as it was created before additional TOIs existed.

Mr. Grissom stated Virginia does use the “Other” TOI because they require companies to combine the experience of the 2010 and 1990 plans when filing Medicare Supplement rates, so in a sense they cannot use multiple TOIs. He stated this suggestion would be helpful for Virginiafilers.

Ms. Jones asked if MS06 is used with the understanding that it is related to Medicare Supplement – Standard Plans and if MS09 is used with the understanding that it is related to Medicare Select 2020. Ms. Woltkamp stated that MS09 is basically the same
thing as MS06 and is for Medicare Supplement—Other, but it is for those 2010 plans that went into place Jan. 1, 2010, so it would be the offsetting “other” TOI/sub-TOI for MS07 through MS08.

Ms. Motter asked if Working Group members would like to reach out to their staff and discuss this further during tomorrow’s scheduled Working Group meeting. Ms. Mackenzie and Ms. Nguyen stated they would like the option to resume this discussion tomorrow after getting additional input. Ms. Motter asked that everyone look at: 1) how they are currently accepting these types of filings; 2) if the way the filings are currently received is working well; and 3) if they think the suggestion would be helpful or if maybe changing the current descriptions to be clearer would be a good option.

Ms. Clausen stated she would like to suggest an edit to the H13 TOI. Ms. Motter stated she could provide that suggestion to be discussed during the June 30 Working Group meeting.

Having no further business, the Speed to Market (EX) Working Group adjourned.
The E-Commerce (EX) Working Group of the Innovation and Technology (EX) Task Force met June 30, 2021. The following Working Group members participated: Kathleen A. Birrane and Robert Baron, Chairs (MD); Jully Pae (CA); Heather Droge (KS); Tom Travis (LA); Cynthia Amann (MO); Martin Swanson (NE); Chris Aufenthie (ND); Lori Barron (OH); John Lacek (PA); Elizabeth Kelleher Dwyer (RI); and Bryce Carlen (WA).

1. Heard an Introduction to the Working Group, Establishment, and Background

Commissioner Birrane stated that the first item on the agenda is to provide an introduction to the Working Group, explain what led up to the establishment of the Working Group, and explain some additional background information. She then called on Denise Matthews (NAIC) to provide background information.

Ms. Matthews recalled that the Innovation and Technology (EX) Task Force in 2020 set a request for information to interested parties asking for information related to specific regulatory relief or accommodations offered by the states because of the COVID-19 pandemic that interested parties would recommend being made permanent as they relate to innovation and technology. She stated that this request is consistent with the Task Force’s charge of monitoring technology developments to develop regulatory guidance, as appropriate, to ensure that regulation does not impede or create obstacles to necessary and beneficial consumer innovations. The request also asked if there is some type of regulatory relief or accommodation offered, or if there continue to be laws, regulatory guidance, or established practices in place that prohibit or limit insurers or producers from implementing or using newer technologies. The request further asked if there are also data methods or processes that are now necessary to continue to serve customers and maintain operations, especially in this remote work environment and social distancing situation.

Ms. Matthews explained that those responses were compiled into a summary document, which was presented to the Task Force at the 2020 Fall National Meeting and was included in the materials for this meeting. Nine responses were received, and the comments were grouped into four categories, including: 1) electronic commerce; 2) regulatory capabilities; 3) claims facilitation; and 4) surplus lines. Included among these responses was a recommendation and draft bulletin provided by the American Council on Life Insurers (ACLI). After reviewing these responses and finalizing the Working Group’s 2021 charges, it was decided that more information was needed for the Working Group to take specific action.

Ms. Matthews said a second request for information was sent to those who responded to the initial request, and a summary of those responses was prepared as well. A consumer representative also provided a comment, and more specific information was requested regarding whether the issues identified are more interpretive or signal a lack of uniform interpretation versus an actual legislative issue where the legislative language needs to be reviewed. The request also went on to request suggestions regarding the prioritization of these issues, and the summary of these responses were also included as materials for this meeting.

Ms. Matthews explained that the second request responses indicated a preference to prioritize e-commerce and digitalization in general, including allowing for e-signatures, e-delivery of documentation, and information regarding e-notarization. The responses also included discussions of changing the paradigm from what is mostly an opt-in scenario for consumers to an opt-out where exchanging information digitally or electronically would become the default, with consumers having the ability to opt-out of that option.

Regarding specific action items, Ms. Matthews said the ACLI and the American Property Casualty Insurance Association (ACPIA) suggested forming a working group to survey states about Uniform Electronic Transactions Act (UETA) exceptions, and to begin work on laws and regulations that might need to be changed to accommodate e-commerce or digitalization, as well as interpretive guidance where legislative changes are not needed.

Ms. Matthews said the second category of survey responses represents regulatory capabilities and covers the list of items related to allowing online education and training for continuing education (CE) for producers, allowing electronic filings for regulatory filings, and eliminating wet signature requirements. There were no specific action suggestions for this category, and the Task Force agreed to defer the education and training item to the Producer Licensing (D) Task Force.
Claims facilitation was a category of responses from the first request for information, and Ms. Matthews explained that Commissioner Godfread had noted that this was not included in the responses to the second request for information. He also noted that it was not clear if this was just an oversight since not all of those who responded to the first request for information responded to the second, or if it means this category does not seem to command prioritization at this time. Ms. Matthews said there may not be obstacles related to this area at this time, but it might still be something for the Working Group to consider.

Ms. Matthews said the last category of responses was specific to surplus lines, and some of the respondents noted that the Surplus Lines (C) Task Force is currently working to amend the Nonadmitted Insurance Model Act (#870), so it may be appropriate to defer this item to the Task Force, which has in fact occurred. She noted that the Task Force requested a modification to any Request for NAIC Model Law Development that previously focused solely on Model #870, and that request was approved to address broader amendments to the model that would include additional references to the other modernization amendments. She said these particular issues summarized in the request for information documents will be handled in that workstream under the Task Force.

Ms. Matthews said other comment letters provided examples of specific states, where either the interpretation or the law prohibits doing business digitally, and three respondents, including the ACLI, the ACPIA, and the National Association of Professional Insurance Agents (PIA) indicated support for drafting a model bulletin to cover some of the non-legislative issues.

Following the review and summary of the request for information responses, Ms. Matthews said the Innovation and Technology (EX) Task Force discussed them during the Spring National Meeting, agreed to the referrals previously discussed, and stated that it would turn its focus to the other identified issues. The Task Force also decided to form this new Working Group to develop a workplan and determine appropriate deliverables to address these issues. Ms. Matthews then asked Superintendent Dwyer for her comments.

Superintendent Dwyer said there is low hanging fruit here that drives industry crazy, costs money that does not need to be spent and is not there for consumer protection. She said if the Working Group can identify those issues and assist in getting the states on the same page, it can reduce the costs for everybody and pave the way for innovation, so that is what the Working Group is looking at doing. She noted that when getting down to a statute, it gets very difficult, as Working Group members all must individually go to their legislators, which does not mean those issues are off the table, it is just that the issues that are not statutory are easier. She said the Working Group needs continuous input from the people who are doing this and trying to comply with the states in order to understand where it should go, so she asked for that input from people who are in the know by letting the Working Group know where it should focus.

Commissioner Birrane agreed with Superintendent Dwyer’s comments, and she said the focus of this work is infinite practicality. She also said what we are really dealing with here are the things that drive companies and others who are trying to work in this space crazy because they do not make any sense and they serve no valuable regulatory or consumer protection purpose, but instead slow things down, impede business for everybody, and are often harmful to consumers. She also discussed antiquated paper processes and delivery processes and stated that while individuals were at home, they were often unable to get to their office to get their mail because it had to be sent via mail. Then, when people were able to get things electronically, mail was sent both ways because that is what must be done statutorily, so we must find ways to innovate.

2. Discussed its Charges

Commissioner Birrane then introduced the Working Group’s charges and asked for input from members of the Working Group and other interested state insurance regulators. No comments were received.

Commissioner Birrane then asked for comments from interested parties. Birny Birnbaum from the Center for Economic Justice (CEJ) said digitalization is not simply converting paper to digital bytes, and visualization can facilitate transactions, consumer understanding, and consumer empowerment while also potentially accomplishing the opposite. Mr. Birnbaum said while the Working Group considers facilitating e-commerce transactions, it should keep in mind a specific consumer protection issue called “dark patterns.” He explained that Colorado law defines “dark patterns” as a user interface designed or manipulated with the substantial effect, severity or impairing user autonomy, decision making, or choice. He stated that “dark patterns” tend to discourage deliberate decision making for users. He said while there are things that can be done with digital disclosures in terms of manipulation that simply cannot be done with paper disclosure, the CEJ is not saying that digital transformation should not occur, but the issue of “dark patterns” be kept in mind as the Working Group approaches a task.
3. Discussed its Workplan and Efforts Moving Forward

Commissioner Birrane said the Working Group’s first step is to understand the legal landscape and identify key legislation, so the Working Group is focused primarily on the UETA. She said Maryland is a good example of a state that has additional legislation in its code specific to property/casualty (P/C) insurance that addresses electronic communications with regard to certain matters. She said some states have adopted the UETA while others have not, and there are various other laws out there as well. Therefore, she said the Working Group believes the most appropriate thing to do is to understand the framework and have a really solid understand. Commissioner Birrane said while the NAIC has done some amount of survey work, it has not done anything to that extent, and she asked what the most efficient way to move this forward is. She also stated that the Working Group has to think about time frames, what it would be able to survey from its individual states, what the states would be able to tell the Working Group, and what the time frames are. She asked if the NAIC should draft a survey for each of the states asking them to identify the relevant laws as a starting point while also keeping in mind interpretation and application. She then asked for comments from members of the Working Group.

Mr. Swanson stated that Nebraska is actually going through this exercise right now internally. He stated that Director Eric Dunning (NE) decided to look back at what Nebraska did during the emergency order when it was declared by its governor, including suspending certain requirements, certain signatures, wet signatures, and things like that. Mr. Swanson said Nebraska has gone through its statutory scheme, noting that it can waive certain things. He noted that some states have passed electronic notary laws, which is less of a burden for some filers. He suggested that one step the Working Group may consider is to ask the states through a survey what they learned through the emergency declarations and what they can apply now in addition to whatever laws they may have.

Ms. Amann said Missouri did something similar government wide and within its department of insurance (DOI), and she said Missouri would be glad to share its results.

Mr. Aufenthie said the NAIC had a list of bulletins that were issued because of the pandemic, and he suggested going back to the states and asking whether they still have those bulletins in effect. He said when the Working Group asks a state if they did or did not keep a bulletin to explain why, as that would give the Working Group good insight into what it is trying to accomplish.

Commissioner Birrane then asked for comments from other interested state insurance regulators. No comments were received.

Commissioner Birrane then asked for comments from interested parties. Patrick C. Reeder (ACLI) stated that ACLI members have spent a lot of time thinking about the UETA, and not just the state implications, as there are also federal implications with the e-sign legislation and how those two pieces of legislation interact. He said one thing the ACLI could do is to put together a briefing explaining what the UETA is, what states have adopted it, what e-sign is, and how it all intersects. He suggested that this may assist the NAIC in framing up some potential survey questions. He also said some ACLI members may be able to share some information and its experiences in this touchless society, noting that the regulatory community made some amazing and very fast accommodations that were critical for its members to stay in this touchless society. He stated that ACLI members want them to be a resource for the Working Group.

Jason Berkowitz (Insured Retirement Institute—IRI) said this is a very important effort for its members. He explained that the IRI operates primarily in the annuity space, and the IRI membership includes all of the major insurance companies that manufacture those products, as well as the distribution arms, including broker dealers and other distributors and asset managers that work behind the scenes on some of these products. He also said the IRI has a very robust internal operations and technology group, and the IRI would be happy to be available to share some of the operations and technology challenges it has been encountering.

Angela Gleason (APCIA) offered that this is very important to its members, and they are willing to assist the Working Group.

Mr. Birnbaum said the CEJ is often part of a coalition with other organizations whose work focuses on consumer’s digital rights and privacy and electronic issues. He suggested that the NAIC contact the Electronic Frontier Foundation and the Center for Digital Democracy (CDD), both of which have worked on these issues and can provide insight that the Working Group may not get from industry.

Following the comments, Commissioner Birrane said this gives the Working Group enough to begin putting together a draft of its initial approach in terms of data, and she should circulate to the Working Group the takeaways from the meeting, as well as a timeframe.
Commissioner Birrane then said the Working Group should begin thinking about what its deliverable will look like. She said in this context, the deliverable may not need to be a model, but the Working Group could discuss something along the lines of a bulletin or a white paper.

Superintendent Dwyer suggested a white paper might possibly be a good deliverable, but a bulletin might be even better. She said in her experience, the states do not really realize they are doing it. As an example, she said hard copy jurat pages come into her office, and she sees the hard copies and wonders why they are getting all of them. She said short of seeing these documents, one might even know it is happening. Therefore, a bulletin might be something that informs the entire department or a part of the department that knows they are getting paper documents or requiring something. She also said as the Working Group goes along, there may be other deliverables as well.

Mr. Swanson said one of his immediate thoughts when thinking about these issues is to draft a white paper, but when the Working Group digs into this issue more and get results back from all of the information it gathers, whether it drafts a bulletin or white paper, there should be recommendations to the letter committees saying the Working Group found some places where it can do better through electronic methods.

Commissioner Birrane said it is too early to ask members to subscribe to a drafting group because the Working Group needs to get further along in terms of where it is going to end up. She said the most important thing for the Working Group to focus on is what the query process is, how the Working Group is going to gather the categories of information that have been discussed, and what form and format the Working Group wants it in.

4. **Discussed Other Matters**

Commissioner Birrane asked whether the Working Group would like to meet virtually in conjunction with the Summer National Meeting. She said holding a meeting might be helpful because by that time, her hope is that the Working Group would have had the opportunity to put some of the query frameworks together, circulate them, and have a brief discussion. There were no objections to holding another meeting, so she said she would work to get that scheduled.

Having no further business, the E-Commerce (EX) Working Group adjourned.
LONG-TERM CARE INSURANCE (EX) TASK FORCE

Long-Term Care Insurance (EX) Task Force and Long-Term Care Insurance Multistate Rate Review (EX) Subgroup

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The Long-Term Care Insurance (EX) Task Force met Aug. 13, 2021, immediately followed by a meeting of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup.

The following Task Force members participated: Scott A. White, Chair (VA); Michael Conway, Vice Chair (CO); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Alan McClain (AR); Evan G. Daniels (AZ); Ricardo Lara represented by Perry Kupferman (CA); Andrew N. Mais (CT); Karima M. Woods represented by Philip Barlow (DC); Trinidad Navarro represented by Fleur McKendell (DE); David Altmair (FL); Colin M. Hayashida represented by Martha Im (HI); Doug Ommen (IA); Dean L. Cameron (ID); Dana Popish Severingham represented by Shannon Whalen (IL); Amy L. Beard and Scott Shover (IN); Vicki Schmidt (KS); James J. Donelon (LA); Gary D. Anderson (MA); Eric A. Cioppa (ME); Anita G. Fox represented by Karen Dennis (MI); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers (MO); Mike Chaney (MS); Troy Downing (MT); Mike Causey (NC); Jon Godfrey (ND); Eric Dunning and Rhonda Ahrens (NE); Marlene Caride (NJ); Russell Toal (NM); Barbara D. Richardson (NV); Judith L. French (OH); Glen Mulready (OK); Andrew Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Raymond G. Farmer (SC); Larry D. Deiter (SD); Carter Lawrence (TN); Doug Slape (TX); Jonathan T. Pike and Tomasz Serbinowski (UT); Michael S. Pieciak represented by Anna Van Fleet (VT); Mike Kreidler and Lichiou Lee (WA); Mark Aftable (WI); James A. Dodrill (WV); and Jeff Rude (WY).

The following Subgroup members participated: Michael Conway, Chair (CO); Alan McClain (AR); Andrew N. Mais (CT); Philip Barlow (DC); David Altmair (FL); Doug Ommen (IA); Dean L. Cameron (ID); Amy L. Beard (IN); James J. Donelon (LA); Anita G. Fox represented by Karen Dennis (MI); Grace Arnold represented by Fred Andersen (MN); Eric Dunning and Rhonda Ahrens (NE); Marlene Caride (NJ); Russell Toal (NM); Barbara D. Richardson (NV); Judith L. French (OH); Glen Mulready (OK); Andrew Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Raymond G. Farmer (SC); Doug Slape (TX); Tomasz Serbinowski (UT); Scott A. White (VA); Michael S. Pieciak represented by Anna Van Fleet (VT); Mike Kreidler and Lichiou Lee (WA); and James A. Dodrill (WV).

1. **Long-Term Care Insurance (EX) Task Force**
   a. **Adopted its July 6 Minutes**

The Task Force met July 6 and took the following action: 1) adopted its Spring National Meeting minutes; and 2) received the reports of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup and the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup.

Commissioner Altman made a motion, seconded by Commissioner Caride, to adopt the Task Force’s July 6 minutes (Attachment One). The motion passed unanimously.

b. **Heard an Update on Industry Trends**

Mr. Andersen said the Valuation Analysis (E) Working Group oversees reserve valuation and related solvency of companies with large long-term care insurance (LTCI) blocks of business. It has reviewed *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) filings this past year. The Working Group interacts with companies and domestic state insurance departments on such matters. In past years, the areas of focus included evaluation of investment return and morbidity incidence improvement assumptions. Mr. Andersen said the key area of focus this year has been on studying the variation of cost-of-care and trends due to the impact of COVID-19 and the aging baby boomer generation. Cost-of-care trends affect companies with policies that include 5% compound inflation protection where often the actual daily cost-of-care assumption is less than the inflation-protected daily maximum benefit stated in the policy. The Working Group plans to monitor trends for that issue over the next several months and years. The Working Group is working with the California Department of Insurance (DOI), which has a team of LTCI actuaries that assist in the AG 51 reviews.

Commissioner Ridling asked if the Task Force should be monitoring for possible future solvency concerns and what should be looked at during insolvency. Commissioner White said that solvency analysis is ongoing. It is being conducted by the actuarial group through its annual review of insurers’ AG 51 filings, and through having discussions with the company and its domestic...
state insurance regulator if reserves need to be strengthened. Mr. Andersen said the Valuation Analysis (E) Working Group has been performing targeted and broad-based reviews for three to four years and has been engaged with the companies and the NAIC on their work. He invited any of the state insurance regulators who would like to discuss these activities or any ideas for enhancements to this work to contact him or Commissioner White.

c. Received the Report of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup

Commissioner Conway said the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup met June 22 to hear verbal comments on the exposure draft of the operational sections of the LTCI Multi-State Rate Review Framework (MSA Framework). The drafting group has met several times discuss those comments and has identified some key issues yet to be decided. The Subgroup also exposed the actuarial sections of the MSA Framework for a public comment period. Five comment letters were received. The drafting group will continue working on edits to both the operational and actuarial sections in response to the comments to finalize the MSA Framework. Commissioner Conway said the Subgroup anticipates a second exposure draft of both the operational and actuarial aspects of the MSA Framework by the middle of September and will be conducting several meetings this fall.

Director Cameron made a motion, seconded by Commissioner Conway, to receive the report of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup (Attachment Two). The motion passed unanimously.

d. Received the Report of the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup

Commissioner Altman said the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup met July 28, July 22 and May 4. During its May 4 meeting, the Subgroup heard four industry presentations on LTCI innovation and wellness programs. The presenters were invited to assist the Subgroup with identifying potential issues with offering wellness programs to policyholders with in-force LTCI policies. The presentations touched on things insurers need to consider before implementing a wellness program; experiences with and lessons learned from a pilot program offered by an insurer; a hypothetical view of what the future state of in-home long-term care (LTC) services might look like; and issues related to unfair discrimination concerns, rebating concerns, and wellness programs as they relate to tax qualified LTCI policies.

Commissioner Altman said after its July 22 meeting, the Subgroup exposed a document titled *Issues Related to LTC Wellness Benefits* for a public comment period ending Sept. 5. She encouraged state insurance regulators and interested parties to review the document and provide feedback to the Subgroup. The document outlines issues, observations, and next steps for various topics, including:

- Effectiveness of LTC wellness programs.
- Preventions of unfair discrimination related to extra-contractual benefits and costs.
- Consumer confusion over wellness programs.
- Rebating and whether some LTC wellness benefits run afoul of anti-rebating laws.
- Tax considerations for policyholders.
- The regulatory role in approving or evaluating LTC wellness approaches.
- Actuarial considerations of the impact of LTC wellness benefits.
- Data privacy.

Commissioner Altman said the Subgroup received comments on the draft “RBO Consumer Notices Checklist” in July. This checklist is intended to establish a consistent approach to drafting and reviewing LTCI reduced benefit options (RBO) policyholder communications, and to provide an optional tool to use. The checklist can be used by states for guidance and is not required to be used for the review of insurer communications with policyholders. The Subgroup met July 28 to work through the comments received and to make edits to the checklist. The Subgroup plans to meet Aug. 23 to finalize the checklist.

Commissioner Altmaier made a motion, seconded by Commissioner Caride, to receive the report of the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup (Attachment Three). The motion passed unanimously.

e. Released the LTCG Actuarial Consulting Group Report

Commissioner White said the NAIC engaged LTCG Actuarial Consulting Group to conduct a data call of certain insurers to assist the Task Force in evaluating the extent to which state rate review policies and practices have led to cross-state rate subsidization. The public LTCG report (Attachment Four) includes key points in the executive summary and data in different frames. The data call and analysis does show such cross-state rate subsidization does exist. The report took time to deliver as
the original work product of LTCG was considered confidential because the information was gathered under Virginia confidentiality statutes. Steps had to be taken to allow it to be shared publicly and to work through some contractual issues with LTCG regarding its scope of work and deliverables. This report is being released to the public for informational purposes only, and the Task Force does not expect further discussion on the matter.

f. Discussed the MSA Framework Timeline and Next Steps

Commissioner White said a timeline for completing the MSA Framework has been developed, which includes processes to receive feedback from both state insurance regulators and interested parties. He said the following timeline is anticipated for the operational aspects of the MSA Framework:

- Discuss pending revisions during today’s meeting.
- Aim to complete the next version of the operational aspects of the MSA Framework by Aug. 30.
- Assuming the next draft is completed by Aug. 30, then hold a Long-Term Care Insurance Multistate Rate Review (EX) Subgroup regulator-to-regulator meeting the week of Sept. 6, which will be scheduled soon.
- Pending further edits from the Subgroup, the operational aspects would be re-exposed for a 30-day public comment period the week of Sept. 22, with comments due prior to a Subgroup meeting the week of Oct. 25.
- Hold a Subgroup open meeting the week of Oct. 25 to discuss comments received.
- The drafting group will consider near final comments and produce a third draft version by Nov. 8.

Commissioner White said the following timeline is anticipated for the actuarial aspects of the MSA Framework:

- The Subgroup will hear oral summary comments during today’s meeting.
- The drafting group plans to analyze and produce a second draft version and expose it for a 30-day public comment period by the week of Sept. 13, with comments due prior to a Subgroup meeting the week of Oct. 25.

Having no further business, the Long-Term Care Insurance (EX) Task Force adjourned into the Subgroup meeting.

2. Long-Term Care Insurance Multistate Rate Review (EX) Subgroup

a. Discussed Revisions to the Operational Section of the Draft Multistate Rate Review Framework

Commissioner Conway said the drafting group has met several times over the past two months to work through the comment letters and has made progress. There are a couple key points that the drafting group thinks the Subgroup still needs to evaluate and discuss further, specifically what information in the MSA process and MSA filing should be confidential vs. public. The answer may depend partly on how states’ insurance laws and protections apply in general, or specifically to rate filings. Another key issue yet to be finalized is the type and level of detail of information that should be included in a report that is shared with the insurer. Commissioner Conway said he recognizes the value in good communication with the insurer during the review process but still need to address the level of detail that is needed. He said this will be an iterative process with insurers to strike the right balance between transparency and the protection of sensitive information.

Commissioner Conway said the current draft will change, as there needs to be more discussion on these issues. Based on that discussion, further decisions can be made on administrative and logistical questions that were raised in the comments, specifically, the use of the Interstate Insurance Product Regulation Compact (Compact) staff and the System for Electronic Rate and Form Filings (SERFF) to assist in the administration of rate proposals and the process of finalizing the review and approval of the reports. The Subgroup is aiming to produce the next version of the draft by Aug. 30 and meet in regulator-to-regulator session during the week of Sept. 6.

Ms. Ahrens said there were several comments received on the operational aspects of the MSA Framework regarding the need for both insurers and state insurance regulators to participate in the MSA process for it to achieve its goal of more consistency in approving actuarially justified rate requests in a timely fashion. The MSA process is novel concept and through the pilot project, she said the Subgroup is learning with each review how to improve the process for the next review. It is anticipated that this process will evolve rapidly over time. The hope is that both industry and the state insurance departments will also find the benefits of the process and that relying on this process and its reports will become more compelling as experience is gained. She said that evolution is something the Task Force and this Subgroup will be closely monitoring and reevaluating to help ensure they are moving towards their goal.
Ms. Ahrens said an important change is the addition of what will be referred to as an “MSA Associate Program,” which is aimed at addressing the concerns of state insurance regulators that more states need to be actively involved in participating in the actual MSA review rather than being limited or that the MSA team may be too small of a group of regulatory actuaries. While there would still be a core team, the proposed mentorship program recognizes that some state insurance departments may lack LTCI actuarial expertise and need involvement in a process like this to help staff to gain LTCI experience. It also recognizes limitations on state insurance departments’ resources but allows for meaningful participation with less time dedication, such as serving as a peer reviewer.

Ms. Ahrens said another key change is the addition of a sample MSA Advisory Report that reflects in more detail the type of information that will be included, understanding that each report will be customized to the filing and that the report may be refined over time.

b. **Heard Comments on the Exposure Draft of the Actuarial Section of the Draft MSA Framework**

Commissioner Conway said the actuarial section of the MSA Framework was exposed for a public comment period ending July 26. Five comment letters were received. Each commentor was asked to summarize key points from their letter.

Andrew Dalton (American Academy of Actuaries—Academy) summarized the Academy’s comment letter (Attachment Five) by outlining key areas of comments:

- Regarding “actuarial judgement,” the Academy recommends the use of the term “professional judgement.”
- Regarding the decision-making process of the MSA team, the Academy recommends additional information on: 1) how the three actuarial approaches are aggregated; 2) what happens if the Minnesota and Texas approaches conflict; 3) what mechanisms exist for dealing with “catch-up” and “transition” provisions in the Texas approach; 4) how differences in historical rate increases are handled; and 5) how long the MSA recommendation lasts.
- Regarding industry standards and benchmarking, the Academy recommends: 1) consultation with the filing actuary before determinations of “unreasonable or unsupported” assumptions are made; 2) consideration that some insurers use the same assumptions for rate increase and asset adequacy testing, as this may have implications for asset adequacy testing; 3) clarification on “industry average assumptions at the time of original pricing”; and 4) future explanation of the 58/85 test.
- Regarding non-actuarial considerations, these issues can have actuarial implications.
- The Academy’s comment letter includes several editorial points for consideration.

Mr. Dalton said the Academy appreciates the effort in developing the MSA Framework but has concerns that there may be little value if state insurance departments do not follow the MSA recommendations. The Academy recommends ongoing monitoring of state insurance departments’ use of the MSA recommendations.

Mr. Andersen said the letter was helpful and that many of the items for which the Academy is seeking clarification will be addressed in the MSA Framework. Regarding the need for state insurance department participation, he said he hopes that upon implementation of the MSA Framework, that over time, insurers and state insurance regulators will have a greater comfort level with the MSA process and that there will be more interaction with those insurers and state insurance regulators.

Ms. Ahrens said regarding the Academy’s comment that the lowest result would always be the recommendation, in Nebraska, they use elements of both the Texas and Minnesota approach. The intent to having two methods is not to choose the lowest or highest number or to have a prevailing method, but rather to choose the one that makes the most sense for the unique aspects of each rate filing.

Jan Graeber (American Council of Life Insurers—ACLI) summarized the joint comment letter from the ACLI and America’s Health Insurance Plans (AHIP) (Attachment Six). She said the ACLI and AHIP strongly support the work to achieve the Task Force’s charge. She said they view the actuarial section to be at the core of achieving the Task Force charge and that it deserves robust discussion though several rounds of exposure. Ms. Graeber said the ACLI and AHIP comments are high-level, and they look forward to providing more detailed comments in the future.

Ms. Graeber said the comments include a list of questions and issues. She said the MSA Framework should include transparency and consistency. The MSA Framework should include the rationale or criteria that determines the method the MSA team will apply. She said carriers need to understand the methodology to be used by the MSA team before the carriers prepare and make rate filings. She highlighted comments in the letter that note that certain provisions of the Texas method were not clearly included.
Ms. Graeber said the 2018 NAIC Long-Term Care (B) Pricing Subgroup’s paper, *Long-Term Care Insurance Approaches to Reviewing Premium Rate Increases* was result of deliberate and collaborative effort, where each method was fully vetted. She said any clarifications or modifications to the methodologies in that paper should only be made after the same type of robust discussion and vetting occurs as 2018. She encouraged the Task Force to charge the Long-Term Care Pricing (B) Subgroup or other actuarial group with re-vetting these methods before they are included in the MSA Framework.

Ms. Graeber said within the Minnesota approach, the term “anti-bait and switch adjustment” draws a legal conclusion and recommends the term “original assumption adjustment.”

Commissioner Conway said there are issues that remain to be addressed. He said there will be further opportunities for state insurance regulators and interested parties to comment on the MSA Framework and engage in solutions to issues. He said the MSA process will be evolving and the MSA team expects to learn and make improvements over time. He said it is important that the Subgroup keep moving this project forward as Commissioner White described in his discussion of the timeline.

Superintendent Toal said he supports the MSA effort. He said however, that there needs to be a reasonableness test beyond the actuarial assessment. He said a request for rate increases of 157%, 189% and 226% are not reasonable or sustainable to him or for policyholders. He said state insurance regulators need to have discussions with insurers to understand the rate increase and, if necessary, perform multistate examinations.

Commissioner Conway said the reasonableness aspect is in direct response to the fact that the focus cannot only be on the actuarial aspects. He said that some state laws require a reasonableness approach and that other states have caps that need to be considered.

Commissioner White said he believes many members of the Task Force are focused on making sure consumers are not absorbing high rate increases. The Task Force is working on ways to balance that priority with ensuring that insurers are able to pay claims in the future by receiving actuarially appropriate rate increases. He said one of the benefits of the MSA Framework are the methodologies that consider the types of concerns that Superintendent Toal raised. He said, however, that how we address these rate increases for consumers must be consistent from state-to-state. The Texas and Minnesota methods are designed so that insurers cannot recoup past losses. The methods are focused on ensuring the increases are prospective in nature. The Minnesota method also has a cost-sharing element that starts when a rate increase exceeds a certain amount. He said state insurance regulators need to scrutinize the insurers. The Valuation Analysis (E) Working Group is monitoring these insurers and ensuring they hold proper reserves. The data state insurance regulators have available is better than five years ago. Results may reflect that some insurers must adjust reserves for rising costs. When that happens, it is a reasonable consideration for the insurer to request to recoup part of that through rate increases.

Commissioner Richardson asked Ms. Graeber if “transparency” refers to the method specific to a company’s review. Ms. Graeber said she is referring to transparency of when the Texas or Minnesota methods are used in the MSA review. In 2018, examples under the two methods had similar results. She said that may not be true now. She said the insurer needs to know which method and criteria will be used to review their filing before they make their rate filing. She said Mr. Ahrens said Nebraska uses aspects of both methods based on the characteristics of the filing. She said insurers are looking for transparency on those criteria. Commissioner Richardson said that if the results of the methods ultimately are different, upfront transparency may not give insurers the results they are looking for. Commissioner Conway said the MSA team is going to apply aspects and consideration of both the Texas and Minnesota approaches, as each will have different characteristics. He said the MSA team will not be able to inform an insurer which approach is applied to an insurer before the filing is made. He said the MSA process is transparent in that it outlines the two approaches that will be used, as opposed to 56 jurisdictions using 56 different approaches. He said both state insurance regulators and insurers will continue to learn and improve this process over time.

Mr. Slape said significant rate increases are difficult, but state insurance regulators need to look at what led up to that rate increase request. If the reason is that insurers delayed making the request, the Texas and Minnesota methodologies require the company to subsidize that. If the reason for the rate increase is because prior rate increases were not approved, state insurance regulators need to reconcile that also. Perpetuating the problem will make it worse. He said this needs to be reconciled in a way that consumers still get the value they purchased and that they are in the best position to make their own decision. Cancellation rates are still low, which indicates consumers still value the product. Both industry and state insurance regulators own some of the problem, and hopefully state insurance regulators can find a solution so that regulators are not exacerbating the problem. Commissioner Conway said there is also good work being accomplished around RBOs, which is an additional component to finding a solution.
Superintendent Toal asked Ms. Graeber why an insurer would need to know which methodology the state insurance department would use. The insurer would include in their rate filing what the insurer has determined independently what is a sound and reasonable request. He asked why it would make a difference if the Texas or Minnesota methodology was used on a rate increase review. Ms. Graeber said it adds clarity to the process. Knowing the criteria and considerations will make for a more timely and efficient process if the insurer knows how the MSA team is going to review their filing. Superintendent Toal said he does not agree.

Commissioner Donelon asked if funded consumer representatives have provided comments. Commissioner Conway said no comment letters were received from funded consumer representatives.

Bonnie Burns (California Health Advocates—CHA) said she had comment on the RBO topics, but she does not have the skills to comment on the actuarial topics. She said if anything, she is counselling consumers who are receiving the rate increase who are upset over the high rate increase they are asked to pay. The consumers must make the decision to either pay the rate increase or to reduce benefits because they have no other choice. She said the state insurance regulators should keep this in mind when considering the actuarial issues. She said there is no reason an insurer should raise rates on the cost of care because they do not pay claims based on the cost of care; rather, it is a fixed amount. If they have 5% inflation protection, the insurer should have already calculated the cost of that protection. She said another actuarial group indicated cost of care is not driving the increase in premiums. Commissioner Conway said state insurance regulators are concerned about the consumer and have had similar difficult conversations with consumers who are facing rate increases.

Samuel Cuscovitch (FinancialMedic LLC) summarized his comment letter (Attachment Seven). He said his consumer group is a grassroots group looking at LTCI as part of financial independence and retirement issues. He said FinancialMedic reviewed an actuarial paper on “phantom premium” and approximately 250 filings in Connecticut. Based on this, his group determined that what takes place is essentially a “charge back.” FinancialMedic ran models to determine the extent of the charge backs, approximately 40%. He said his group’s comment letter includes an example of such. He said a problem is that the source of the real premium and the rate adjudication method is not disclosed by the insurers. He said his group considers these rate increases to be elder abuse. Without nailing down the rate adjudication method, he is unsure how the NAIC can embark on RBO initiatives or determine that there is cross-state subsidization. He said he thinks the rate adjudication method needs to be solidified and vetted before assuming RBOs or cross-state subsidization are high priorities.

Mr. Andersen said the issue of past losses was a key topic of the public actuarial meetings that spanned four to five years, so he thinks there is a good understanding of that issue, which is reflected in the Texas and Minnesota methodologies. He said when these policies were originally sold, the estimate of benefits was much lower than the actual benefits and the question has been how much of the gap is the responsibility of the insurer vs. passing it on to the consumer. He said even though premiums are higher, the value proposition still works in favor of the consumer. There is still value to the consumer, but now it is more expensive.

Ms. VanFleet summarized the Vermont comment letter (Attachment Eight). She said the comments address the wellness section of Appendix D of the MSA Framework. She said any offer associated with a rate action that involves the collection of data using artificial intelligence (AI) should clearly explain how information will be collected and used to avoid profiting and potential discriminatory actions on behalf of the insurer. Any offer to an insured tied to a rate increase should be supported with data showing why and how the rate impact is directly correlated to the offer. Rate increases add thousands of dollars to the consumer and are often a hardship for elderly consumers on fixed incomes and may not be able to consider their own best interest. The comment letter recommends keeping the wellness program offers separate from implementation of large rate increases (e.g., 10%–15%). Then, there would be no question that the consumer was coerced, rather than persuaded, to the part in the wellness program.

Ms. Lee said summarized the Washington comment letter (Attachment Nine). She said a few key criteria need to be addressed to achieve the maximum value of the MSA process. If the MSA process is not binding, it may affect the goal of nationwide uniformity and defeat the purposes of the MSA process. To minimize the differences across states, more states need to participate in the MSA rate review, and the use of the results should be mandatory. She asked if the rate changes recommended by the MSA team can be implemented by all states and meet existing state laws and rules. If not, she asked if this invalidates the actuarial work of the MSA team. Some states have capped an LTCI rate increase regardless of actuarial justification. If the MSA team recommends a higher rate increase than a particular state’s capped rate increase, the actuarial assumptions may no longer be valid. Also, those states without a rate cap will be continuing to subsidize the states with a rate cap. She said a key issue to address is if the MSA review can meet the proprietary or confidentiality requirements of the participating states. MSA rate reviews will be done by drawing on staff support from various state insurance departments. She asked if the MSA team can effectively maintain confidentiality and meet individual state’s proprietary information law. She highlighted other
comments in the letter regarding the actuarial considerations, specifically that the MSA report should not conflict with various states’ laws, rules, and procedures, and that the NAIC should conduct a study to determine whether the Minnesota and Texas approaches are consistent with states’ laws and rules. She said the methods in the MSA Framework are somewhat different from the review performed in Washington.

Having no further business, the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup adjourned.

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Draft: 7/12/21

Long-Term Care Insurance (EX) Task Force
Virtual Meeting
July 6, 2021

The Long-Term Care Insurance (EX) Task Force met July 6, 2021. The following Task Force members participated: Scott A. White, Chair (VA); Michael Conway, Vice Chair, represented by Sydney Sloan (CO); Jim L. Ridling (AL); Alan McClain (AR); Ricardo Lara represented by Perry Kupferman (CA); Andrew N. Mais (CT); Karima M. Woods represented by Philip Barlow (DC); Trinidad Navarro represented by Susan Jennette (DE); David Altmaier represented by John Reilly (FL); Colin M. Hayashida (HI); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron (ID); Dana Popish Severinghaus (IL); Amy L. Beard represented by Scott Shofer (IN); Vicki Schmidt (KS); James J. Donelon represented by Tom Travis (LA); Gary D. Anderson (MA); Eric A. Cioppa (ME); Anita G. Fox represented by Karen Dennis (MI); Grace Arnold represented by Fred Andersen (MN); Mike Causey represented by Tracy Biehn (NC); Jon Godfread represented by John Arnold (ND); Eric Dunning represented by Rhonda Ahrens (NE); Russell Toal (NM); Barbara D. Richardson (NV); Judith L. French (OH); Glen Mulready (OK); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Raymond G. Farmer (SC); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence (TN); Doug Slape (TX); Jonathan T. Pike represented by Tomasz Serbinowski (UT); Michael S. Pieciak represented by Anna Van Fleet (VT); Mike Kreidler (WA); Mark Afable (WI); James A. Dodrill (WV); and Jeff Rude (WY).

1. **Adopted its Spring National Meeting Minutes**

Commissioner Altman made a motion, seconded by Superintendent Toal, to adopt the Task Force’s April 9 minutes (see NAIC Proceedings – Spring 2021, Long-Term Care Insurance (EX) Task Force). The motion passed unanimously.

2. **Received the Report of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup**

Mr. Andersen said the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup met June 22 to discuss comments received on the exposure draft of the operational sections of the Long-Term Care Insurance (LTCI) Multi-State Rate Review Framework (LTCI MSA Framework).

Mr. Andersen said during the call, Michigan provided comments that included, among other issues:

- Further clarification is needed regarding the role of the Interstate Insurance Product Regulation Commission (Compact).
- The benefits of the Multi-State Actuarial LTCI Rate Review (MSA) process to states will only be realized if most states use the process and rely on the MSA review results.
- Michigan agrees that the governing body for the MSA team should be the Long-Term Care Insurance (EX) Task Force, but it believes there needs to be a regulator-to-regulator technical group like the Financial Analysis (E) Working Group or the Valuation Analysis (E) Working Group that oversees the analytical process and formally approves the MSA Advisory Reports.
- Many states, including Michigan, may be unable to keep the MSA Advisory Report confidential if it is relied upon in the rate determination, as state confidentiality provisions often do not extend to rate review authority.

Mr. Andersen said a joint comment letter was received from the American Council of Life Insurers (ACLI) and America’s Health Insurance Plans (AHIP). He said their comment letter included, among other issues:

- Transparency of the MSA process is critical to its success. Insurers should receive the MSA Advisory Report to have meaningful conversations with state insurance regulators before the MSA Advisory Report is finalized. Insurers need to know which states relied on the MSA Advisory Report, and to what extent, in making their rate increase determinations.
- A majority of both insurers and states need to participate in the MSA process to ensure its success.
- There needs to be a balance between adequate insurer confidentiality and providing enough information to stakeholders in MSA rate reviews.
Mr. Andersen said a comment letter was received from the American Academy of Actuaries (Academy). He said the Academy’s comment letter included, among other issues:

- The MSA team should be supervised by actuaries qualified in LTCI, and they should be members of the Academy to help ensure compliance with Actuarial Standards of Practice (ASOPs).
- Participation of an adequate number of states is needed for the MSA process to be successful.
- The MSA process should be streamlined to collect all necessary rate review information without duplicate requests to insurers from states.

Mr. Andersen said the Subgroup found all the comments to be helpful, and it instructed the drafting group to address the comments. The drafting group will continue working on edits to the operational draft in response to the comments, and the Subgroup will re-release it for a short comment period when it is ready. The next version is expected by the Summer National Meeting.

Mr. Andersen said the first draft of the actuarial aspects of the LTCI MSA Framework was released for a 45-day public comment period ending July 26. The draft provides complete details on how the MSA team will evaluate a submitted rate proposal under the Texas and Minnesota actuarial methodologies.

Commissioner Richardson made a motion, seconded by Superintendent Toal, to receive the report of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup. The motion passed unanimously.

3. Received the Report of the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup

Commissioner Altman said the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup met May 4. During this meeting, the Subgroup began work on its charge of, “potential development of a process to evaluate innovative options that allow for insurers to offer benefits that lessen the likelihood of an insured needing long-term care services, including evaluation of the suitability of and regulatory barriers to proposed options.”

Commissioner Altman said the Subgroup heard four industry presentations on LTCI innovation and wellness programs. The presenters were invited to assist the Subgroup with identifying potential issues with offering wellness programs to policyholders with in-force LTCI policies. The presentations touched on issues that insurers need to consider before implementing a wellness program; experiences with and lessons learned from a pilot program offered by an insurer; a hypothetical view of what the future state of in-home long-term care (LTC) services might look like; and issues related to unfair discrimination concerns, rebating concerns, and wellness programs as they relate to tax qualified LTCI policies.

Commissioner Altman said the Subgroup exposed a draft Reduced Benefit Options (RBO) Consumer Notices Checklist for a 30-day public comment period ending July 21. The checklist is intended to establish a consistent approach to drafting and reviewing LTCI RBO policyholder communications. The checklist can be used by states for guidance, and it is not required to be used for the review of insurer communications with policyholders. The next meeting of the Subgroup is July 22.

Commissioner Kreidler made a motion, seconded by Director Cameron, to receive the report of the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup. The motion passed unanimously.

Having no further business, the Long-Term Care Insurance (EX) Task Force adjourned.
The Long-Term Care Insurance Multistate Rate Review (EX) Subgroup met June 22, 2021. The following Subgroup members participated: Michael Conway, Chair (CO); Paul Lombardo (CT); Philip Barlow (DC); Benjamin Ben (FL); Stephen Chamblee (IN); Andria Seip (IA); Rich Piazza (LA); Karen Dennis (MI); Fred Andersen (MN); Rhonda Ahrens (NE); Russel Toal (NM); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Andrew Dvorine (SC); Tomasz Serbinowski (UT); Bob Grissom (VA); Anna Van Fleet (VT); and Mike Kreidler (WA). Also participating was: Perry Kupferman (CA).

1. Discussed Comments on a Framework Draft

Mr. Conway said the Subgroup received comments on an exposure of the operational sections of a draft Long-Term Care Insurance (LTCI) Multi-State Rate Review Framework (Framework) from the Michigan Department of Insurance and Financial Services (DIFS), the American Academy of Actuaries (Academy), the American Council of Life Insurers (ACLI), and America’s Health Insurance Plans (AHIP). He said the Subgroup also exposed the actuarial sections of the Framework with comments due July 26, and another meeting will be held to discuss comments received on the actuarial sections.

Mr. Conway said the Subgroup has been discussing how the Advisory Reports (Reports) produced by the Multi-State Actuarial LTCI Rate Review Team (MSA Team) will be kept confidential, whether they will be kept confidential, and whether they should be kept confidential. He said as states rely on the Reports in making rate increase decisions, it will be necessary to make public the aspects of the Reports state insurance regulators relied upon to inform interested parties of the reasoning behind rate increase decisions.

Ms. Dennis gave a summary of comments submitted by the Michigan DIFS (Attachment Two-A). She said Michigan seeks further clarification regarding the authority of the Interstate Insurance Product Regulation Commission (Compact) to accept and maintain filings under the MSA review. She said if the Compact infrastructure is being used simply to facilitate sharing and monitoring among states, Michigan recommends that a separate System for Electronic Rate and Form Filing (SERFF) area be created outside of the Compact that permits the submission of MSA filings without accidentally falling under the authority of the Compact.

Ms. Dennis said Michigan has concerns that the MSA review process may duplicate rate review efforts made by states if the work of the MSA Team is not coordinated with individual states. She said many states, including Michigan, may be unable to keep the Reports confidential if they are relied upon in the rate determination, as state confidentiality statutes often do not extend to rate review authority. She said the benefits of the MSA process to states will be realized only if the majority of states use the process and rely on the MSA review results.

Ms. Dennis said Michigan agrees that the governing body for the MSA Team and process should be the existing Long-Term Care Insurance (EX) Task Force, but it suggested that there needs to be an active regulator-to-regulator technical group, similar to the Financial Analysis (E) Working Group or the Valuation Analysis (E) Working Group, to oversee the analytical process and formally approve the Reports.

Mr. Conway said the Subgroup agrees that the success of the MSA process depends on having enough states participate, and the Subgroup will continue to research and address issues related to the confidentiality of the Reports. He said the Subgroup will continue work on developing a structure for governance of the MSA process.

Jan Graeber (ACLI) gave a summary of comments (Attachment Two-B) submitted by the ACLI and AHIP. Mr. Conway asked if the ACLI and AHIP are requesting that the Reports’ confidentiality be based on each state’s respective confidentiality laws. Ms. Graeber said that depends on the granularity of the contents of the Reports. She said any information that is normally treated as confidential in a rate filing should not be in a public version of the Reports.

Andrew Dalton (Milliman) gave a summary of comments (Attachment Two-C) submitted by the Academy. Ms. Ahrens said she agrees that at least one key member of the MSA Team should be a member of the Academy, but she also envisions the MSA process as a vehicle for developing actuarial resources through mentoring people that are not yet Academy members. Mr.
Kupferman said rate increases on group LTCI blocks should be reviewed under the MSA process. Mr. Conway said the Subgroup will discuss the inclusion of group blocks in the review process, and he does not think their review was intended to be excluded.

Mr. Conway said the Subgroup will continue working on edits to the operational sections of the draft in response to the comments, and it will then re-expose it for additional comment.

Having no further business, the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup adjourned.
5/24/2021
Good morning,

Please see Michigan’s comments below:

(1) **General comment:** We seek further clarification regarding the Compact’s authority to accept and maintain filings under the MSA review. We also seek additional detail regarding how the process for requesting an MSA review is done, e.g. how insurers are advised about the process, how states are notified. If the Compact infrastructure is being used simply to facilitate sharing and monitoring among states, we would recommend that a separate SERFF area-instance be made outside of the Compact that permits the submission of MSA filings without accidentally falling under the authority of the Compact.

(2) **Section I-D (page 4):** The benefit to states will only be realized if the majority of states use the process and rely on the MSA Review results. If only the states that have historically approved rate requests utilize this “program”, there may be little or no change to the current situation. The benefit for insurers may be impacted by delays in ability to implement needed increases. It appears the MSA review will take approximately 35 days after which the insurer submits their rate increase filing to each state. Since each state has varying statutory review periods, some states may take action more quickly than other states. Any delay in approving a rate increase, could result in the need for additional rate increases in a shorter amount of time.

(3) **Section I-E(4) (page 6):** Many states, including Michigan, may be unable to keep the MSA report confidential if it is relied upon in the rate determination as state confidentiality provisions often do not extend to rate review authority. The task force will want to consider the implications of the report not being able to be held confidential.

(4) **Section I-F (page 6):** We agree the governing body for the MSA Team should be the LTC Insurance (EX) task force, but believe strongly there needs to be a regulator-to-regulator subgroup like FAWG or VAWG that oversees the process and formally approves the MSA Advisory Reports. This subgroup could include testimony from the company and permit appeals as necessary. It would also permit affected states to participate and better understand the MSA report’s conclusions. The FAWG and VAWG models have gained broad approval from both regulators and industry and would seem to be the most appropriate structure for the MSA Team. This structure would also protect the NAIC and the MSA Team from any liability arising from issuing the report, especially in the event of company insolvency.

(5) **Section III-A (page 8):** We assume the second bullet point requires 5,000 policyholders nationwide. We would suggest adding “nationwide” at the end of the bullet for clarity.

(6) **Section III-B (page 9):** We seek more detail on the fee schedule proposed for the MSA Review, in particular whether the payment is made by the insurer or the state and whether the NAIC or the respective MSA Team receive the payment. Whether it is a reimbursement for fees incurred during the course of an examination or fees paid by the insurer for receipt and use of the report has contractual implications. If the authority to issue the report is derived from the task force or subgroup, the fees appear to be more like fee reimbursement for an examination.

(7) **Section III-B (page 9):** We seek to clarify that the rate filing include the SERFF tracking number for the associated/impacted form filing(s).

(8) **Section III-C (page 9):** The certification limits misuse of the report by the company and limits an insurer’s authority to challenge the report unless it is used by the states in their review and determination. Please advise if states who consent to the use of the MSA report are required to accept the report as-is. If so we would further recommend the regulator to regulator subgroup structure to allow interested/affected states to participate in the final review and to maintain
the report within the standard examination process, thereby avoiding the need to have states consent to the use of the MSA Review or Advisory Report.

(9) **Section VII (pages 12-13):** The MSA Report appears to be an actuarial communication. We would encourage the MSA Team to review the applicable actuarial standards of practice to ensure appropriate disclosures are made within the reports, including references to how the report complies with the standards. We would also encourage the purpose and use to be separated from the Disclaimers section for clarity.

(10)**Section VIII-Appendix B (page 13):** We seek clarification regarding if the checklist is confidential or can individual states incorporate it into their respective filing requirements. This would ensure additional consistency across LTC rate filings, whether or not submitted to the MSA Team.

Thank you,

*Karen Dennis, Director*

Office of Insurance Rates and Forms  
Michigan Department of Insurance and Financial Services  
877-999-6442 or 517-881-7228 (work cell)  
dennisk1@michigan.gov  

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May 24, 2021

Commissioner Michael Conway
Chairman, NAIC LTC Multi-State Rate Review (EX) Subgroup
Colorado Insurance Department

Dear Commissioner Conway and Subgroup Members,

The American Council of Life Insurers (ACLI) and the American Association of Health Insurance Plans (AHIP) strongly support the work of the NAIC Long-Term Care (EX) Task Force in achieving its charge of developing a consistent national approach for reviewing long-term care (LTC) rates and identifying options for consumers to modify benefits when faced with a premium increase on their LTC policy. We applaud the commitment of state insurance commissioners and LTC subject matter experts from state insurance departments for their time and effort spent on addressing this important issue. As an industry, we understand that the work has presented challenges and we remain committed to working with you to address these challenges.

Thank you for the opportunity to comment on the draft Operational Section of the Long-Term Care Insurance Multi-State Rate Review Framework (Framework), exposed by the NAIC LTC (EX) Task Force on April 9, 2021. While we appreciate this opportunity to comment, it is difficult to provide complete comments without the ability to review the document in its entirety, specifically, the Actuarial Section, which we believe will be the core of the Framework document. As a result, our comments at this time are more conceptual in nature. We look forward to an opportunity to provide more detailed comments when the entire Framework document is complete.

**Executive Summary**

We strongly support the Multi-State Rate Review (MSRR) concept as a strategy to address the challenges facing industry, consumers, regulators and the overall LTC market. Our comments are grouped into the following areas, which are key to the stability of the LTC market and paramount to the success of the Task Force in achieving its charge.

1. **Transparency and Consistency of:**
   - the Multi-state Actuarial (MSA) Review Process, and

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1 The American Council of Life Insurers advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. Ninety million American families depend on our members for life insurance, annuities, retirement plans, long-term care (LTC) insurance, disability income insurance, reinsurance, dental, vision, and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States.

2 AHIP is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.
May 24, 2021

- the methodology for determining actuarially appropriate rate increases that achieve and preserve equity among policyholders in all states;

2. State and Insurer Participation in the MSA Review Process

3. Confidentiality of the Insurer’s Rate Increase Proposal

We believe it is important to view each of the above areas in light of, and assessed against the Task Force’s charge to:

*Develop a consistent national approach for reviewing LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization.*

**Transparency and Consistency**

Insurers best protect their policyholders when they can fulfill the obligations they made to these policyholders. This is accomplished when insurers have some level of predictability in their ability to effectively manage their LTC business over time. At its core, this level of predictability can only be achieved through transparency and consistency within the MSA Review Process. We encourage the MSRR subgroup to include elements for achieving greater transparency and predictability within the Framework document. We have identified the following elements that will enhance transparency and predictability within the MSA Review Process:

*Insurer Receipt of the MSA Advisory Report and Recommendation.*

The MSA Review Process will present significant challenges if the insurer does not receive the MSA Advisory Report. Without receipt of the recommendation and report, there will be an inequality in the parties’ knowledge about the actuarial analysis used and, therefore, potentially, confidence in the recommended rate table. Without understanding the actuarial analysis underlying the MSA Team recommendation, insurers will be unable to engage in a meaningful, productive dialogue with the MSA Team and participating states about the application of that analysis to the insurer’s particular block of business.

*Insurer and MSA Team Engagement*

Insurers are in the best position to provide insights and information about their blocks of business. We encourage the MSRR subgroup to include an opportunity for insurers to review the recommendation and interact with the MSA Team recommendation before it is final. Without this step, if an insurer disagrees with the MSA Team recommendation, it will be necessary for the insurer to appeal to each individual state. This will add a significant amount of time to the entire process and reduce efficiency.

In addition, including industry in the webinars with other participating states will enable questions to be addressed in a consistent and efficient manner.

We suggest language consistent with the language below, be added to Section IV, Subsection B – Completion of the MSA Review Process

*Information Sharing Between the MSA Team and the Insurer*

Throughout the MSA Team review, the MSA Team will communicate with the insurer and address any questions from the insurer about the MSA Team’s analysis and review. Prior
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To finalizing the MSA Advisory Report and Recommendation, the insurer will be given an opportunity to review the report and recommendation. If the MSA Team recommendation differs from the rate proposal submitted by the insurer, the insurer will be given the opportunity to provide additional feedback and support of its proposal.

State Reliance on the MSA Team Recommendation

We recognize that the MSA recommendation is that – a recommendation – and that each state retains its ability to review or approve an insurer’s rate increase filing. Yet, the process should enable insurers to understand which states are relying on the MSA recommendation and to what extent. If a state deviates from the MSA recommendation, the reason should be clearly explained to the insurer. At a minimum, this level of disclosure will provide insight into the consistencies (or inconsistencies) across states compared to the MSA recommendation, resulting in a higher level of transparency and consistency within the process.

We suggest that language consistent with the following be added to Section I. Subsection F. - Governing Body and Role of the NAIC Long-Term Care Insurance (EX) Task Force:

At least semi-annually, the Task Force will disclose a list of the rate increase filings reviewed to all stakeholders, along with the following information for each:

- Identification of the states that participated in the MSA Review Process for each filing, and
- A description of the general manner in which each participating state utilized the MSA Team’s review and recommendation to make decisions on an insurer’s rate increase filing, e.g., Adoption (adoption of the MSA Team’s review and recommendation); Consideration (active consideration of the MSA Team’s review and recommendation as a supplement to the state’s separate review process); Receipt Only (no reliance on MSA Team’s review and recommendation in the state’s review process).

At least annually, and with input from state regulators, industry, and other stakeholders, the Task Force will review the Framework document and amend it, as necessary, to refine the MSA Review Process.

We believe that this level of transparency could serve as a first step in encouraging the participation of both states and insurers.

Methodology Used in the MSA Team Recommendation

The Framework states that the MSA Team’s review of rate proposals will resemble a state-specific rate review process utilizing consistent actuarial standards and methodologies. In addition, the MSA Team will apply the Minnesota (Blended If-Knew/Make-Up) and Texas (Prospective Present Value) approaches, as described in the 2018 NAIC LTC Pricing Subgroup’s paper – “Long-term Care Insurance Approaches to Reviewing Premium Rate Increases”, to calculate recommended, approvable rate increases. We suggest that the Actuarial Section of the final Framework document outline specific reasons for use of one method over another.

A primary component leading to the success of the MSA Review Process is achieving an adequate rate level for policyholders in all states. As proposed, the process also gives states the discretion to continue to apply state-specific non-actuarial restrictions and caps on rate
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increase amounts. Again, we recognize the independence of each state’s authority, but allowing states to impose artificial rate caps on what the MSA Team has determined to be an actuarially justified rate could perpetuate the historical discrepancies between states, which will not address cross-state inequities. It will also undermine the Task Force’s charge to develop “a consistent national approach” to achieve “actuarially appropriate increases.”

To ensure the success of the MSA Review Process and ensure that the Task Force achieve its charge, the MSA Team should set forth its expectation that a state will follow the MSA recommendation and not impose artificial, state-specific rate restrictions or caps unless the state justifies those requirements as being actuarially justified and necessary, or specifically mandated by state law.

It should be recognized that state restrictions or caps to actuarially justified rate increases will require future increases to be filed and will result in higher actuarially justified ultimate premium rates for insureds in that state in order to maintain equity over the life of the policy.

In addition, the methodology used by the MSA Team in determining its recommendation must be actuarially sound and acknowledge an insurer’s ability to achieve and preserve equity among policyholders in all states over the lifetime of the policy. Transparency in this piece of the process will result in greater consistency and confidence in outcomes, which is key to the Task Force achieving its charge.

State and Insurer Participation

An adequate level of participation from both insurers and states is central to the success of the MSA Review Process and to the Task Force achieving its charge to ensure a more consistent national approach to reviewing and approving actuarially justified rate increases on LTC blocks of business. Without sufficient state commitment and participation in the MSA Review Process, along with state reliance on the information provided to and reviewed by the MSA Team, there is no incentive for insurers to use the MSA Review Process. Increased insurer participation will result if there is a commitment by states to participate in the MSA Review Process and rely on the MSA Team recommendation.

Lack of state and insurer participation could result in failure of the MSA Review Process and the Task Force charge. Failure of the Task Force charge will result in continued significant inconsistencies in state level actions on rate increases and an increased potential for future insolvencies and market disruption. We hope that there are not future insolvencies, but the need to act broadly and strategically to reduce that risk should not be ignored. Any future insolvency could have significant ramifications to state based regulation.

Confidentiality

All materials submitted by the insurer to the MSA Team, along with communications between the insurer and the MSA Team, the MSA Team’s analysis, recommendation and Advisory Report should be maintained as confidential. Once finalized, the MSA Advisory Report and Recommendation should be submitted directly by the MSA Team to each participating state where the insurer files its rate increase request. Once submitted to each participating state, the MSA Advisory Report and Recommendation should be maintained by each state as confidential. Any materials submitted directly to the participating state by the insurer in support of its rate increase request, should be afforded the same level of confidentiality as LTC increase requests submitted to that state outside of the MSA Review Process.
May 24, 2021

CONCLUSION

We share your fundamental concern of ensuring that policyholders receive the benefit of their insurance policies when they need it. Maintaining a guaranteed renewable product with limited or no rate adjustment flexibility is not sustainable. Insurers want to be part of a stable and vibrant market, one where insurers are willing to stay in the market, and hopefully one where others want to return to or join the market.

We recognize that the MSA Review Process is new and lessons learned over time will serve to improve and refine the overall process. We appreciate the MSRR subgroup’s hard work and analysis to identify and develop key parameters for an MSA Review Process to review and approve actuarially justified rate increases. Success of the MSA Review Process will help to ensure market stability.

Thank you for the opportunity to provide these comments. We will submit more detailed comments once the Framework document is exposed in its entirety. ACLI/AHIP welcomes the opportunity to discuss our comments with you, and we welcome the opportunity to contribute to additional discussion regarding the comments raised in our letter.

Sincerely,

Jan M. Graeber
Senior Actuary, ACLI

Ray Nelson
AHIP Consulting Actuary
May 24, 2021

Scott A. White, Chair
Michael Conway, Vice Chair
Long-Term Care (EX) Task Force
National Association of Insurance Commissioners (NAIC)

Attn: Jane Koenigsman, Senior Manager, Life and Health Financial Analysis

Re: Exposure Draft: Long-Term Care Insurance (LTCI) Multistate Rate Review Framework

Dear Commissioners White and Conway:

The American Academy of Actuaries (Academy)\(^1\) Long-Term Care Reform Subcommittee appreciates the opportunity to offer comments on the exposure draft Long-Term Care Insurance Multi-State Rate Review Framework (“Framework”) released April 9, 2021.

We would first like to emphasize the importance of actuarial input from the beginning of any process involving the consideration, design, and evaluation of a potential long-term care (LTC) policy approach. Actuaries are uniquely qualified according to their professional standards and play a crucial role in the financing and design of LTC financing systems—from private long-term care insurance (LTCI) to public programs that provide LTC benefits. Actuaries have specialized expertise in managing the risk of adverse selection in insurance coverages, the ability to recognize and incorporate uncertainty into cost projections and premiums, and experience in evaluating the long-term solvency and sustainability of public and private insurance programs.

An actuarial perspective can provide a basis for exploration of new and innovative review frameworks. We would refer the task force to two specific publications for examples of such perspective. One is an October 2018 Academy issue brief on considerations for treatment of past losses in rate increase requests for long-term care insurance.\(^2\) The second is a June 2016 Academy issue brief to enhance understanding of what is leading to significant rate increases, examine how the need for a rate increase is determined, discuss the effects of increases on various stakeholders, and explore alternatives to premium rate increases.\(^3\)

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\(^{1}\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

\(^{2}\) American Academy of Actuaries, *Long-Term Care Insurance: Considerations for Treatment of Past Losses in Rate Increase Requests*, October 2018.

\(^{3}\) American Academy of Actuaries, *Understanding Premium Rate Increases on Private Long-Term Care Insurance Policyholders*, June 2016.
The remainder of this letter provides our comments on the Framework, grouped into four categories.

**Objectives of Multi-State Actuarial (MSA) Review**

The Long-Term Care Reform Subcommittee appreciates the NAIC’s objective of “developing a consistent national approach for reviewing current LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner.”

The multi-state actuarial LTCI rate review (“MSA Review”) proposed in the Framework has the potential to create a robust actuarial review, independent of state-specific considerations, to advance the stated objective. However, it will be critical to consider detailed proposals for Actuarial Review, Reduced Benefit Options, and Non-Actuarial Considerations, which appear only as “placeholders” in the draft Framework. The subcommittee is reserving comment on Appendix B of the draft until its information requirements can be considered in context with exposure drafts of the placeholder sections.

We suggest that the Framework include a description of the Minnesota and Texas approaches applied by the MSA Review team, or a citation to specific documents.

It would be helpful for future evaluation if the NAIC could release an analysis or summary of the pilot program referenced in the draft Framework. In particular, what criteria have been or will be used to evaluate the success of the MSA Review process? If an MSA Review process is adopted, will there be future provision for feedback from industry participants, consumers, and other stakeholders, in addition to regulators?

**Actuarial Qualifications**

The subcommittee recognizes the potential benefit to state insurance regulators of the MSA Review process in developing and expanding specific LTCI actuarial expertise among the regulatory community. Having one or more suitably experienced and qualified actuaries participate in and supervise the work of the MSA Team will be important to the current and future viability of the process, providing opportunities for additional actuaries to meet the requirements of the U.S. Qualification Standards applicable to members of the American Academy of Actuaries and other U.S. actuarial organizations as they relate to LTCI. We recommend that at least one of the qualified actuaries signing off on an MSA Review be a member of the American Academy of Actuaries, in addition to the requirements currently proposed in the Framework for membership on the MSA Team.

Qualified actuaries will be able to assure that the work of the MSA Team complies with appropriate actuarial standards of practice (ASOPs). We believe it will be important for the MSA Team’s report to discuss the reasonableness of actuarial projections and to disclose the impacts of any non-actuarial factors that were considered.
State Participation and Block Eligibility

The Framework defines states as either “impacted” or “participating.” The Framework allows states to choose to be a Participating State in the MSA Review. Further, states that choose to participate can choose whether to follow the recommendation of the MSA Review. This maintains the states’ authority over rate filings. However, it means that the MSA Review does not create finality in the filing process. The Framework may not encourage insurers to use the MSA Review process if it is believed to add an additional layer of filing review without shortening the approval process on a state-by-state basis.

Several criteria are provided for a rate proposal to be eligible for an MSA Review. It is unclear whether insurers would be allowed to pool the experience of similar policy forms within or across legal entities when submitting a filing for an LTCI product. The subcommittee suggests that pooling be allowed where there is adequate homogeneity across the pooled policies. This approach would be consistent with current approaches taken by most state regulators and would allow for blocks with prior rate increases to be pooled in a similar manner as the prior filings.

It is unclear whether rate increases on group LTCI blocks would be reviewed under the MSA Review. The subcommittee believes that this should be clarified. Adjustments to the definitions of Impacted State and Participating State may be needed because group certificates can be issued in a state where the state does not have jurisdiction over the rates.

MSA Review Process

One of the stated goals of the MSA Review is to provide timely rate decisions. To the extent that there are any duplicative or redundant steps in the process, we recommend that they be removed or combined. For example, if several Participating States require a certain piece of information that the MSA Review team believes is valuable, that information should be added to the list of information required for an MSA Review. Additionally, if Participating States agree that the listing of information for an MSA Review (as outlined in Appendix B) is exhaustive and no further requests for information are needed as part of the state review, the filing process could be streamlined.

The Framework implies that insurers will have access to the final results of the MSA Review, which will be outlined in an MSA Advisory Report. It does not appear that insurers will have access to the draft report. Prior to the final report being provided to the insurer, the draft report will be shared with Participating States. We believe it is important that insurers have an opportunity to review the draft results of the MSA Review in order to provide clarifications, correct any misunderstandings, or dispute the recommendation of the MSA Review. The subcommittee believes it would be beneficial for the process for the Framework to include discussion of an appeal process that would be available to insurers to dispute the findings of the MSA Review. Insurers would retain the right to withdraw a filing from the MSA Review process, without prejudice to a rate filing in any individual state.

Section III.C of the Framework describes a required certification by an officer of the insurer requesting an MSA Review to abide by certain conditions. The subcommittee suggests that the second sentence of the first paragraph be deleted.
The Framework describes MSA Review team members maintaining confidentiality of MSA Advisory Reports and other information. However, if the MSA Advisory Report is to be included in the filing record, or filed by the insurer with Participating States, we believe the report would become public based on limited confidentiality allowed by some states.

Conclusion

Thank you for the opportunity to provide input on the development of the MSA Review process. The Academy’s LTC Reform Subcommittee looks forward to providing comments on the complete Framework document when it becomes available. The Subcommittee thanks members who participated in the drafting of this comment letter, including J. Patrick Kinney, MAAA, FSA; Mike Bergerson, MAAA, FSA; Steve Schoonveld, MAAA, FSA; Mark Billingsley, MAAA, FSA; Jim Glickman, MAAA, FSA, FCA; Zenaida Samaniego, MAAA, FSA; and Perry Kupferman, MAAA, FSA.

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We would welcome the opportunity to speak with you in more detail and answer any questions you have regarding these comments or on other topics. If you have any questions or would like to discuss further, please contact Matthew Williams, the Academy’s senior health policy analyst, at williams@actuary.org.

Sincerely,

Andrew H. Dalton, MAAA, FSA
Vice Chairperson, LTC Reform Subcommittee
American Academy of Actuaries

CC: Eric King, Health Actuary, NAIC
Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup
Virtual Meeting
July 28, 2021

The Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met July 28, 2021. The following Subgroup members participated: Jessica K. Altman, Chair, and Shannen Logue (PA); Sarah Bailey (AK); Perry Kupferman (CA); Susan Jennette (DE); Andria Seip (IA); Dana Popish Severinghaus (IL); Rich Piazza (LA); Larry D. Deiter (SD); Brian Hoffmeister (TN); Tomasz Serbinowski (UT); Scott A. White (VA); Anna Van Fleet (VT); Melanie Anderson (WA); and Joylynn Fix (WV).

1. **Discussed Comments Received on a Draft RBO Consumer Notices Checklist.**

Ms. Van Fleet presented comment letters received (Attachment Three-A, Attachment Three-B, Attachment Three-C, Attachment Three-D) in response to an exposure of a draft Reduced Benefit Options (RBO) Consumer Notices Checklist (Checklist). She presented a version of the draft (Attachment Three-E) that incorporates the comments, with notes on the proposed treatment of each comment.

Discussion of the comments ended with question 39 of the Checklist. Commissioner Altman said the Subgroup will schedule another meeting to finish discussion of the comments.

Having no further business, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup adjourned.
The Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met July 22, 2021. The following Subgroup members participated: Jessica K. Altman, Chair, and Shannen Logue (PA); Lori K. Wing-Heir (AK); Perry Kupferman (CA); Trinidad Navarro (DE); Andria Seip (IA); Rich Piazza (LA); Karen Dennis (MI); Fred Andersen (MN); Rhonda Ahrens (NE); Larry D. Deiter (SD); Carter Lawrence (TN); Tomasz Serbinowski (UT); Scott A. White and Thomas J. Sanford (VA); and Anna Van Fleet (VT).

1. Exposed an LTCI Innovation and Wellness Program Issues Draft

Mr. Andersen presented a draft document (Attachment Three-F) that discusses issues related to long-term care insurance (LTCI) wellness programs. He said the Subgroup wants to receive public feedback on the document, have collaborative discussions about key issues, and revise the document accordingly. He said the Subgroup intends to provide clarity on the key issues by the end of the year.

Mr. Andersen gave an overview of the draft’s background section, Section 1, Section 3, and Section 7. He said industry tax experts and the federal government will be consulted to add to Section 5. He said Section 6, Section 7, and Section 9 are still being developed. Mr. Sanford gave an overview of Section 2 and Section 4. Ms. Logue gave an overview of Section 8.

The Subgroup agreed to expose the document for a 45-day public comment period ending Sept. 5.

Having no further business, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup adjourned.
The Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met May 4, 2021. The following Subgroup members participated: Jessica K. Altman, Chair, and Shannen Logue (PA); Lori K. Wing-Heir (AK); Perry Kupferman (CA); Trinidad Navarro (DE); Andria Seip (IA); Rich Piazza (LA); Karen Dennis (MI); Fred Andersen (MN); Larry D. Deiter (SD); Carter Lawrence (TN); Tomasz Serbinowski (UT); Bob Grissom (VA); Anna Van Fleet (VT); and Joylynn Fix (WV).

1. Heard Presentations on LTCI Innovation and Wellness Programs

Mr. Andersen said the purpose of the meeting is to help identify potential issues with offering wellness programs to policyholders with in-force long-term care insurance (LTCI) policies. He said the Subgroup plans to identify all such issues and begin addressing the issues over the following few weeks with the assistance of state insurance regulators and interested parties. He said the primary goal of implementing wellness programs is to improve policyholder health and lower claim costs for insurers, leading to fewer and lower rate increases and less insurer financial distress.

Vince Bodnar (Bain Capital Insurance) said he has been working with several carriers on thinking through various wellness program offerings and will give an overview of where industry stands with implementing these programs. He said wellness programs are common with health insurance (HI) and that LTCI wellness programs are not the same as those for HI. He said LTCI is generally purchased by younger people and kept for decades before it is used. He said there is much known through initial underwriting about an LTCI policyholder’s health at issue, but much less is known decades later at the time when claims are likely. He said LTCI carriers do not have much information about what sorts of interventions are helpful for LTCI policyholders, so they must look to other programs, such as Medicaid Managed Long Term Services and Supports (MMLTSS) and continuing care retirement communities (CCRC) for ideas that may be transferrable to LTCI. He said another handicap for carriers is that there are no long-term care (LTC) provider networks similar to those for HI. He said there are roughly 200,000 to 300,000 people on claim nationwide out of approximately 6,000,000 policyholders, so the volume needed to support provider networks is not available.

Mr. Bodnar said interest in wellness programs has increased greatly over the past two years. He said most carriers now have staff assigned to investigate wellness program issues and are beginning to offer pilot wellness programs to policyholders. He said a recent Intercompany Long Term Care Insurance (ILTCI) conference featured an LTCI wellness track, which included nine different sessions.

Mr. Bodnar said industry has been careful about what these programs are called so there is not a perception that these are efforts to avoid paying claims. He said the programs are being portrayed as ways to enhance policyholder health and to help them age in place if so desired.

Mr. Bodnar said there is an emerging provider service landscape that has made itself known over the past year or so. He said it is composed of providers that already serve MMLTSS and CCRC customers. He said there are also emerging financial technology, InsurTech and health technology providers that are showcasing technology and data analytic services for wellness programs. He said carriers are becoming aware of these providers and what services are offered.

Mr. Bodnar said some carriers are just beginning to become aware of what services can be provided, while others are farther along and are conducting pilots for working wellness programs. He said currently active pilots can be divided into two categories. He said the first focuses on the pre-claim population. He said carriers of this type tend to be holistic in their approach and do not center on any particular service, but rather they reach out to policyholders to assess their needs with home modifications or durable medical equipment. He said these programs usually divide their policyholder populations into a control group that is not offered the program and a test group that is offered the program. He said the second category is for the on-claim population, and they are designed to provide coordination of care for the claimant. He said these pilots are most concerned with those receiving care at home and minimizing transfers from home care to more expensive facility care. He said several of the carriers offering these pilot programs have received positive feedback from policyholders.
Charlie Philbrook (John Hancock) said one of his responsibilities at John Hancock is the company’s LTC wellness offering, the Living Independently and Falls-free Together (LIFT) program. He said it is a pilot program that has been in operation for a few years and is nearing its end. He said offers for the program are mailed to policyholders, followed with phone calls to them to increase participation. He said mailings were limited to policyholders ages 85 and older, as they are more likely to experience falls than younger policyholders. He said once the offer is accepted, a health coach visits the policyholder for a face-to-face assessment, with the primary goal of improving the insured’s physical environment. He said this includes looking for loose rugs and other slip and fall hazards, grab bars in the bathroom, and shower seats. He said the program has evolved to where questions are asked about nutritional and sleep habits, but the focus is still mainly on the insured’s physical environment. He said an action plan is then provided to the insured that lists ways to improve the physical environment, and then follow-up calls are made every three months to check on progress towards completing the plan. He said the program ends after one year. He said the assessment and action plan are free to the insured, but any modifications to their home are the insured’s responsibility.

Mr. Philbrook said the LIFT program began in 2008 when John Hancock and another carrier partnered with a vendor and participated in a pilot program that was funded by the U.S. Department of Health and Human Services (DHHS). He said roughly 1,000 policyholders participated in the pilot, and the program ended and was not reinstated until three years ago when it was resumed by John Hancock.

Mr. Philbrook said the success of the pilot is measured in terms of if a positive impact is made on customers’ lives and if a positive impact is made on John Hancock by delaying claims by making home environments safer. He said nothing but positive feedback about the program has been received from customers. He said the health coaches gain the insureds’ trust, and there are stories of insureds wanting to speak with a health coach more frequently than every three months. He said despite all the positive feedback, only about 10% of eligible insureds enroll in the program. He said this acceptance rate is common with other insurers offering similar programs.

Mr. Philbrook said it takes at least five years for experience to emerge that will enable an insurer to measure the impact on claims that a wellness program may have. He said an insurer should examine reductions in claim incidence over the first year or two, and then examine impacts to claim continuance over the next four or five years. He said John Hancock is only just beginning to scratch the surface of its pilot claims experience, as the program has only been operational for about three years.

Mr. Philbrook said there is the possibility of downside risk from a wellness program to an insurer in the form of decreased mortality due to better insured health and fewer policyholder lapses due to the enhanced insured engagement created by the program.

Mr. Philbrook said John Hancock is examining whether there are increases in claim duration that may be caused by delaying claim incidence.

Mr. Philbrook said three things have been learned from the pilot program. He said the program was likely too narrowly focused on the insureds’ physical environments. He said more effort should be made by John Hancock to assist in implementing the action plan, such as installing grab bars in the insured’s home, or setting up home meal deliveries. He said there was a selection bias in that healthier insureds tended to enroll in the program more often the less-healthy ones, and it is unhealthy people that will benefit most from a wellness program.

Mike Gugig (Transamerica) said he will give an overview of what the future state of home care might look like in the next few years, particularly given rapid technological advances. He said he wants to give a sense of how care coordinated between providers and insurers may work but be clear that insurers cannot accomplish this on their own. He said enabling policyholders to continue to live in their homes instead of transferring to an assisted living facility is beneficial to both the insurer and the policyholder. He said the majority of policyholders prefer to remain in their homes. He said a 2018 AARP study found that 77% of adults aged 50 and over in the U.S. want to remain in their homes as long as possible as they age, but only 50% of those surveyed realized that in-home LTC options are available.

Mr. Gugig said if Transamerica is able to establish a safe home setting for provision of LTC services, he thinks policyholders will react positively and will have a better quality of life. He said using home care results in lower benefit payments, which leaves more in the pool of money available to the insured if they do ultimately need to receive institutional care. He said lower claims costs also benefit the insurer and remaining policyholders in that lower claims costs result in less need for rate increases.
Mr. Gugig said in situations where family members are providing informal LTC, there is a risk of the burden being so great that they decide that the insured will have to be placed in a facility. He said offering the option of home care can prevent the insured’s transition to institutional care.

Mr. Gugig said many studies show that caregivers, both professional and unpaid, are negatively affected by the current state of home care. He said when caregivers experience burnout, the likelihood of the patient transferring to facility care greatly increases. He said providing support for caregivers is critical, and his hypothetical future state of home care includes technology that will allow caregivers to take a break. He gave an example of an 85-year-old woman who is cognitively impaired but not so severely that she is unable to do anything for herself. He described this individual as being right at the point of being eligible to go on claim. He asked what can be done to ensure she remains in her home as long as possible and what can be done to ease her caregiver’s burden. He proposed developing a systemic approach to care that will ease burdens on patients and caregivers using a set of technologies that will monitor patients and alert caregivers when necessary. He said some examples are the use of simple technologies to determine if the patient is using water in the bathroom as an indication of whether they are getting out of bed, electrical monitors to determine if the refrigerator is being opened or an oven has been used, and door and window sensors to determine if doors or windows have been opened at an unusual time. He said geofencing can be used as a virtual fence to alert caregivers if the patient has left their home. He said bed monitors can determine when the patient left the bed. He said a single application can be used to integrate all of these monitoring technologies into one place. He said ridesharing or state disabled transportation services can also be incorporated into the application and that using these services can ease the burden on the caregiver of transporting the patient to medical and other appointments.

Mr. Gugig said increasing the prestige of paid caregivers’ positions, pay for this work and creating opportunities for career growth can help create a better future state of home care. He said one way to expand the role of paid caregivers is to train them in the use of patient monitoring technologies and make them the point of contact for patient alerts.

Mr. Gugig said the coordination of care between policyholders, insurers and care providers is essential to the success of the future state of home care services.

Nolan Tully (Faegre Drinker Biddle & Reath LLP) said unfair discrimination concerns, rebating concerns and tax qualification issues as they relate to LTCI wellness program offerings are items state insurance regulators and lawmakers need to address. He said it is important to remember that underwriting of an insured depends on some level of discrimination, but the key element is that this discrimination is not unfair. He said all wellness interventions are not appropriate for all policyholders. He gave the example of a fall prevention program being appropriate for an 85-year-old but not a 60-year-old. He said programs aimed at preventing or delaying the development of cognitive impairment should generally be targeted towards younger policyholders. He said carriers he has worked with are sensitive about how they introduce wellness programs, how they develop pilot programs and how they identify which policyholders are the best fit for program participation. He said that the carrier community has rolled out programs using broad consent, with policyholders having to opt into a program, and that he has not seen any carrier contemplate or move forward with a program that did not require a policyholder to affirmatively opt-in. He said programs have also been implemented that do not target any one group of policyholders, but rather they wait for any policyholder to enroll without prompting.

Mr. Tully said an important element of these programs is their reliance on technologies such as artificial intelligence (AI), predictive modeling and logarithmic computing. He said the carrier community is careful that the technological components of these programs are devised and implemented in a nondiscriminatory way, and these elements continue to be monitored for non-permitted discrimination throughout the program pilots. He said input from the regulatory community on discrimination issues will make it easier to structure pilots and their implementation.

Mr. Tully said the proposed amended Section 4 H of the NAIC Fair Trade Practices Act (#880) as it relates to rebating has had a significant positive impact on wellness program development. He said there are a number of specifically excepted rebating practices that are helpful to wellness program implementation, and he encourages state legislatures and state insurance regulators to adopt the proposed changes.

Mr. Tully said Section 7702 B of the federal Internal Revenue Code sets forth the triggers that are required to be present in a tax-qualified LTCI policy. He said a tax-qualified policy must count severe cognitive impairment or requiring substantial assistance with two or more activities of daily living (ADLS) as triggers for LTCI benefit eligibility. He said by the time this threshold has been reached, it is too late to intervene in a way that will materially prevent further deterioration. He said there are many wellness programs that can be beneficial to the policyholder, but they will need to be in effect before the eligibility
triggers have been reached, possibly decades prior. He said he thinks resolving these issues will require engagement with the federal government and the U.S. Department of the Treasury (Treasury Department).

Mr. Andersen said in addition to the issues discussed today, difficulty for insurers in evaluating the effectiveness of wellness programs on claim cost reduction, data privacy issues, and general fairness and reasonableness of the offerings all need to be considered. He said another issue for state insurance regulators is their role in preapproving and reviewing proposed programs, and what the review process will look like. He said there is a large number of ideas for wellness programs, and state insurance regulators will need to be cautious of focusing on only a few of these ideas at the risk of excluding others.

Ms. Altman said there are many startup companies currently leveraging data analysis, and data integrity and how data is used are important considerations. She asked how the presenters are considering these issues as they form new partnerships with these companies. Mr. Bodnar said conversations he has had with carriers indicate that data privacy is a large concern to them, and this concern has created something of a barrier to carriers partnering with vendors. He said the vendors are used to having access to more data for other health insurance applications than is generally available from LTCI policies. He said carriers have no hard knowledge of what interventions are effective, and they need more information on what causes an insured to go on claim. He said often the reason for going on claim is a social issue rather than a medical one, and data related to social issues is needed to make intervention models effective. He said building the predictive analytic structure needed for this is important, but he said he has not seen much progress toward this. Mr. Tully said he has seen the same thing and that carriers are focused on these issues when developing pilot programs. He said what is seen in the pilots will govern how data privacy issues are addressed with vendors for future programs. He also said carriers should ensure that the results of data collection and analysis do not produce unintended results. Mr. Gugig said he understands that carriers have been performing data security due diligence before partnering with vendors.

2. **Asked for Volunteers for an RBO Consumer Notices Checklist Drafting Group**

Ms. Altman said the Subgroup plans to resume work on the Reduced Benefit Options (RBO) Consumer Notices Checklist (Checklist) it had begun working on last year. She asked for volunteers to join a drafting group to revise the Checklist before it is exposed for public comment.

Having no further business, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup adjourned.
Commissioner Jessica Altman  
Chairman, NAIC LTCI Reduced Benefit Options (EX) Subgroup  
Pennsylvania Insurance Department  

July 21, 2021  

Dear Commissioner Altman,

The American Council of Life Insurers (ACLI)\(^1\) and the American Association of Health Insurance Plans (AHIP)\(^2\) appreciate the opportunity to comment on the draft Checklist for Premium Increase Communications (Checklist), exposed by the NAIC LTC (EX) Task Force on June 21, 2021. We believe the cooperative working relationship we share with the Task Force, and other stakeholders, in addition to our combined efforts, will result in a Checklist that helps to make RBO consumer communications consistent and clear.

ACLI/AHIP support the work of the NAIC Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup in its charge to help consumers manage the impact of long-term care rate increases. By improving uniformity and clarity in consumer notices for reduced benefit options (RBO), consumers will better understand and objectively compare RBOs, and thereby choose the best options for their personal circumstances.

**EXECUTIVE SUMMARY**

Long-term care insurance mitigates the risk of catastrophic long-term care costs. How long-term care insurance accomplishes this important public good differs depending on the insurer, the policy terms, and the individual circumstances of the policyholder. When a long-term care rate increase becomes necessary, insurers need flexibility to determine what options make the most sense for their blocks of business and their policyholders. A Checklist that accommodates these varying factors will promote a robust and innovative RBO offering in the event of a premium increase.

As the Checklist’s introduction states, the Checklist is meant as guidance and does not carry the weight of law or impose any legal liability. The RBO principles adopted by the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup on November 30, 2020 should steer the Checklist queries. The Checklist should not create new requirements, but rather, standardize, clarify, and compile existing requirements and guidelines. Further, as the Checklist is only meant as guidance for insurers in drafting, and regulators in reviewing, RBO communications, the Checklist should explicitly state, that unless otherwise mandated by a particular state, an insurer is not required to include a completed Checklist with the filings.

In addition to this comment letter, we include specific, proposed edits to the Checklist. ACLI/AHIP request that this letter be considered in combination with our suggested amendments.
SERFF FILING

Question 1 lists specific materials to include with the rate increase filing. Because some of those materials would not be applicable to all rate increase filings, readily available at the time of filing, and/or required by the state, we suggest a more general question, “Does the filing contain all materials required to be filed in connection with the rate increase request?”

Rephrasing question 3 to be more general would account for the different notification timing requirements amongst states, as well as the possibility notifications might be sent electronically.

On question 4 we recommend adding “new” before “innovation options” for additional clarification.

We recommend question 5 be amended to reference state-required samples of policyholder communications, so as not to imply a new requirement where one does not currently exist.

We find question 6 to be ambiguous and suggest removal, or clarification, without implying a new requirement regarding customer service operations.

Finally, we believe question 7 should reference required state-specific pre-rate increase filing notification procedures and that the example be removed because it could confuse insurers and regulators in instances where the scenarios given in the example do not apply.

READABILITY AND ACCESSIBILITY

We suggest the questions in this section be amended to remove specific requirements of readability and accessibility to give insurers maximum flexibility in creating communications that best serve their policyholders.

For instance, in question 8, instead of assigning the order of information in a communication, the question should indicate the end goal, “Does the communication clearly present the essential information and/or primary action?” The order of information is irrelevant so long as the communication is easy to follow, logical, and important information is clearly presented.

In question 11, removing the reference to 11-point type, but keeping the guidance that the communication be in “easily readable font” accounts for the additional impact formatting, layout, font, illustrations, bullet points, logos, etc. have on readability. Type size is just one element of many that make a communication easy to read and understand.

The Flesch reading ease score in question 15 implies a specific, new requirement. For this reason, and because the question is redundant with questions 8 through 14, which establish readability, we recommend question 15 be removed entirely.
Amending question 16 to simply ask, “Are the RBOs clear and not misleading?” without implying a specific side-by-side format gives insurers greater flexibility in presenting information, unique to their business, as plainly as possible.

We believe questions 18 and 19 imply new, specific requirements for insurers in accommodating policyholders with disabilities or who do not speak English as a first language. All insurers must already meet the requirements of the Americans with Disabilities Act and other laws governing accessibility in all their policyholder communications. To avoid implying or creating new requirements, we suggest removing questions 18 and 19.

IDENTIFICATION
To both simplify and clarify questions 25 and 26, as well as the actual RBO communication, we recommend these questions read:

“25. Does the communication clearly explain how the consumer may elect an option? Does the election documentation allow the consumer to clearly indicate his or her choice?
26. Does the communication clearly explain that the consumer is not being singled out for the increase?”

As written, question 26 suggests the communication attempt to explain class basis, a technical concept. The goal is to let policyholders know they are not being singled out for an increase and our edits would help to emphasize this.

COMMUNICATION TOUCH AND TONE
Question 27, which asks whether the communication reminds consumers to reflect on why they may have purchased the policy, is both subjective and prescriptive. Question 28, which asks whether the communication expresses empathy, is the same. Because all other items in the Checklist will help to ensure policyholders think through their decision by accounting for multiple factors—a statement directing a policyholder to reflect is unwarranted. Moreover, since the communication’s very purpose is to help policyholders manage a rate increase, we believe the question about empathy is both needless and overly subjective. Whether or not a communication expresses empathy is open to interpretation. The goal is to help. The more helpful a communication is—the more empathetic is it likely to be perceived.

Since it is impossible to list all RBOs in one communication, we suggest question 30 simply read, “Are examples of the reduced benefit options represented fairly?” To avoid overwhelming or confusing policyholders, some options will likely not be in the communication, but accessible by contacting the insurer directly, or elsewhere, as the insurer directs. Insurers can discuss specific options available to a policyholder, while accounting for a policyholder’s personal situation and current benefit levels. We want to ensure that regulators do not then conclude that the RBOs included in a communication are unfairly presented, while those RBOs that policyholders access outside the communication are unfairly de-emphasized.
CONSULTATION AND CONTACT INFORMATION

We recommend question 35 be reworded to refer generally to any required government resources. Resources differ, depending on the state. Departments of insurance have varying policies about information or guidance they are willing to provide in the event of a rate increase.

UNDERSTANDING OPTIONS — PRESENTATION

Depending on the insurer, type of policy, and many other factors, it is possible policyholders could have dozens of RBOs. Including explanations for even 5 to 7 RBOs, as the Checklist suggests in question 39, is likely to be overwhelming and confusing to policyholders trying to decide amongst them. Consequently, we believe it is preferable to remove the reference to a specific number of RBOs and use “reasonable” as the guideline.

Question 40, referring to the right to reduce coverage at any time, ought to be removed entirely. Not all options are available at any time, some have time limits, and sometimes policyholders have the lowest level of benefits possible, based on a state’s minimum benefit standards, with no option to reduce further. Also, RBOs might not be offered to policyholders currently on claim. Additionally, question 40 is redundant with questions 45 and 46, which already address deadlines.

UNDERSTANDING OPTIONS — PAST RATE ACTIONS

Question 43 pertains to including a 10-year nationwide rate increase history in the RBO communication. This information could be pertinent to the decision to purchase coverage and is provided in the outline of coverage upon purchase of a policy. In contrast, the RBO communication focuses on the current change in premium, the policyholder’s options, and the potential for a future rate increase. Past rate increases vary widely due to prior state action and are not necessarily predictive of future increases. To avoid confusing policyholders, or inadvertently influencing them to decide against their best interests, we strongly recommend question 43 be removed entirely.

UNDERSTANDING OPTIONS — WINDOW OF TIME TO ACT

We tweaked the wording in question 45 to make it clearer.

We also amended question 47 to improve accuracy and account for differences in policies and state laws. We recommend the question read, “Does the communication indicate what happens if no payment is received? For example, if the policy lapses within 120 days, does it advise Contingent Benefit Upon Lapse will apply, if applicable?” Contingent benefit upon lapse (CBUL) is more accurate in this instance than “contingent non-forfeiture.” Additionally, it’s important to note that CBUL is not applicable for all forms in all states. In some states, CBUL is only effective for policies issued after a certain date or is not an option at all.
UNDERSTANDING OPTIONS – CURRENT BENEFITS
We believe question 48 should be edited to allow insurers to either include, or direct the policyholder to, helpful information. An RBO communication that includes all benefit-related information could easily become unwieldy, lengthy, and confusing. Directing a policyholder to a website or some other resource would likely be the more manageable and effective option.

We think question 49, which references inflation option illustrations, should be removed from the Checklist for a few reasons. First, not all policies have a lifetime maximum benefit in dollars. Second, any future projection included in an RBO communication could be construed as a promise of future benefits. Third, including inflation option projections could confuse and overwhelm a policyholder already comparing multiple RBOs. And finally, a general illustration does not account for critical elements such as whether some benefits had previously been received, the policyholder’s location at the time of receiving benefits, cost of care when benefits are received, additional policy terms, etc.

UNDERSTANDING OPTIONS – PERSONAL DECISION
We would like clarification on question 50. Will an insurer be able to refer to options that may be applicable to an individual policyholder?

Question 51, pertaining to descriptions of the policyholder’s RBOs, is duplicative of questions 30 and 39 and should be removed.

We suggest a change of wording in question 52.

Finally, question 53, which refers to providing an unbiased resource to research cost of care, should be removed. An insurer cannot ensure an unbiased resource exists, nor can cost of care be predicted since it is heavily dependent on location and timing of benefits, both uncertain.

UNDERSTANDING OPTIONS – VALUE OF OPTIONS
We recommend question 54 be amended to remove the reference to value and to read, “Are the resulting benefits from each presented option clearly explained?” The question could be interpreted to mean general value or monetary value. The concept of value is too subjective to be a guideline. Perception of value differs depending on the personal circumstances of each individual policyholder, including their current age, health conditions, financial position, availability of caregivers, spouse/partner considerations, etc. Further, assessing value on behalf of policyholders could constitute steering. The communication should be objective, thereby aiding policyholders to make decisions in their best interest.

UNDERSTANDING OPTIONS – IMPACT OF DECISION
We recommend clarifying question 59 to read, “For phased-in increases: Is there a table with all phase-in dates and premium amounts if no reduced benefit option is elected?” It would be
impossible to create a table with this information without knowing what the policyholder elected.

We also recommend question 60 be amended to accommodate a wider range of deadlines to send communications prior to a rate increase because states’ time frames can differ quite a bit.

Lastly, the language in question 61, “Does the communication disclose that not all reduction options are equal in value?” is problematic. The same reasons we give for changing question 54 apply here. The concept of value is too subjective to be a guideline. Further, the entire communication, in addition to any supplemental information the insurer may direct the policyholder to consider, will demonstrate the differences between, and consequences of choosing, each RBO. For these reasons we advise deleting question 61.

CONCLUSION

Thank you for the opportunity to provide these comments. ACLI/AHIP welcome the opportunity to discuss our comments with you in the near future.

Sincerely,

Jan M. Graeber
Ray Nelson
Senior Actuary, ACLI  
AHIP Consulting Actuary

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1 The American Council of Life Insurers advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. Ninety million American families depend on our members for life insurance, annuities, retirement plans, long-term care (LTC) insurance, disability income insurance, reinsurance, dental, vision, and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States.

2 AHIP is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.
Checklist for Premium Increase Communications

AUTHORITY
The Long-Term Care Insurance Reduced Benefit Options (RBO) (EX) Subgroup is composed of regulators from 17 state insurance departments. It has been tasked with assisting the Long-Term Care Insurance (EX) Task Force in completing the following charge:

*Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases.*

The Long-Term Care Insurance (EX) Task Force adopted the Long-Term Care Insurance RBO Communication Principles. The Long-Term Care Insurance RBO EX Subgroup has been charged with developing a complementary checklist that can be leveraged by state regulators and Long-Term Care Insurance insurers.

INTRODUCTION
This checklist is intended to establish a consistent approach to drafting and reviewing Long-Term Care Insurance RBO policyholder communications. The checklist can be used as guidance and does not carry the weight of law or impose any legal liability.

State regulators may consider the checklist excessive, deficient, or not focused on issues specific to consumer experience in a particular state. State regulators are encouraged to modify the checklist to suit the needs of the Department.

Leveraging the checklist could enable insurers and state regulators to mitigate consumer confusion, complaints, improve the quality of the communication, and ensure the information presented:

- Reads in a clear, logical, not overly complex manner.
- Identifies if the options are presented fairly and without subtle coercion.
- Includes appropriate referrals to external resources, definitions, disclosures, and visualization tools.

RECOMMENDS that state regulators adapt the checklist to reflect their state regulations, laws, or statutes and adopt when reviewing filed Long-Term Care Insurance RBO Communications.

CALLS ON all insurance companies to consider the checklist when developing reduced benefit option policyholder communications in the event of a rate increase. The insurance company is not expected to include the Checklist with the filings.
# Checklist for Premium Increase Communications

<table>
<thead>
<tr>
<th>Insurer name:</th>
<th>Date of filing:</th>
<th>Product form:</th>
<th>Tracking number(s) SERFF rate filing:</th>
<th>Tracking number(s) SERFF form filing:</th>
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<tr>
<td>☐</td>
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<td>1. Does the filing contain all materials <em>required to be filed in connection with the rate increase request?</em> to include: policyholder communication, supplemental FAQ, graphs, illustrations, website screenshots (screenshots may be requested if communication refers policyholder to website for more information)?</td>
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<td>2. Has actuarial review of the rate increase been completed?</td>
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<td>3. Will the rate <em>increase notification</em> be mailed/sent pursuant to the notification timing requirements of the state “at least 45 days prior to the policyholder anniversary date (or billing date if state law allows)?</td>
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<td>4. Have all new innovation options presented in the communication been mentioned prominently as part of the filing? Have they been vetted by policy and actuarial staff?</td>
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<td>5. Are there sample policyholder communications <em>included with the filing, if required by the state</em> with a statement of variability?</td>
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6. Are there insurer rules for customer service interactions regarding RBOs?

7. Were any required state-specific pre-rate increase filing notification procedures followed? For example: VT has insurers notify consumers of rate increases when filed in addition to notification 45-60 days before effective date. PA posts filed rate increase details on their website.

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<tr>
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<td>8. Is the communication easy to follow? Does it flow logically? Does it display clearly present the essential information and/or the primary action first (followed by the nonessential information)?</td>
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<td>9. Are all insurance technical terms clearly explained in the communication?</td>
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<td>10. Are all technical terms used consistently throughout the communication?</td>
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<td>11. Is the communication in an easily readable font in at least [11-point] type?</td>
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<td>12. Does the communication use headings to help the reader find information easily?</td>
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<td>13. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?</td>
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<td>14. Are tables, charts, and other graphics, easy to read and understand?</td>
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<td>15. Are the grade level and reading ease scores appropriate ([8th grade] or lower; Flesch reading ease score [60] or higher)?</td>
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<tr>
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<tr>
<td>Are there side-by-side illustrations of options compared with current benefits? Are the RBOs clear and not misleading?</td>
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<td>If FAQs are included, are they succinct and easy to understand?</td>
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<td>Does the insurer provide appropriate accommodations for policyholders with disabilities? For example, accessibility of online and written materials to all interested parties, including those with disabilities such as blindness, deafness and hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity and combinations of these.</td>
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<td>Does the insurer provide access to translation services as needed?</td>
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<td>Does the communication answer what is happening?</td>
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<td>Does the communication answer why the consumer is receiving a rate increase?</td>
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<td>Does the communication indicate when the rate increase will be effective?</td>
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<td>Does the communication clearly indicate they have options?</td>
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<td>COMMUNICATION TOUCH AND TONE</td>
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<td>24.23. Does the communication clearly indicate explain how to the consumer may elect an option? Does the election documentation clearly indicate the allow the consumer to clearly indicate his or her's choice?</td>
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<td>26. Does the communication clearly explain that the consumer is not describe “class basis”?</td>
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<td>24. Are consumers. Does the communication clearly explain that the consumer is not being singled out for the increase?</td>
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<td>Suggested text: “Overall experience of all contracts in your class...”</td>
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<td>27.25. Does the communication remind consumers to reflect on why they may have purchased the policy?</td>
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<td>28.26. Does the communication express empathy?</td>
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<td>29.27. Is there a statement telling consumers how to contact the insurer for more information or help understanding their options?</td>
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<td>30.28. Are examples of the options represented fairly? Is one option emphasized, mentioned multiple times or bolded where the others are not?</td>
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<td>31.29. Are the words used that could influence a policyholder’s decision such as must or avoid? For instance, consider “now,” instead of “must.” Consider “mitigation options,” “offset premium impact,” or “manage an increase” instead of “avoid an increase.”</td>
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<td>CONSULTATION AND CONTACT INFORMATION</td>
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<td>24.29. Are the words used that could influence a policyholder’s decision such as must or avoid? For instance, consider “now,” instead of “must.” Consider “mitigation options,” “offset premium impact,” or “manage an increase” instead of “avoid an increase.”</td>
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<td>Is the insurer’s consumer service number easy to find? Is it clear what hours and days consumer service is open?</td>
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<td>31</td>
<td>Are website links and phone numbers accurate and functional?</td>
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<td>32</td>
<td>Does the insurer encourage consumers to consult with multiple sources to include any of the following: Financial planner, producer, or trusted family member?</td>
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<td>33</td>
<td>Does the communication include any required reference to SHIPP or other long-term care-related government resources? Does it specify the Department can only give general information?</td>
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<td>34</td>
<td>Does the communication encourage consumers to consult with a tax advisor if the reduction options include a cash buy out or could cause loss Partnership status?</td>
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<td>35</td>
<td>Does the communication have a clearly worded, descriptive title or subject line? For example: Your Long-Term Care Premiums Are Increasing</td>
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<td>36</td>
<td>Are the options included with the rate increase notification communication? Is it clear that the policyholder can ask for additional options?</td>
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<td>37</td>
<td>Are the number of options presented reasonable (5-7 options)?</td>
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<td>UNDERSTANDING OPTIONS – PAST RATE ACTIONS</td>
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<td>40.38. Is the Right to Reduce Coverage at Any Time clear? Does the communication explain that outside of a rate increase, the consumer may have the right to reduce benefits?</td>
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<tr>
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<td>45.43. Does the communication indicate what the reader must do to elect an option and provide the deadline to do it?</td>
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<td>46.44. For options that are only available during the decision window, is it clear to consumers?</td>
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<td>47.45. Does the communication answer what happens if no payment is received? For example, if no payment received, the policy lapses.</td>
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<td>Yes</td>
<td>No</td>
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<td>UNDERSTANDING OPTIONS – CURRENT BENEFITS</td>
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<td>Does the communication include or direct the policyholder to all the following helpful information, such as? Current benefits (daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status) in list form?</td>
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<td>If current benefits have an inflation option, include lifetime maximum benefit in dollars illustrated both five and fifteen years into the future?</td>
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<td>Are the options presented available to the policyholder?</td>
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<td>Does the communication contain descriptions of the consumer’s options (including daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)?</td>
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<td>Does the communication prompt the policyholder to consider their personal situation, such as: current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need and cost of institutionalized care?</td>
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<td>Does the communication provide an unbiased resource(s) for policyholders to research the cost of care?</td>
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<td>☐</td>
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<td><strong>54.52.</strong> Do options clearly indicate value for consumers? Are the resulting benefits from each presented option clearly explained? Does Contingent Nonforfeiture (CNF) Benefit Upon Lapse and other limited options clearly describe the reduction in value resulting benefits (benefit period)?</td>
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<td><strong>55.53.</strong> Is there a statement telling consumers how to contact the insurer for more information, the full list of options, or help understand their options?</td>
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<tr>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<td><strong>56.54.</strong> Is there a statement telling policyholders they can maintain current benefits by paying the increased premium?</td>
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<td><strong>57.55.</strong> Do the options reflect the impact of the inflation option in terms of growth or reduction if the option is to remove or reduce inflation?</td>
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<td><strong>58.56.</strong> If dropping inflation protection results in the loss of accumulated benefit amount, is that disclosed?</td>
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<td><strong>59.57.</strong> For phased-in increases: Is there a table with all phase-in dates and premium amounts if no reduced benefit option is elected?</td>
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<td><strong>60.58.</strong> For phased-in increases, are there communications sent at least 45-60 days before each phase of the increase?</td>
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<td><strong>61.59.</strong> Does the communication disclose that not all reduction options are equal in value?</td>
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</tbody>
</table>
Checklist for Premium Increase Communications

Comments from Bonnie Burns (identified as BB) and Brenda Cude (identified as BC)

AUTHORITY
The Long-Term Care Insurance Reduced Benefit Options (RBO) (EX) Subgroup is composed of regulators from 17 state insurance departments. It has been tasked with assisting the Long-Term Care Insurance (EX) Task Force in completing the following charge:

Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases.

The Long-Term Care Insurance (EX) Task Force adopted the Long-Term Care Insurance RBO Communication Principles. The Long-Term Care Insurance RBO EX Subgroup has been charged with developing a complementary checklist that can be leveraged by state regulators and Long-Term Care Insurance insurers.

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This checklist is intended to establish a consistent approach to drafting and reviewing Long-Term Care Insurance RBO policyholder communications. The checklist can be used as guidance and does not carry the weight of law or impose any legal liability.

State regulators may consider the checklist excessive, deficient, or not focused on issues specific to consumer experience in a particular state. State regulators are encouraged to modify the checklist to suit the needs of the Department.

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- Reads in a clear, logical, not overly complex manner.
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• Includes appropriate referrals to external resources, definitions, disclosures, and visualization tools.

The RBO (EX) Subgroup **RECOMMENDS** that state regulators adapt the checklist to reflect their state regulations, laws, or statutes and adopt-use the checklist when reviewing filed Long-Term Care Insurance RBO Communications.

The RBO (EX) Subgroup **CALLS ON** all insurance companies to consider the checklist when developing reduced benefit option policyholder communications in the event of a rate increase.
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<td>14. Are tables, charts, and other graphics easy to read and understand?</td>
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<td>17. If FAQs are included, are they succinct and easy to understand?</td>
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<td>18. Does the insurer provide appropriate accommodations for policyholders with disabilities or for policyholders for whom English is not a first language?</td>
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<td>19. Does the insurer provide access to translation services as needed for policyholders for whom English is not a first language?</td>
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<td>20. Does the communication answer what is happening?</td>
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<td>21. Does the communication answer why the consumer is receiving a rate increase?</td>
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For example, accessibility of its online and written material to all interested parties, including those with disabilities such as blindness or low vision, deafness and hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity and combinations of these.
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
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<td>22. Does the communication reflect negatively on the Department of</td>
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<td>23. Does the communication indicate when the rate increase will be</td>
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<td>24. Does the communication clearly indicate the policyholder have</td>
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<td>effective?</td>
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<td>25. Does the communication clearly indicate how to elect an option?</td>
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<td>26. Does the communication clearly describe “class basis”?:</td>
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<td>27. Does the communication remind consumers to reflect on why they</td>
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<td>28. Does the communication express empathy and understanding of the</td>
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<td>29. Is there a statement telling consumers how to contact the insurer</td>
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Suggested text: “Overall experience of all contracts in your class…”
<table>
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<td>30. Are the options represented fairly? Options are not presented fairly if one option is emphasized, mentioned multiple times or bolded when the other options are not?</td>
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<td>☐</td>
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<td>31. Are the words used that could influence a policyholder’s decision, such as must or avoid? For instance, consider “now,” instead of “must.” Consider “mitigation options,” “offset premium impact,” or “manage an increase” instead of “avoid an increase.”</td>
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<td>32. Is the insurer’s consumer service number easy to find? Is it clear what hours and days consumer service is open?</td>
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<td>33. Are website links and phone numbers accurate and functional?</td>
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<td>34. Does the Insurer encourage consumers to consult with multiple sources to include any of the following: Financial planner, producer, state SHIP program with the state-specific name of the program, or trusted family member?</td>
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<td>35. Does the Insurer encourage consumers to consult the Department of Insurance? Does it specify the Department can only give general information?</td>
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<td>36. Does the communication encourage consumers to consult with a tax advisor if the reduction options include a cash buy out or could cause loss Partnership status?</td>
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<td>Question</td>
<td>Yes</td>
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<td>37. Does the communication have a clearly worded, descriptive title or</td>
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<td>subject line? For example: Your Long-Term Care Premiums Are Increasing.</td>
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<td>38. Are the options included with the rate increase notification</td>
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<td>communication? Is it clear that the policyholder can ask for additional</td>
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<td>options?</td>
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<td>39. Are the number of options presented reasonable (5-7 options)?</td>
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<td>40. Is the Right to Reduce Coverage at Any Time of a policyholder’s</td>
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<td>choosing clear? Are the instructions about how to do that clear?</td>
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<td>41. Is there enough information to make a decision? If other sources</td>
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<td>are referenced like videos, websites, etc. are they supplemental education materials or are they required sources to choose an option?</td>
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<td>42. Does the communication include a statement that premiums may</td>
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<td>increase in the future? Is it clear that any future increase will include RBOs? Is a date shown when an insurer plans to file within a known time period, or when an insurer has already submitted a rate filing?</td>
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<td>UNDERSTANDING OPTIONS – WINDOW OF TIME TO ACT</td>
<td>UNDERSTANDING OPTIONS – CURRENT BENEFITS</td>
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<td>43.</td>
<td>Does the communication include a 10-year nationwide rate increase history for this and similar forms? Yes ☐ No ☐ N/A ☐</td>
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<td>44.</td>
<td>Does the communication disclose the policy is guaranteed renewable? Yes ☐ No ☐ N/A ☐</td>
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<td>45.</td>
<td>Does the communication indicate what the reader must do and the deadline to do it? Yes ☐ No ☐ N/A ☐</td>
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<tr>
<td>46.</td>
<td>For options that are only available during the decision window, is that limitation clear to consumers? Yes ☐ No ☐ N/A ☐</td>
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<td>47.</td>
<td>Does the communication explain that if no payment is received within 120 days, does the communication explain that what means? Yes ☐ No ☐ N/A ☐</td>
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<td>48.</td>
<td>Does the communication include all the following information? (Current policy benefits (daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status) in list form) Yes ☐ No ☐ N/A ☐</td>
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<td>49. If current benefits have an inflation option, does the communication include the lifetime maximum benefit in dollars, illustrated both five and fifteen years into the future?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<td>50. Are the options presented available to the policyholder?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<td>51. Does the communication contain descriptions of the consumer’s options (including changes in the daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<td>52. Does the communication prompt the policyholder to consider their personal situation, such as: current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need for institutionalized care?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<td>53. Does the communication provide an unbiased resource(s) for policyholders to research the cost of care?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<td>54. Do options clearly indicate value for consumers? Does Contingent Nonforfeiture (CNF) and other limited options clearly describe the reduction in value (benefit period)?</td>
<td>Yes</td>
<td>No</td>
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<td>55. Is there a statement telling consumers how to contact the insurer for more information, to request the full list of options, or to help understand their options?</td>
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<td>56. Is there a prominent statement telling policyholders they can maintain their current benefits by paying the increased premium?</td>
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<td>57. Do the options reflect the impact of removing or reducing the inflation option on their terms of growth or reduction of future benefits?</td>
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<td>58. If dropping inflation protection results in the loss of accumulated benefit amount, is that disclosed?</td>
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<td>59. For phased increases: Are all communications sent 45-60 days before each phase of the increase?</td>
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Checklist for Premium Increase Communications

AUTHORITY

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[The LTC Task Force? The RBO Subgroup?] RECOMMENDS that state regulators adapt the checklist to reflect their state regulations, laws, or statutes and adopt when reviewing filed Long-Term Care Insurance RBO Communications.

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**Commented [A1]:** Could we add an example of a rule that a regulator should be looking for?

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<th>27. Does the communication remind consumers to reflect on why they may have purchased the policy?</th>
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<th>28. Does the communication express empathy?</th>
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<th>29. Is there a statement telling consumers how to contact the insurer for more information or help understanding their options?</th>
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<th>30. Are the options represented fairly? Is one option emphasized, mentioned multiple times or bolded where the others are not?</th>
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<th>31. Are words used that could influence a policyholder’s decision, such as must or avoid? For instance, consider “now,” instead of “must.” Consider “mitigation options,” “offset premium impact,” or “manage an increase” instead of “avoid an increase.”</th>
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<th>32. Is the insurer’s consumer service number easy to find? Is it clear what hours and days consumer service is open?</th>
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<th>33. Are website links and phone numbers accurate and functional?</th>
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<th>34. Does the Insurer encourage consumers to consult with multiple sources to include any of the following: Financial planner, producer, or trusted family member?</th>
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<td>UNDERSTANDING OPTIONS - PRESENTATION</td>
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<td>35. Does the Insurer encourage consumers to consult the Department of Insurance? Does it specify the Departments can only give general information?</td>
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<td>36. Does the communication encourage consumers to consult with a tax advisor if the reduction options include a cash buy out or could cause loss of Partnership status?</td>
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<td>37. Does the communication have a clearly worded, descriptive title or subject line? For example: Your Long-Term Care Premiums Are Increasing.</td>
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<td>38. Are the options included with the rate increase notification communication? Is it clear that the policyholder can ask for additional options?</td>
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<td>39. Are the number of options presented reasonable (5-7 options)?</td>
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<td>40. Is the right to reduce coverage at any time clear?</td>
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<td>41. Is there enough information to make a decision? If other sources are referenced like videos, websites, etc. are they supplemental education materials or are they required sources to decide on an option?</td>
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<td>42. Does the communication include a statement that premiums may increase in the future?</td>
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<td>43. Does the communication include a 10-year nationwide rate increase history for this and similar forms?</td>
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<td>44. Does the communication disclose the policy is guaranteed renewable?</td>
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<td>45. Does the communication indicate what the reader must do and the deadline to do it?</td>
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<td>46. For options that are only available during the decision window, is it clear to consumers?</td>
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<td>47. Does the communication answer what happens if no payment is sent? For example, if no payment is received within 120 days, does it advise Contingent Non-Forfeiture will apply?</td>
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<td>48. Does the communication include all the following information? Current benefits (daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status) in list form?</td>
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<td>49. If current benefits have an inflation option, does the communication include lifetime maximum benefit in dollars illustrated both five and fifteen years into the future?</td>
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<td>50. Are the options presented available to the policyholder?</td>
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<td>51. Does the communication contain descriptions of the consumer's options (including daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)?</td>
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<td>52. Does the communication prompt the policyholder to consider their personal situation, such as: current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need for institutionalized care?</td>
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<td>53. Does the communication provide an unbiased resource(s) for policyholders to research the cost of care?</td>
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<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>UNDERSTANDING OPTIONS – VALUE OF OPTIONS</td>
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<td>54. Do options clearly indicate value for consumers? Do Contingent Nonforfeiture (CNF) and other limited options clearly describe the reduction in value (benefit period)?</td>
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<td>56. Is there a statement telling policyholders they can maintain current benefits by paying the increased premium?</td>
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Commented [A3]: Is this question different than # 48?

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Commented [A4]: Does this question add anything to # 29 and 32?
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<td>57. Do the options reflect the impact of the inflation option in terms of growth or reduction if the option is to remove or reduce inflation?</td>
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<td>58. If dropping inflation protection results in the loss of accumulated benefit amount, is that disclosed?</td>
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<td>59. For phased-in increases: Is there a table with all phase-in dates and premium amounts?</td>
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<td>60. For phased-in increases, are there communications sent 45-60 days before each phase of the increase?</td>
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<td>61. Does the communication disclose that not all reduction options are equal in value?</td>
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Checklist for Premium Increase Communications

AUTHORITY

The Long-Term Care Insurance Reduced Benefit Options (RBO) (EX) Subgroup is composed of regulators from 17 state insurance departments. It has been tasked with assisting the Long-Term Care Insurance (EX) Task Force in completing the following charge:

Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases.

The Long-Term Care Insurance (EX) Task Force adopted the Long-Term Care Insurance RBO Communication Principles. The Long-Term Care Insurance RBO EX Subgroup has been charged with developing a complementary checklist that can be leveraged by state regulators and Long-Term Care Insurance insurers.

INTRODUCTION

This checklist is intended to establish a consistent approach to drafting and reviewing Long-Term Care Insurance RBO policyholder communications. The checklist can be used as guidance and does not carry the weight of law or impose any legal liability.

State regulators may consider the checklist excessive, deficient, or not focused on issues specific to consumer experience in a particular state. State regulators are encouraged to modify the checklist to suit the needs of the Department.

Leveraging the checklist could enable insurers and state regulators to mitigate consumer confusion, complaints, improve the quality of the communication, and ensure the information presented:

- Reads in a clear, logical, not overly complex manner.
- Identifies if the options are presented fairly and without subtle coercion.
- Includes appropriate referrals to external resources, definitions, disclosures, and visualization tools.

RECOMMENDS that state regulators adapt the checklist to reflect their state regulations, laws, or statutes and adopt when reviewing filed Long-Term Care Insurance RBO Communications.

CALLS ON all insurance companies to consider the checklist when developing reduced benefit option policyholder communications in the event of a rate increase.
## Checklist for Premium Increase Communications

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<td>1. Does the filing contain all materials to include: policyholder communication, supplemental FAQ, graphs, illustrations, website screenshots (screenshots may be requested if communication refers policyholder to website for more information)?</td>
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<td>2. Has actuarial review of the rate increase been completed?</td>
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<td>3. Will the rate action be mailed at least 45 days prior to the policyholder anniversary date (or billing date if state law allows)?</td>
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<td>4. Have all innovation options presented in the communication been mentioned prominently as part of the filing? Have they been vetted by policy and actuarial staff?</td>
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<td>5. Are there sample policyholder communications with a statement of variability?</td>
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<td>6. Are there insurer rules for customer service interactions regarding RBOs?</td>
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<td>7. Were state-specific pre-rate increase filing notification procedures followed? For example: VT has insurers notify consumers of rate increases when filed in addition to notification 45-60 days before effective date. PA posts filed rate increase details on their website.</td>
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<td>8. Is the communication easy to follow? Does it flow logically? Does it display the essential information and/or the primary action first (followed by the nonessential information)?</td>
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<td>9. Are all insurance technical terms clearly explained in the communication?</td>
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<td>10. Are all technical terms used consistently throughout the communication?</td>
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<td>11. Is the communication in an easily readable font? Are the grade level and reading ease scores appropriate (8th grade or lower; Flesch reading ease score 60 or higher)?</td>
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<td>12. Does the communication use headings to help the reader find information easily?</td>
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<td>13. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?</td>
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<td>14. Are tables, charts, and other graphics, easy to read and understand?</td>
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<td>35. Does the Insurer encourage consumers to consult the Department of</td>
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<td>Insurance? Does it specify the Department can only give general</td>
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<td>information?</td>
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<td>36. Does the communication encourage consumers to consult with a tax</td>
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<td>advisor if the reduction options include a cash buy out or could cause</td>
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<td>loss of Partnership status?</td>
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<td>37. Does the communication have a clearly worded, descriptive title or</td>
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<td>subject line? For example: Your Long-Term Care Premiums Are Increasing</td>
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<td>38. Are the options included with the rate increase notification</td>
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<td>communication? Is it clear that the policyholder can ask for additional</td>
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<td>options?</td>
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<td>39. Are the number of options presented reasonable (5-7 options)?</td>
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<tr>
<td>40. Is the Right to Reduce Coverage at Any Time clear?</td>
<td>☐</td>
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<td>41. Is there enough information to make a decision if other sources are</td>
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<td>referenced like videos, websites, etc. are they supplemental education</td>
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<td>materials or are they required sources to decide on an option?</td>
<td>☐</td>
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<td>42. Does the communication include a statement that premiums may increase</td>
<td>☐</td>
<td>☐</td>
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<td>in the future?</td>
<td>☐</td>
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<td>43. Does the communication include a 10-year nationwide rate increase history for this and similar forms?</td>
<td>Yes No N/A</td>
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<tr>
<td>44. Does the communication disclose the policy is guaranteed renewal?</td>
<td>Yes No N/A</td>
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<tr>
<td>45. Does the communication indicate what the reader must do and the deadline to do it?</td>
<td>Yes No N/A</td>
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<td>46. For options that are only available during the decision window, is it clear to consumers?</td>
<td>Yes No N/A</td>
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<tr>
<td>47. Does the communication answer what happens if no payment is sent? For example, if no payment received within 120 days, does it advise Contingent Non-Forfeiture will apply?</td>
<td>Yes No N/A</td>
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<tr>
<td>48. Does the communication include all the following information? Current benefits (daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status) in list form?</td>
<td>Yes No N/A</td>
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<td>49. If current benefits have an inflation option include lifetime maximum benefit in dollars illustrated both five and fifteen years into the future?</td>
<td>Yes No N/A</td>
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</table>

Commented [A10]: I think this is missing a few words.
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Page Reference and Filing Notes</th>
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<tbody>
<tr>
<td>51. Does the communication contain descriptions of the consumer's options (including daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)?</td>
<td>☐</td>
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<tr>
<td>52. Does the communication prompt the policyholder to consider their personal situation, such as: current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need for institutionalized care?</td>
<td>☐</td>
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<tr>
<td>53. Does the communication provide an unbiased resource(s) for policyholders to research the cost of care?</td>
<td>Yes</td>
<td>☐</td>
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<tr>
<td>54. Do options clearly indicate value for consumers? Does Contingent Nonforfeiture (CNF) and other limited options clearly describe the reduction in value (benefit period)?</td>
<td>☐</td>
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<td>55. Is there a statement telling consumers how to contact the insurer for more information, the full list of options, or help understand their options?</td>
<td>Yes</td>
<td>☐</td>
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<td>56. Is there a statement telling policyholders they can maintain current benefits by paying the increased premium?</td>
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<td>57. Do the options reflect the impact of the inflation option in terms of growth or reduction if the option is to remove or reduce inflation?</td>
<td>☐</td>
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Commented [A11]: Questions 50 and 51 seem like they have been already addressed above in terms of the presentation and readability of options. Worth considering some consolidation.

Commented [A12]: Redundant of one or more of the above questions.
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<tr>
<td>58. If dropping inflation protection results in the loss of accumulated benefit amount, is that disclosed?</td>
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<td>59. For phased-in increases: Is there a table with all phase-in dates and premium amounts?</td>
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<td>60. For phased-in increases, are there communications sent 45-60 days before each phase of the increase?</td>
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<td>61. Does the communication disclose that not all reduction options are equal in value?</td>
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Commented [A13]: I don't think this is ever fair. Is that a consideration? You shouldn't lose inflation to date—it should be forward-looking.
Comments as of 7-21-21 Noted

Checklist for Premium Increase Communications

AUTHORITY

The Long-Term Care Insurance Reduced Benefit Options (RBO) (EX) Subgroup is composed of regulators from 17 state insurance departments. It has been tasked with assisting the Long-Term Care Insurance (EX) Task Force in completing the following charge:

Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases.

The Long-Term Care Insurance (EX) Task Force adopted the Long-Term Care Insurance RBO Communication Principles. The Long-Term Care Insurance RBO EX Subgroup has been charged with developing a complementary checklist that can be leveraged by state regulators and Long-Term Care Insurance insurers.

INTRODUCTION

This checklist is intended to establish a consistent approach to drafting and reviewing Long-Term Care Insurance RBO policyholder communications. The checklist can be used as guidance and does not carry the weight of law or impose any legal liability.

State regulators may consider the checklist excessive, deficient, or not focused on issues specific to consumer experience in a particular state. State regulators are encouraged to modify the checklist to suit the needs of the Department.

Leveraging the checklist could enable insurers and state regulators to mitigate consumer confusion, and complaints, improve the quality of the communication, and ensure the information presented:

- Reads in a clear, logical, not overly complex manner.
- Identifies the options are fairly and without subtle coercion.
- Includes appropriate referrals to external resources, definitions, disclosures, and visualization tools.

Suggested Edits from BB & BC:

State regulators who consider the checklist excessive, deficient, or not focused on issues specific to consumer experience in their state are encouraged to modify the checklist to suit the needs of the Department.
Leveraging the checklist could enable insurers and state regulators to mitigate consumer confusion and complaints, improve the quality of consumer communications, and to ensure the information presented. The checklist seeks to ensure that consumer communications:

- Reads in a clear, logical, not overly complex manner.
- Identifies if the options are presented fairly and without subtle coercion.
- Includes appropriate referrals to external resources, definitions, disclosures, and visualization tools.

[The LTC Task Force? The RBO Subgroup?] RECOMMENDS that state regulators adapt the checklist to reflect their state regulations, laws, or statutes and use the checklist when reviewing filed Long-Term Care Insurance RBO Communications.

CALLS ON all insurance companies to consider the checklist when developing reduced benefit option policyholder communications in the event of a rate increase.
## Checklist for Premium Increase Communications

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<td><strong>Product form:</strong></td>
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<td><strong>Tracking number(s) SERFF rate filing:</strong></td>
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<tr>
<td><strong>1.</strong> Does the filing contain all materials, including policyholder communication, supplemental FAQ, graphs, illustrations, website screenshots (expected if communication refers policyholder to website for more information)?</td>
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<td><strong>2.</strong> Has actuarial review of the rate increase been completed?</td>
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<td><strong>3.</strong> Will notice of the rate action be mailed at least 45 days prior to the policyholder anniversary date (or billing date if state law allows)?</td>
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<td><strong>4.</strong> Have all innovation options presented in the communication been clearly explained in the filing? Have they been vetted by policy and actuarial staff?</td>
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<td><strong>5.</strong> Are there sample policyholder communications with a statement of variability?</td>
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<td><strong>6.</strong> Are there insurer rules and training for customer service interactions regarding RBOs?</td>
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**Notes:**

- Deleted: to
depicted screenshots may be requested

**Commented [A6]:** ACLI: Question 1 lists specific materials to include with the rate increase filing. Because some of those materials would not be applicable to all rate increase filings, readily available at the time of filing, and/or required by the state, we suggest a more general question, “Does the filing contain all materials required to be filed in connection with the rate increase request?”

**Commented [A7]:** BB & BC

**Commented [A8]:** BB & BC

**Commented [A9]:** ACLI: Rephrasing question 3 to be more general would account for the different notification timing requirements amongst states, as well as the possibility notifications might be sent electronically.

**Commented [A10]:** BB: Should this be RBOs?

**Commented [A11]:** CA

**Commented [A12]:** ACLI: On question 4 we recommend adding “new” before “innovation options” for additional clarification.

**Commented [A13]:** ACLI: We recommend question 5 be amended to reference state-required samples of policyholder communications, so as not to imply a new requirement where one does not currently exist.

**Commented [A14]:** CA: Could we add an example?

**Commented [A15]:** BB & BC

**Commented [A16]:** BB: I’ve had experience with

**Commented [A17]:** MH: What is this looking for?

**Commented [A18]:** ACLI: We find question 6 to be...
### READABILITY AND ACCESSIBILITY

<table>
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<th>Yes</th>
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7. Were state-specific pre-rate increase filing notification procedures followed? For example: VT has insurers notify consumers of rate increases when filed in addition to notification 45-60 days before effective date. PA posts filed rate increase details on their website.  

8. Is the communication easy to follow? Does it flow logically? Does it display the essential information and/or the primary action first (followed by the nonessential information)? Is the primary message of the communication presented first and clearly worded?  

9. Are all technical insurance terms clearly explained in the communication?  

10. Are all technical terms used consistently throughout the communication?  

11. Is the communication in an easily readable font in at least [11-point] type?  

12. Does the communication use headings to help the reader find information easily?  

13. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?  

14. Are tables, charts, and other graphics, easy to read and understand?  

15. Are the grade level and reading ease scores appropriate ([8th grade] or lower; Flesch reading ease score [60] or higher)?  

16. Are there side-by-side illustrations of options compared with current benefits? Are they clear and not misleading?  

ACLI: Finally, we believe question 7 should reference required state-specific pre-rate increase filing notification procedures and that the example be removed because it could confuse insurers and regulators in instances where the scenarios given in the example do not apply.  

ACLI: We suggest the questions in this section be amended to remove specific requirements of readability and accessibility to give insurers maximum flexibility in creating communications that best serve their policyholders.  

ACLI: In question 8, instead of assigning the order of information in a communication, the question should indicate the end goal, "Does the communication clearly present the essential information and/or primary action?" The order of information is irrelevant so long as the communication is easy to follow, logical, and important information is clearly presented.  

In question 11, removing the reference to 11-point type, but keeping the guidance that the communication be in "easily readable font" accounts for the additional impact formatting, layout, and accessibility.  

Perhaps there should be some reference here to people with visual problems, size of text, and contrast to ensure accessibility.  

ACLI: If these are the standards you are expecting, then perhaps the checklist should be revised.  

ACLI: Amending question 16 to simply ask, "Are the RBOs clear and not misleading?"
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<th>Question</th>
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<tbody>
<tr>
<td>17. If FAQs are included, are they succinct and easy to understand?</td>
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<tr>
<td>18. Does the insurer provide appropriate accommodations for policyholders with disabilities or for policyholders for whom English is not a first language? For example, accessibility of its online and written material to all interested parties, including those with disabilities such as blindness, low vision, deafness and hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity and combinations of these.</td>
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<tr>
<td>19. Does the insurer provide access to translation services as needed for policyholders for whom English is not a first language?</td>
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<td>20. Does the communication answer what is happening?</td>
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<td>21. Does the communication answer why the consumer is receiving a rate increase?</td>
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<td>22. Does the communication reflect negatively on the Department of Insurance?</td>
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<td>23. Does the communication indicate when the rate increase will be effective?</td>
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<td>24. Does the communication clearly indicate the policyholder has options?</td>
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<td>25. Does the communication clearly indicate how to elect an option? Does the election documentation clearly indicate the consumer's choice?</td>
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**Commented [A30]:** ACII: We believe questions 18 and 19 imply new, specific requirements for insurers in accommodating policyholders with disabilities or who do not speak English as a first language. All insurers must already meet the requirements of the Americans with Disabilities Act and other laws governing accessibility in all their policyholder communications. To avoid implying or creating new requirements, we suggest removing questions 18 and 19.

**Commented [A31]:** BB: Macular degeneration and other visual conditions can make text and tables hard to read. Some people use various magnifying devices and can only see portions of a page or table at a time.

**Commented [A32]:** MH: This ends up being redundant of the prior question. I'd either pull language out of the prior question or delete this as a stand-alone question.

**Commented [A33]:** BC: Are examples needed to illustrate how the department might view a communication to reflect negatively on the department?

**Commented [A34]:** BB: Maybe this can be re-worded: Does the communication include information about how to contact the Department of Insurance?

**Commented [A35]:** BB & BC


**Commented [A37]:** BB: When check boxes are used to indicate a choice, there should be some way to verify that choice on the form returned to the insurer to avoid mistakes.

**Commented [A38]:** ACII: To both simplify and clarify questions 25 and 26, as well as the actual RBO communication, we recommend these questions...
<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<th>Page Reference and Filing Notes</th>
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<td>☐</td>
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<td>26. Does the communication clearly describe “class basis”? Are consumers being singled out for the increase? Suggested text: “Overall experience of all contracts in your class...”</td>
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<td>27. Does the communication remind consumers to reflect on the original reason they bought the policy?</td>
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<td>28. Does the communication express empathy and understanding of the difficulty of evaluating choices?</td>
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<td>29. Is there a statement telling consumers how to contact the insurer for more information or help understanding their options?</td>
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<td>30. Are the options represented fairly? Options are not presented fairly if one option is emphasized, mentioned multiple times or bolded when the other options are not?</td>
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<td>31. Are words used that could influence a policyholder’s decision, such as must or avoid? For instance, consider “now,” instead of “must.” Consider “mitigation options,” “offset premium impact,” or “manage an increase” instead of “avoid an increase.”</td>
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<td>32. Is the insurer’s consumer service number easy to find? Is it clear what hours and days consumer service is open?</td>
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<td>33. Are website links and phone numbers accurate and functional?</td>
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Commented [A39]: BC: Consumers don’t think of their policies as contracts.
Commented [A40]: ACLI: Question 27, which asks whether the communication reminds consumers to reflect on why they may have purchased the policy, is both subjective and prescriptive. Question 28, which asks whether the communication expresses empathy, is the same. Because all other items in the Checklist will help to ensure policyholders think through their decision by accounting for multiple factors—a statement directing a policyholder to reflect is unwarranted. Moreover, since the communication’s very purpose is to help policyholders manage a rate increase, we believe the question about empathy is ...

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Commented [A41]: BB & BC
Commented [A42]: BB & BC

Commented [A43]: ACLI: Since it is impossible to list ...

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Commented [A44]: CA: If the answer to the first is ...

Commented [A45]: BB & BC

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Commented [A47]: BC: I don’t understand how “now”...

Commented [A48]: BC: A term many consumers would ...

Commented [A49]: BC: High reading level.

Commented [A50]: BB: Is the number direct to ...

Commented [A51]: BB: Are customer service ...

Commented [A52]: MH: Might be worth consol...

Commented [A53]: MH: I’d hope so...is this to si...
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<th>34. Does the Insurer encourage consumers to consult with multiple sources to include any of the following: Financial planner, producer, state SHIP program, with the state-specific name of the program, or trusted family member?</th>
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<td>35. Does the Insurer encourage consumers to consult the Department of Insurance? Does it specify the Department can only give general information?</td>
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<td>36. Does the communication encourage consumers to consult with a tax advisor if the reduction options include a cash buy out or could cause loss of Partnership status?</td>
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<tr>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>UNDERSTANDING OPTIONS - PRESENTATION</td>
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<td>Page Reference and Filing Notes</td>
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<td>37. Does the communication have a clearly worded, descriptive title or subject line? For example: Your Long-Term Care Premiums Are Increasing.</td>
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<td>38. Are the options included with the rate increase notification communication? Is it clear that the policyholder can ask for additional options?</td>
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<td>39. Are the number of options presented reasonable (5-7 options)?</td>
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<td>40. Is the right to reduce coverage at any time at any time of a policyholder’s choosing clear? Are the instructions about how to do that clear?</td>
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<td>41. Is there enough information to make a decision? If other sources are referenced like videos, websites, etc. are they supplemental education materials or are they required sources to choose an option?</td>
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<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>UNDERSTANDING OPTIONS – PAST RATE ACTIONS</td>
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42. Does the communication include a statement that premiums may increase in the future? Is it clear that any future increase will include RBOs? Is a date shown when an insurer plans to file within a known time period, or when an insurer has already submitted a rate filing?

43. Does the communication include a 10-year nationwide rate increase history for this and similar forms?

44. Does the communication disclose the policy is guaranteed renewable and clearly explain guaranteed renewable?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>UNDERSTANDING OPTIONS – WINDOW OF TIME TO ACT</th>
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45. Does the communication indicate what the reader must do and the deadline to do it?

46. If options are only available during the decision window, is that limitation clear to consumers?

47. Does the communication address what happens if the policyholder does not send payment? For example, if no payment is received within 120 days, does the communication explain that Contingent Non-Forfeiture will apply and what that means?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>UNDERSTANDING OPTIONS – CURRENT BENEFITS</th>
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48. Does the communication include all the following information? Current policy benefits (daily benefit, elimination period, current

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Commented [A69]: BB & BC
Commented [A70]: MH: Are insurers supposed to include the 10-year nationwide rate increase history? I'm not sure that is relevant for the consumer and may be more of a distraction.
Commented [A71]: ACLI: Question 43 pertains to including a 10-year nationwide rate increase history in the RBO communication. This information could be pertinent to the decision to purchase coverage and is provided in the outline of coverage upon purchase of a policy. In contrast, the RBO communication focuses on the current change in premium, the policyholder’s options, and the potential for a future rate increase. Past rate increases vary widely due to prior state action and are not necessarily predictive of future increases. To avoid confusing policyholders or inadvertently influencing them to decide against their best interests... [27]

Deleted: renewal
Commented [A72]: BB & BC
Commented [A73]: CA
Commented [A74]: ACLI: We tweaked the word... [28]
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Deleted: that
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Commented [A75]: BB & BC
Commented [A76]: ACLI: We also amended que... [29]
Deleted: answer
Deleted: no payment is sent
Deleted: it advise
Commented [A77]: BB & BC
Commented [A78]: ACLI: We believe question 4... [30]
Commented [A79]: BB & BC
49. If current benefits have an inflation option, does the communication include the lifetime maximum benefit in dollars illustrated both five and fifteen years into the future?

Yes □ No □ N/A

50. Are the options presented available to the policyholder?

Yes □ No □ N/A

51. Does the communication contain descriptions of the consumer’s options (including changes in the daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)?

Yes □ No □ N/A

52. Does the communication prompt the policyholder to consider their personal situation, such as: current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need for institutionalized care?

Yes □ No □ N/A

53. Does the communication provide an unbiased resource(s) for policyholders to research the cost of care?

Yes □ No □ N/A

54. Do options clearly indicate value for consumers? Contingent Nonforfeiture (CNF) and other limited options clearly describe the reduction in value (benefit period)?

Yes □ No □ N/A

Commented [A80]: ACLI: We think question 49, which references inflation option illustrations, should be removed from the Checklist for a few reasons. First, not all policies have a lifetime maximum benefit in dollars. Second, any future projection included in the RBO communication could be construed as a promise of future benefits. Third, including inflation option projections could confuse and overwhelm a policyholder already comparing multiple RBOs. 

Commented [A81]: CA

Commented [A82]: BB & BC

Commented [A83]: MH: think this is missing a few words.

Commented [A84]: ACLI: We would like clarification on question 50. Will an insurer be able to refer to...

Commented [A85]: BB: I don’t understand this question. Why would some options not be available?

Commented [A86]: ACLI: Question 51, pertaining to descriptions of the policyholder’s RBOs, is duplicative...

Commented [A87]: BB & BC

Commented [A88]: CA: Is this question different than #48?

Commented [A89]: MH: Questions 50 and 51 seem like they have been already addressed above in terms of...

Commented [A90]: ACLI: We suggest a change of wording in question 52.

Commented [A91]: ACLI: We suggest a change of wording in question 52.

Commented [A92]: ACLI: Finally, question 53, which refers to providing an unbiased resource to...

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Commented [A93]: CA

Commented [A94]: BC: I don’t understand what this means.
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Notes</th>
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<tbody>
<tr>
<td>55. Is there a statement telling consumers how to contact the insurer for more information, to request the full list of options, or help understand their options?</td>
<td></td>
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<td>N/A</td>
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<td>56. Is there a prominent statement telling policyholders they can maintain their current benefits by paying the increased premium?</td>
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<td>N/A</td>
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<td>57. Do the options reflect the impact of removing or reducing the inflation option on the growth or reduction of future benefits?</td>
<td></td>
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<td>N/A</td>
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<td>58. If dropping inflation protection results in the loss of accumulated benefit amount, is that disclosed?</td>
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<td>N/A</td>
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<td>59. For phased-in increases, is there a table with all phase-in dates and premium amounts?</td>
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<td>N/A</td>
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<td>60. For phased-in increases, are there communications sent 45-60 days before each phase of the increase?</td>
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<td>N/A</td>
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<td>61. Does the communication disclose that all reduction options require careful consideration and are not of equal value?</td>
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<td>N/A</td>
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</table>
CA: Could we add an example of a rule that a regulator should be looking for?

BB: I’ve had experience with customer service reps in foreign countries with strong accents and little knowledge of options.

MH: What is this looking for? Is the suggestion that DOIs should be getting the customer service script for RBO conversations? Possible deletion.

ACLI: We find question 6 to be ambiguous and suggest removal, or clarification, without implying a new requirement regarding customer service operations.

ACLI: In question 11, removing the reference to 11-point type, but keeping the guidance that the communication be in “easily readable font” accounts for the additional impact formatting, layout, font, illustrations, bullet points, logos, etc. have on readability. Type size is just one element of many that make a communication easy to read and understand.

BB: Perhaps there should be some reference here to people with visual problems, size of text, color, formatting?

BC: Do the brackets indicate that a state that has different standards may change to match their standards? If so, a drafting note if needed.

BC: If these are the standards you are expecting, then perhaps the checklist should be edited. The statistics for it currently are 12th grade and a Flesch Reading Ease Score of 32.

ACLI: The Flesch reading ease score in question 15 implies a specific, new requirement. For this reason, and because the question is redundant with questions 8 through 14, which establish readability, we recommend question 15 be removed entirely.

ACLI: Amending question 16 to simply ask, “Are the RBOs clear and not misleading?” without implying a specific side-by-side format gives insurers greater flexibility in presenting information, unique to their business, as plainly as possible.

ACLI: To both simplify and clarify questions 25 and 26, as well as the actual RBO communication, we recommend these questions read:
“25. Does the communication clearly explain how the consumer may elect an option? Does the election documentation allow the consumer to clearly indicate his or her choice? 26. Does the communication clearly explain that the consumer is not being singled out for the increase?”

As written, question 26 suggests the communication attempt to explain class basis, a technical concept. The goal is to let policyholders know they are not being singled out for an increase and our edits would help to emphasize this.

ACLI: Question 27, which asks whether the communication reminds consumers to reflect on why they may have purchased the policy, is both subjective and prescriptive. Question 28, which asks whether the communication expresses empathy, is the same. Because all other items in the Checklist will help to ensure policyholders think through their decision by accounting for multiple factors—a statement directing a policyholder to reflect is unwarranted. Moreover, since the communication’s very purpose is to help policyholders manage a rate increase, we believe the question about empathy is both needless and overly subjective. Whether or not a communication expresses empathy is open to interpretation. The goal is to help. The more helpful a communication is—the more empathetic is it likely to be perceived.

ACLI: Since it is impossible to list all RBOs in one communication, we suggest question 30 simply read, “Are examples of the reduced benefit options represented fairly?” To avoid overwhelming or confusing policyholders, some options will likely not be in the communication, but accessible by contacting the insurer directly, or elsewhere, as the insurer directs. Insurers can discuss specific options available to a policyholder, while accounting for a policyholder’s personal situation and current benefit levels. We want to ensure that regulators do not then conclude that the RBOs included in a communication are unfairly presented, while those RBOs that policyholders access outside the communication are unfairly de-emphasized.

CA: If the answer to the first is “yes,” the answer to the second is likely to be “no,” so this doesn’t work well with the yes/no checklist.

BC: I don’t understand how “now” is an alternative to “must.”

BB: A term many consumers would not understand.

BB: Is the number direct to consumer service and individuals who can answer specific questions? The phone number should not consist of a lengthy phone tree that is difficult for consumers to navigate.

BB: Are customer service representatives located in other countries screened for their ability to clearly communicate with elderly policyholders who may have hearing difficulties, difficulty with heavy accents, unable to process fast speech?
MH: Might be worth consolidating with question 29.

MH: I’d hope so...is this to suggest that the filing team should test the website addresses and phone numbers? Is that what we typically do with other filings?

Page 7: [21] Commented [A58]   Author
ACLI: We recommend question 35 be reworded to refer generally to any required government resources. Resources differ, depending on the state. Departments of insurance have varying policies about information or guidance they are willing to provide in the event of a rate increase.

Page 7: [22] Commented [A60]   Author
MH: Might be worth consolidating with question 34.

Page 7: [23] Commented [A61]   Author
MH: s 7 options "reasonable?" I think 5 or fewer is more appropriate.

ACLI: Depending on the insurer, type of policy, and many other factors, it is possible policyholders could have dozens of RBOs. Including explanations for even 5 to 7 RBOs, as the Checklist suggests in question 39, is likely to be overwhelming and confusing to policyholders trying to decide amongst them. Consequently, we believe it is preferable to remove the reference to a specific number of RBOs and use "reasonable" as the guideline.

BB: Some insurers may offer 2 or 3 options. Is 5 a required number of RBO’s to be offered? Seven seems an excessive number of options and would be hard to compare the value of each one. The highest number of RBO’s I’ve seen offered is 5 through a court ordered settlement.

Page 7: [26] Commented [A65]   Author
ACLI: Question 40, referring to the right to reduce coverage at any time, ought to be removed entirely. Not all options are available at any time, some have time limits, and sometimes policyholders have the lowest level of benefits possible, based on a state’s minimum benefit standards, with no option to reduce further. Also, RBOs might not be offered to policyholders currently on claim. Additionally, question 40 is redundant with questions 45 and 46, which already address deadlines.

Page 8: [27] Commented [A71]   Author
ACLI: Question 43 pertains to including a 10-year nationwide rate increase history in the RBO communication. This information could be pertinent to the decision to purchase coverage and is provided in the outline of coverage upon purchase of a policy. In contrast, the RBO communication focuses on the current change in premium, the policyholder’s options, and the potential for a future rate increase. Past rate increases vary widely due to prior state action and are not necessarily predictive of future increases. To avoid confusing policyholders, or inadvertently influencing them to decide against their best interests, we strongly recommend question 43 be removed entirely.

Page 8: [28] Commented [A74]   Author
ACLI: We tweaked the wording in question 45 to make it clearer.
ACLI: We also amended question 47 to improve accuracy and account for differences in policies and state laws. We recommend the question read, “Does the communication indicate what happens if no payment is received? For example, if the policy lapses within 120 days, does it advise Contingent Benefit Upon Lapse will apply, if applicable?” Contingent benefit upon lapse (CBUL) is more accurate in this instance than “contingent non-forfeiture.” Additionally, it’s important to note that CBUL is not applicable for all forms in all states. In some states, CBUL is only effective for policies issued after a certain date or is not an option at all.

ACLI: We believe question 48 should be edited to allow insurers to either include, or direct the policyholder to, helpful information. An RBO communication that includes all benefit-related information could easily become unwieldy, lengthy, and confusing. Directing a policyholder to a website or some other resource would likely be the more manageable and effective option.

ACLI: We think question 49, which references inflation option illustrations, should be removed from the Checklist for a few reasons. First, not all policies have a lifetime maximum benefit in dollars. Second, any future projection included in an RBO communication could be construed as a promise of future benefits. Third, including inflation option projections could confuse and overwhelm a policyholder already comparing multiple RBOs. And finally, a general illustration does not account for critical elements such as whether some benefits had previously been received, the policyholder’s location at the time of receiving benefits, cost of care when benefits are received, additional policy terms, etc.

ACLI: We would like clarification on question 50. Will an insurer be able to refer to options that may be applicable to an individual policyholder?

BB: I don’t understand this question. Why would some options not be available to a policyholder? In some cases an insurer may offer various options connected to a policy form depending on the benefits of each insured, i.e., lifetime benefits or limited durations, various forms of inflation protection. Is the instruction trying to say that an insurer can’t use one form with all the options connected to a policy form, some of which are not available to certain policyholders?

ACLI: Question 51, pertaining to descriptions of the policyholder’s RBOs, is duplicative of questions 30 and 39 and should be removed.

MH: Questions 50 and 51 seem like they have been already addressed above in terms of the presentation and readability of options. Worth considering some consolidation.
ACLI: Finally, question 53, which refers to providing an unbiased resource to research cost of care, should be removed. An insurer cannot ensure an unbiased resource exists, nor can cost of care be predicted since it is heavily dependent on location and timing of benefits, both uncertain.

ACLI: We recommend question 54 be amended to remove the reference to value and to read, “Are the resulting benefits from each presented option clearly explained?” The question could be interpreted to mean general value or monetary value. The concept of value is too subjective to be a guideline. Perception of value differs depending on the personal circumstances of each individual policyholder, including their current age, health conditions, financial position, availability of caregivers, spouse/partner considerations, etc. Further, assessing value on behalf of policyholders could constitute steering. The communication should be objective, thereby aiding policyholders to make decisions in their best interest.

ACLI: We also recommend question 60 be amended to accommodate a wider range of deadlines to send communications prior to a rate increase because states’ time frames can differ quite a bit.

ACLI: Lastly, the language in question 61, “Does the communication disclose that not all reduction options are equal in value?” is problematic. The same reasons we give for changing question 54 apply here. The concept of value is too subjective to be a guideline. Further, the entire communication, in addition to any supplemental information the insurer may direct the policyholder to consider, will demonstrate the differences between, and consequences of choosing, each RBO. For these reasons we advise deleting question 61.
Issues related to LTC wellness benefits

First draft, work in progress – 7/22/2021

Background:

Stand-alone long-term care insurance is a unique industry, in that higher-than-expected claims’ costs have resulted in substantial rate increases for consumers and financial losses and in some cases solvency concerns for insurance companies.

Technology firms are developing approaches that could be used by insurance companies to potentially prevent or lower the severity of LTC claims and improve health outcomes in a space called “LTC wellness”. Examples of these early interventions include:

- Fall prevention programs;
- Home modification consultations, analysis and implementation to facilitate aging in place;
- Caregiver support programs for both formal and informal caregivers;
- Next generation care coordination services;
- Technological solutions aimed at improvements in cognitive impairment prevention and early diagnosis.

In light of systemic, LTC-related financial challenges, insurance companies, insurance regulators, and tech firms are interested in working together to explore some of these claim cost-reducing innovations. Here are some potential barriers to increased adoption of these new approaches and how those barriers could potentially be addressed, with details provided below the list:

1. Analysis of effectiveness
2. Unfair discrimination
3. Consumer confusion
4. Rebating
5. Tax considerations
6. Regulatory role in approving or evaluating LTC wellness approaches
7. Actuarial considerations
8. Data privacy
9. Other considerations
Details:

1. Analysis of effectiveness
   a. Issue: in light of the lag time between policyholder age during LTC wellness efforts and policyholder age when claim incidence becomes more common, what issues arise from insurers' lack of knowledge of effectiveness of LTC wellness programs in reducing claim costs, and how can those issues be addressed?
      i. The cost of innovation efforts, with no guarantee of any returns, may dissuade some insurance companies from pursuing these programs.
         1. Expenses are typically upfront and significant.
         2. The financial impact on claims cost is typically unknown and down the road.
      ii. Designing pilot programs is difficult because there is such a variety of programs available, and each block of LTC insurance policies has unique characteristics that might influence the effectiveness of a given program.
      iii. Some companies are concerned about regulatory reaction to these changes.
   b. Current observations
      i. Industry representatives described some current or likely upcoming LTC wellness efforts at the May 4, 2021 NAIC Reduced Benefit Option Subgroup meeting. A theme was that there is great supply and demand for LTC wellness innovation efforts.
      ii. Some insurance companies are exploring or implementing pilot programs. Very early signs on the effectiveness of interventions on impact on policyholder health and claim costs are promising, but data development is slow and it is difficult to implement control trials.
         1. Insurance companies are eager for data and for ways to effectively share data within the legal and regulatory framework so that the industry can effectively respond to positive policyholder experiences and discontinue any programs that fail to make an impact.
      iii. Because there is little competition in the stand-alone LTC insurance market, due to the financial losses accumulated and many insurance companies exiting the actively selling market, sharing of ideas between companies on management of active policies may be possible, although care should be taken regarding anti-trust issues.
   c. Addressing of Issues
      i. Lack of data: With most LTC wellness programs being under-developed or being implemented recently, data is lacking on the extent to which resulting claim cost decreases offset the costs of the programs.
      ii. How to measure health impact: Whether an LTC wellness program effectively reduces claim costs or not, will there be approaches established to measure health benefits to policyholders?
iii. Data sharing: Facilitating the sharing of data, between vendors and insurance companies, and perhaps involving public programs such as Medicaid, is a key element of analyzing effectiveness.

d. Next steps
i. Regulators engage with insurance companies to learn of recent developments.
ii. Research public programs’ data on effectiveness of LTC wellness programs to see if Medicare Advantage, Med Supp, or Medicaid / PACE data is available, relevant, and used.
iii. Determine an approach to monitor success of programs. For example, if 3 to 4 companies are applying 3 to 4 pilot programs and finding success, it would be good news regarding broader, future efforts.
   1. Facilitate the sharing of general results (i.e., not individual policyholder data) among those insurance companies in a way that is within the legal and regulatory boundaries.
iv. Regulators ensure capital supporting LTC liabilities is adequate under a range of scenarios, including one where claims costs continue to increase.

2. Prevention of unfair discrimination related to extra-contractual benefits and costs
   a. Issue: how does an insurer offer a wellness initiative that is not unfairly discriminatory to discrete populations within the broader group of policyholders?
   b. Current observations
      i. There may be state anti-discrimination and bias-related legal issues to address if certain policyholders are targeted, including through Big Data, to receive extra benefits.
         1. For instance, if older policyholders have less of an online footprint than younger policyholders, how would this impact the accuracy of the targeting of LTC wellness benefits or otherwise introduce bias?
         2. [Birny Birnbaum May 4 comment]: If wellness or other efforts to address specific conditions are based on age or the health of the policyholder, this seems like normal value-added products and services for loss prevention and not an example of unfair discrimination.
   a. Issues to address are likely related to creating a clear framework for compliance related to the use of data analytics and artificial intelligence.
   c. Addressing of issues
      i. Equality: How policyholders are offered wellness initiatives could be unfairly discriminatory.
         1. Policyholders of “the same class and of essentially the same hazard” must be treated equally. See NAIC Model Unfair Trade Practices Act (#880) (“Model Law”).
2. How may an insurer “classify” policyholders post underwriting?
   a. What is fair? The insurers will need to provide justification.
      i. For example, under the Model Law the availability of the value-added product or service must be based on documented objective criteria and offered in a manner that is not unfairly discriminatory.
   b. May classification be made by jurisdiction? Does that impact the LTC Multi-State Actuarial Rate Review (MSA) program’s overarching goals?
   c. May classification be made by product form?

ii. Selection: How policyholders are selected for wellness initiatives could be unfairly discriminatory.
   1. Wellness initiatives may be costly to the insurer. How can an insurer test it to validate the benefits before rolling it out more broadly?
      a. Under the Model Act, the insurer may provide the product or service in a manner that is not unfairly discriminatory as part of a pilot or testing program for no more than one year.
   2. Would a random selection of policyholders be unfair?
   3. Should policyholders be given the option to participate in a wellness initiative?
      a. Must all policyholders be given the option to participate?
   4. How much time/data is needed to prove the initiative is valuable?
   5. Prior to offering a wellness program, an insurer should have a logical hypothesis of what benefits could be derived from the program.

iii. Accessibility: How a wellness initiative operates could be unfairly discriminatory.
   1. Does it limit who can participate based on the medium? For example:
      a. Does it require access to a computer or internet for online participation?
      b. Does it require access to a smart phone, texting minutes, etc., to use an app?
      c. Does it require access to roads, pools, sidewalks?
   2. Does any such limitation require alternatives for those unable to participate in the initiative?

iv. Uniformity: If guidance is issued on wellness initiatives, how would states adopt the guidance, especially if states have different standards for allowing wellness programs in LTC insurance?
   1. Have all states adopted the Model Law? If not, what have hurdles been for states that have not adopted the model? Will states adopt updates to the Model Law?
   2. Standards for unfair discrimination, including in the specific context of wellness initiatives, may vary by state requiring insurers and regulators to be aware of the specific requirements of the jurisdiction in question.
a. For example, Alaska permits rewards under wellness programs but requires that the reward be available for “all similarly situated individuals.” See AK Stat § 21.36.110.

3. If some states allowed wellness initiatives and not others, would this conflict with other initiatives, such as the MSA?

d. Dependencies
i. Unfair discrimination guidance needs to consider other wellness initiative issues that include:
1. Analyzing Effectiveness
2. Actuarial Impacts
3. Rebate Standards and Limitations
4. Regulatory Evaluation

e. Next steps
i. Regulators and interested parties discuss the issues noted above, including whether the use of Big Data to predict risks (of e.g., falls or dementia) and offering benefits and services only to those targeted as high risk would cause concerns regarding discrimination.

3. Consumer confusion
a. Issue: potential consumer confusion concerning LTC wellness programs will be highly variable dependent upon factors such as the nature of the program, the consumers involved, and the complexity of regulatory issues.

b. Addressing of issues:
1. Wellness programs with simple to understand direct connections to prevention of common medical issues (e.g., installing a grab bar) will provoke far less confusion than more esoteric programs based on new technological services (e.g., data collection/monitoring of insured activities) with not yet proven results. Simpler programs may also trigger fewer and less complex regulatory/statutory requirements related to privacy, consent, disclosure, etc. resulting in programs that will be more easily understood and documented. Programs with newer technology, more data collection and manipulation, and which are connected to more complex care issues will be more confusing and will trigger more complicated regulatory/statutory requirements.
   1. In these scenarios, there may be a need to first educate consumers on the technology and the data collection/usage and then the program and its potential benefits before disclosure and informed consent can occur. The ability to prevent confusion and achieve adequate education and understanding may be further impacted by the level of technological sophistication and mental acuity of the consumer, factors which often decline with age.
ii. Designing effective communication regarding insurer LTC wellness programs will require in-depth engagement with LTC consumers, policyholders, family members, eldercare subject matter experts, and NAIC consumer representatives. When the vetting group engages with Medicaid programs, PACE, etc. to learn about best practices in wellness programming, the vetting group should take the opportunity to learn about the successes and failures in communication used in implementing these programs, including any relevant focus group data available.

iii. In addition to engaging with Medicaid and PACE, the following organizations may have valuable insights: National Council on Aging (www.ncoa.org), AARP (www.aarp.org), and the National Institute on Aging (www.nia.nih.gov). In addition to engaging with NAIC representatives and these national organizations, the Vermont team would also propose to reach out to Vermont’s sister agencies in state government (The Agency of Disabilities, Aging, and Independent Living (DAIL), and the Agency of Human Services, (AHS)). Lastly, Emily Brown serves on the board of directors for Central Vermont Home Health and Hospice. Engagement with this local group may provide rural eldercare perspectives missing at the national level.

iv. Focus groups designed to elicit feedback on communication style are most helpful when the programming has been determined. In the alternative, guidelines for communication and disclosure designed to minimize confusion and maximize understanding would need to be developed along a spectrum of wellness programs of increasing complexity. The results of vetting group work around rebating, program effectiveness, data privacy, loss of tax-preferred status, and discrimination concerns will determine components of what needs to be tested in focus groups. For instance, if the loss of tax-preferred status is something the vetting group can address at the federal level, it will not need to be considered when determining barriers to effective communication.

v. Building consensus around terminology and building trust are essential to effective communication. In a Medicaid setting, the PACE program (Programs for All Inclusive Care for the Elderly), wellness efforts include a multidisciplinary team of health professionals coordinating care and no cost share on services. (Source: https://www.medicaid.gov/medicaid/long-term-services-supports/pace/programs-all-inclusive-care-elderly-benefits/index.html) This builds trust through human contact with medical professionals.

1. This type of communication is vastly different than the communication between an insurer and a long-term care policyholder facing a rate
increase, where participation may have some impact on the premium rate increase the consumer must pay. As a result, extra care will need to be taken to ensure policyholders truly understand the offer and the level of participation required and that they do not acquiesce based on confusion or because they feel they have no other choice.

vi. As the wellness vetting subgroup works through the issues (program effectiveness, discrimination, data privacy, and tax considerations), the Vermont team hopes to build on the conversations planned with subject matter experts in eldercare programming. The vetting group should plan to add time at the end of the process to explore and understand the vetted programs with consumers via focus group(s) to best anticipate and mitigate consumer confusion.

4. Rebating
   a. Issue: whether some long-term care wellness benefits for policyholders run afoul of the NAIC Model anti-rebating laws or are otherwise prohibited. Those wellness plans may be designed to prevent or lower the severity of LTC insurance claims or to improve health outcomes (“Wellness Initiative”).
   
   b. Addressing issues:
      i. **NAIC Model Law.** The recently amended version of the NAIC Model Unfair Trade Practices Act (#880) ("Model Law") explicitly exempts the type of Wellness Initiatives currently being considered from the prohibition on rebates as an unfair trade practice. Specifically, § 4 (H)(2)(e) of the Model Law excludes from “the definition of discrimination or rebates . . . [t]he offer or provision . . . of value-added products or services at no or reduced cost,” even “when such products or services are not specified in the policy of insurance,” if the product or service meets certain requirements. Amongst procedural requirements, the Model Law requires that the product or service (a) relate to the insurance coverage, (b) be “primarily designed to satisfy” one of nine functions, including providing loss mitigation, reducing claim costs, enhancing health, and incentivizing behavioral changes, and (c) cost a reasonable amount in comparison to premiums or coverage. As the Wellness Initiatives in question would be designed to prevent or lower the severity of LTC insurance claims and improve health outcomes, as long as their cost is reasonably related to the premiums or coverage, then they should not be considered rebates under the recently amended Unfair Trade Practice Act.
      
      ii. **Variations in State Law.** The above cited language from the Unfair Trade Practices Act, § 4 (H)(2)(e), however, is a recent December 2020 addition to the Model Law. As such, most states have yet to specifically address that update and have only
enacted a prior version of the Unfair Trade Practices Act. Unfortunately, the old language of the Model Law was less flexible on this point, which led a number of states to carve out exceptions by individual amendments, regulations, bulletins or desk drawer rules. And the Unfair Trade Practices Act is not the only model law with language prohibiting rebates in the business of insurance. As such, it is much less certain whether the Wellness Initiatives at issue would trigger the law’s anti-rebating provision. And the many state initiatives in this area do not permit a uniform analysis of rebating in each adopting jurisdiction as the precise language, interpretation, and application of the law varies by state.

1. As a result, whether Wellness Initiatives could arguably be considered a rebate remains a question subject to the specifics of each individual state’s rebating law and how each jurisdiction has interpreted and applied that law. To provide a few examples of the variations in state law, even amongst states that have adopted the prior Model Law:
   a. **Alaska**: Statutorily excludes “a reward under a wellness program established under a health care plan that favors an individual” from the definition of rebates so long as seven requirements, including the program being designed to promote health or prevent disease, are met. See AK Stat § 21.36.110.
   b. **Maine**: Statutorily permits provision of a value-added service that is related to the coverage provided by an insurance contract, without fee or at a reduced fee, if it is (a) included within the insurance contract, (b) directly related to the servicing of the insurance contract, or (c) offered to provide risk control for the benefit of a client. See Me. Stat. tit. 24-A, § 2163-A.

2. Thus, under the current legal landscape, those seeking to introduce Wellness Initiatives would need to confirm whether such an initiative would be permissible under each relevant jurisdiction’s rebating law and if there are any state specific requirements for offering such an initiative.

iii. **Trends in State Law.** Notwithstanding the variation in individual state’s laws and if and how they have been amended or interpreted, there does appear to be a general trend that “services are not prohibited if they are directly related to the insurance product sold, are intended to reduce claims, and are provided in a fair and nondiscriminatory manner.” J. Parson, D. Marlett, S. Powell, *Time to Dust Off the Anti-Rebate Laws*, 36 J. Ins. Reg. 7, at 8 (2017). Under this general approach, which aligns with the substantive result of the language in the current Model Law, a Wellness Initiative should not be prohibited as impermissible rebating.
iv. Policy Considerations. The exemptions in the current Model Law and the trend amongst states to permit certain services even if they are not contained within the insurance contract appear to be logical limitations on the scope of anti-rebating statutes. In short, Wellness Initiatives are not the type of conduct that anti-rebating statutes were originally designed to protect consumers against. This is particularly true in the context of LTC insurance where consideration of these initiatives only began significantly after the policies were initially sold, and moreover where the policies have proven to be unprofitable for the insurers. In other words, it is fair to assume that Wellness Initiatives in this context are not being used to either induce the policyholder to enter into the insurance contract, nor to expand the insurer’s share of the LTC insurance market. Rather, they are targeted at improving policyholder health and reducing the frequency and severity of claims.

v. Conclusion. Given the current legal landscape with respect to rebating, to facilitate the success of Wellness Initiatives jurisdictions could either (a) adopt the recently added rebating exemptions found in the current version of the Model Law, which would explicitly permit such initiatives, or (b) take action to interpret and apply their existing laws in a manner that would allow the provision of products or services that are directly related to the insurance policy in question and designed to reduce claims or improve health. Absent adoption of the current version of the Model Law, however, insurers would need to conduct a state-by-state evaluation of rebating laws in all relevant jurisdictions before implementing a Wellness Initiative.

5. Tax considerations
   a. Issue: will non-ADL / non-cognitive benefits cause tax issues for policyholders?
   b. Current observations
      i. There may be tax consequences for consumers if benefits outside the federal definition of LTC benefits are provided, but this may depend on whether initial investment in programs is paid for out of general company expenses or from the benefit pool.
   c. Addressing issues: [section to be drafted]
   d. Next steps:
      i. Engage with the federal government and insurance industry tax experts to work out potential IRS/tax issues.

6. Regulatory role in approving or evaluating LTC wellness approaches
   a. Issue: there is question as to whether LTC wellness approaches need to be approved by regulators or will be implemented by companies and later evaluated by regulators.
b. Current observations:
   i. There is little regulatory clarity or uniformity regarding LTC wellness programs.
c. Addressing issues [section to be drafted]
d. Next steps
   i. Analyze flexibility in existing laws that would allow for innovation that could potentially result in better health for policyholders and lower claims costs for insurance companies.
   ii. Because LTC insurance is in a desperate situation in some cases regarding solvency and rate increases, explore a regulatory sandbox approach regarding LTC wellness innovations.
   iii. Explore whether a company’s commitment towards innovation efforts could be a contingency to receiving a fully actuarially justified rate increase.

7. Actuarial considerations
   a. Issue: how are actuarial issues such as valuation, rate increase reviews, and reasonable value of benefits and options impacted by LTC wellness benefits?
   b. Current observations
      i. Although health outcomes can be expected to improve, to some extent, with LTC wellness programs, it is unclear how future claim costs will be impacted in comparison to the investment in the programs.
      ii. As data emerges, actuarial issues related to the impact of LTC wellness benefits on future claim incidence and severity, could impact rate increases and reserves.
   c. Addressing of Issues
      i. Valuation: Under moderately adverse conditions, as data emerges, future cash flows associated with LTC wellness programs and potential claim cost reductions resulting from the programs may be incorporated into reserve adequacy testing, including Actuarial Guideline 51 stand-alone long-term care analysis, per actuarial standards of practice.
      ii. Rates: As data emerges, future cash flows associated with LTC wellness programs and potential claim cost reductions resulting from the programs may be incorporated into lifetime loss ratio projections associated with rate-increase filings, per actuarial standards of practice.
      iii. The NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation and NAIC Health Actuarial Task Force-adopted Consolidated, Most Commonly Asked Questions - States’ LTC Rate Increase Reviews document suggest that consistency between rate increase assumptions and reserve adequacy assumptions (noting reserve adequacy assumptions may include a margin to account for moderately adverse conditions) may be expected by some regulators.
iv. Reasonable value: The Long-term Care (EX) Task Force has tentatively established guidance that reduced benefit options in lieu of rate increases should provide reasonable value in comparison to the economic value of maintaining benefits and paying the increased premium. To the extent that LTC wellness benefits are tied into reduced benefit options, the holistic concept of reasonable value will likely be a consideration.

d. Next steps
   i. Determine the NAIC venue to work through LTC wellness actuarial issues.

8. Data privacy
   a. Issue: utilization of consumers’ data for wellness initiatives can be used to develop the marketing strategy and a specific wellness initiative, as well as to analyze the impact or effects of a wellness initiative. The use of data to develop the target demographic for new sales, the selection of the existing consumers for wellness initiatives, or to determine the results of the initiative, could result in an insurer or third party data vendor using the data in a way that could be unethical, discriminatory, confusing, or otherwise problematic.
      i. With many of the tech advancements, data on the policyholder would be accessed to, e.g., help identify warning signs of risks such as falls and early-stage dementia.
   b. Current observations
      i. The standards applied by insurance companies and tech firm vendors to ensure certain levels of privacy are generally unknown.
      ii. There are lessons from other types of insurance on the types of privacy-related issues that may develop.
      iii. There are cases, and perhaps a trend, of programs/interventions being implemented without utilizing significant amounts of policyholder personally identifiable information.
   c. Addressing of issues
      i. Data Use to Identify Wellness Initiatives:
         1. Policyholders considerations:
            a. Confusion about why they are being solicited for the initiative.
            b. Suspicion about the motivation of the insurer.
            c. General lack of awareness that data is being collected, and what data is being collected.
            d. General lack the awareness or understanding on how data is collected and used.
            e. Will they know if their data was used to determine a specific wellness initiative for them versus being selected as part of a class of policyholders?
            f. Will the policyholder know what data is going to be used prior to participation?
g. Should the policyholder have the option to “opt in/out” of their data being used internally for other initiatives or for external sale or use?

2. Insurer considerations:
   a. Should insurer communications include why a wellness initiative is being offered; including what data is being used?
   b. Should insurers purchase data regarding their policyholders (e.g. data that shows specific policyholders may have a near term claim - purchasing canes, grab bars, electronic fall detectors, etc.)?
   c. How should wellness initiatives be marketed to a policyholder? Insurers may need to limit what is advertised on the envelope, postcard, etc. due to HIPAA concerns.
   d. Should insurers partner with vendors or service providers to supply specific policyholder data to the wellness company? What data should be sent? How will the data be transferred?
   e. Should insurers focus their data on policyholder specific needs and only offer services relevant to the ongoing needs?
   f. How are opt in/out options, disclosures, etc. being shared with the consumer? Email, letter, text, etc. Is it appropriate to the policyholder’s needs or preferences?
   g. When using third party data providers, what screening or data protection programs are in place?

ii. Data Use During Wellness Initiative Development:
   1. Should insurers purchase policyholder specific information from third party data sources?
      a. Data collected during purchases, search history, television programming, etc.
      b. Should it always be headless, anonymized, or deidentified?
   2. When considering big data, are there unacceptable “correlations”? How will insurers recognize relevant correlations vs irrelevant statistically significant correlations?
   3. Are there data use standards, controls, definitions of personal data, or a data privacy review body in place to ensure the data is used, stored, or shared ethically?
   4. When evaluating the data for wellness initiatives, will it focus on policyholder specific information – for example, will the policyholder’s claims detail or demographic factors determine the type of wellness initiative offered to that policyholder?
   5. Will the risk of a data breach be assessed and protected against by the insurer as well as all vendors or third-party data suppliers?
6. Does the insurer have procedures in place to notify the policyholders of a potential breach?

iii. Wellness Results Data Use:
1. Should the results be sold? Aggregate vs specific demographic information?
2. Should insurers use the results internally for cross marketing other wellness initiatives?
3. Should the policyholder be notified and have the option to “opt in/out” of letting the insurer use the data?
4. Should the results be shared with the policyholder, POA, third party notifier? What guardrails should be in place relative to that sharing?
5. How should the data be shared, if at all, with other vendors or service providers?
6. How long will the data be retained? Will the data be destroyed or disposed?

d. Dependencies
   i. Unfair Discrimination

e. Next steps:
   i. Reach out to experts in the health insurance and Medicare Advantage, Medicare Supplement, or Medicaid / PACE areas to learn from their experiences.
   ii. Identify applicable state privacy laws and HIPAA anti-marketing restrictions.
   iii. Require insurance companies to provide information on privacy protection matters when claims management processes are established.
   iv. Determine if policyholder approval of use of expanded data can be established at certain points in time:
      1. At times of options in lieu of rate increases, can insurance companies get agreement to attain more policyholder data?
   v. Can new contracts be written with evergreen access to some private data?

9. Other considerations
   a. Issue: other legal or market and administrative issues may come into play as LTC wellness programs are established.
   b. Current observations
      i. There are dozens or hundreds of cutting-edge technological advancements being developed to help with aspects of LTC claims management.
         1. It is difficult for insurance companies and regulators to determine which tech advancements are most promising in terms of likelihood of success and degree of impact on consumer health and reducing claims cost.
ii. TPAs or reinsurers used by direct-writing insurance companies may be resistant to administering these additional activities or may be concerned about potential legal ramifications that could impact their firms.

iii. Insurers could potentially be subject to requirements if a policyholder, e.g., is identified as having cognitive impairment and therefore be a risk related to driving or finances.

c. **Addressing issues [section to be drafted]**

d. **Next steps**

i. Determine if there is objection to an insurance company offering an extra-contractual wellness benefit that is not tied to loss ratio / benefits / contracted obligations, i.e., out of expenses?

ii. Determine if benefits offered outside the contract could be considered in a similar category as because a reduced benefit option in lieu of a rate increase, which is essentially a mutually-agreed-to restructuring of the insurance contract.

iii. Either identify or ensure industry members are identifying requirements related to disclosing, e.g., when a policyholder has cognitive impairment and may be a high-risk driver.

iv. Regulatory guidance may help innovators engage in this space.
Executive Summary – Key Takeaways

1. LTC rate increase approval disparities exist between states.

2. Premium inconsistencies exist among states as premium per policy varies greatly. Average premium ranges from $1,755 - $3,656, despite similar benefit distributions.

3. The cost of long-term care services does not appear to be the primary predictor of a state’s LTC claim experience.

LTC Data Call Agenda

<table>
<thead>
<tr>
<th>Executive Summary</th>
<th>Takeaways on the current level of rate differences among state policyholders from the analysis performed on data collected from 19 carriers across 50 states.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope</td>
<td>Data Collection Analysis</td>
</tr>
<tr>
<td></td>
<td>Cumulative Approved Rate Increase Rate Increase Approvals Cost of Care</td>
</tr>
</tbody>
</table>

Executive Summary – Key Takeaways

<table>
<thead>
<tr>
<th>Question</th>
<th>Are LTC rate approvals consistent by state?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome</td>
<td>Evidence suggests inconsistent rate approval levels by state</td>
</tr>
<tr>
<td>1.</td>
<td>Data from 19 carriers and 50 states</td>
</tr>
<tr>
<td>2.</td>
<td>About 1/3 of industry</td>
</tr>
<tr>
<td>3.</td>
<td>1,560+ approved rate increases</td>
</tr>
</tbody>
</table>

See Cumulative Approved Rate Increase section for further detail.
Executive Summary – Key Takeaways

**How much premium is attributable to rate increases?**

**Outcomes:**
- Illustration uses actual rate increases and a theoretically level nationwide original premium.

**Question:**
How much premium is attributable to rate increases?

**Outcome:**
- Illustration uses actual rate increases and a theoretically level nationwide original premium.

**Supporting Documentation**

See Data Collection section for support and further detail

---

Executive Summary – Key Takeaways

**Are premium levels for inforce policies consistent?**

**Outcomes:**
- Evidence suggests consumers are paying different premiums by state, despite similar benefit structure distribution.

**Question:**
Are premium levels for inforce policies consistent?

**Outcome:**
- Evidence suggests consumers are paying different premiums by state, despite similar benefit structure distribution.

**Supporting Documentation**

See the Cost of Care section for further detail

---

Executive Summary – Key Takeaways

**Does the cost of LTC services in a state drive insurance experience?**

**Outcomes:**
- The cost of a nursing home does not appear to be a primary predictor of state LTC experience.

**Question:**
Does the cost of LTC services in a state drive insurance experience?

**Outcome:**
- The cost of a nursing home does not appear to be a primary predictor of state LTC experience.

**Supporting Documentation**

See the Cost of Care section for further detail

---
Outline of purpose and goal of NAIC Workstream #6.

Executive Summary
Scope
Data Collection
Analysis
Cumulative Approved
Rate Increase
Rate Increase Approvals
Cost of Care

LTC Data Call Agenda

Purpose Of Documentation

- This report summarizes and analyzes the data collected from all carriers for their most rate increased blocks. Data for carrier’s largest blocks was collected and reviewed, but not used in the analysis herein.
- State specific experience is compared against nationwide averages for the following:
  - Number of rate increase approvals
  - Cumulative approved rate increase amount
  - Lifetime loss ratios
  - Cashflows including impact of rate increases on lifetime earned premium
  - Cost of Care

Project Scope

- Assist the NAIC Long-Term Care Insurance Task Force and with the help of and under the authority of the Virginia Bureau of Insurance, with facilitating a Long-Term Care Information Data Call with respect to a designated group of long-term care insurers in order to accumulate, analyze and describe to Commissioners the current level of rate differences among state policyholders.

Summary of data collected as well as inforce statistics on both the largest blocks and most rate increased blocks of business as collected in this Data Call.
19 Insurers have submitted data for their most rate increased blocks as well as largest blocks, if different. Data collected includes 27 LTC blocks of business. 
- Over 2.5 million inforce policies provided (about 1/3 of industry). 
- Over 3,500 approved rate increases. 
- Approximately $50 billion of active life reserves. 

The information and analysis contained in this report are based on this collected information. No external information was used to support this analysis with the exception of the 2019 Genworth Cost of Care Survey.

### Inforce Statistics

<table>
<thead>
<tr>
<th></th>
<th>Most Rate Increased Blocks</th>
<th>Largest Blocks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Attained Age</td>
<td>74.8</td>
<td>70.0</td>
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<tr>
<td>Range: 72.7–76.8</td>
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<td>Range: 68.6–72.6</td>
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<tr>
<td>Average Inforce Policy Count</td>
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<td>Range: 1.5e–136.7k</td>
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<td>Range: 2.3e–67.3k</td>
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<tr>
<td>Average Inforce Annual Premium</td>
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<td>Range: $1,705–$3,656</td>
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<td>Range: $948–$3,174</td>
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<tr>
<td>Average Lifetime Loss Ratio w/o Rate Increases</td>
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<td>120.0%</td>
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<td>Range: 117.3%–174.5%</td>
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<td>Range: 96.2%–153.1%</td>
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<tr>
<td>Average Lifetime Loss Ratio w/ Rate Increases</td>
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<td>100.6%</td>
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<td>Range: 97.3%–158.8%</td>
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<td>Range: 78.2%–140.0%</td>
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<tr>
<td>NW Present Value of Historic Earned Premium*</td>
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<td>$67.3B</td>
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<td>NW Present Value of Historic Incurred Claims</td>
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<td>NW Present Value of Future Earned Premium*</td>
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<tr>
<td>NW Present Value of Future Incurred Claims</td>
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<td>$74.1B</td>
</tr>
</tbody>
</table>

*Includes all approved rate increases

### Summary of state specific cumulative rate increase amounts as well as average approved number of rounds compared to nationwide averages.

### LTC Data Call Agenda

- Executive Summary
- Scope
- Data Collection
- Analysis
- Summary of state specific cumulative rate increase amounts as well as average approved number of rounds compared to nationwide averages.

### Annualized Premium Inforce by State

- Average nationwide annualized premium inforce is $2,903.
- The average annualized premium inforce varies from $1,705 - $3,656 on the most rate increased blocks of business across all states. In general, the average annualized premium varies pretty significantly for states with similar distributions of policy characteristics implying policyholders in some states are paying more than policyholders in other states for generally the same benefits.
- For 45 states over 60% of all inforce policies have an inflation rider.
- For 34 states over 30% of all inforce policies have a lifetime benefit period. For those states, the average annualized/premium inforce varies from $2,042 - $3,315.

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Analysis: Cumulative Approved Rate Increase

- States are bucketed into 5 groups by rate increase patterns:
  - Group 1 includes states with highest inforce
  - Group 5 includes states with lowest inforce

- States with lower cumulative amounts:
  - Group 5

- States with higher cumulative amounts:
  - Group 1

This does not consider timing of approvals.

Number of approvals not only driver for states with higher cumulative amounts.

Summary of state specific rate increase approvals and policy lifetime impact of rate increase approval amounts relative to original rates.
Lifetime Premium Impact

- States bucketed into 5 groups by size
- States ranked by inforce and policy lifetime impact of rate increase approval amounts relative to original rates.
- Example, premium paid by State X policyholders over the life of policies (past and future) will be 30.0% higher than original levels.
- Average impact of rate increase on nationwide lifetime premium is 20.2%.
- This does not consider timing of approvals. Early approvals have bigger impact.

Average Number of Requested and Approved Rate Increases

- The number of requested and approved rate increases by state.
- Average Nationwide number of requested increases is 61.
- Average Nationwide number of approved rate increases is 33.

Average Single % Requested and Approved Rate Increases

- Average % of requested and approved rate increases by state.
- Average single Nationwide requested rate increase amount is 19%.
- Average single Nationwde approved rate increase amount is 37%.
- Average cumulative Nationwide approved rate increase is 72%.

LTC Data Call Agenda

- Executive Summary
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- Cumulative Approved Rate Increase
- Rate Increase Approvals
- Cost of Care

Summary of cost of care by state based on the most recent Genworth Cost of Care Report. Compare cost of care with state specific loss ratios, average annualized premium, and cumulative approved rate increase amounts.
### Analysis: Cost Of Care By State

- We reviewed the annual median cost of care rates from the 2019 Genworth Cost of Care Survey for the following:
  - Semiprivate room in a nursing home
  - Adult day care
  - Home health aide
- For each site of care and by state, we compared the annual median cost of care rates to lifetime loss ratios, annualized premium inforce, and cumulative approved rate increase amount.
- In every scenario we did not see a clear correlation between state specific experience and state specific annual median cost of care rates

### Additional Observations

- The annual median cost of a semi-private room in a nursing home for 5/10 top states by inforce volume were lower than the nationwide average.
- The annual median cost for an adult day care for 7/10 top states by inforce volume were lower than the nationwide average.
- The annual median cost of homecare services for 5/10 top states by inforce volume were lower than the nationwide average.
- Over 5/10 top states by inforce volume had lower 5 year annual growth rates for cost of care when compared to nationwide averages. This includes nursing home, adult day care, and homecare services.

### Reliance and Limitations

- The analysis provided in this document are based on work developed by Long Term Care Group, Inc. (LTCC) from data collected from insurers in response to the NAIC Data Call Workstream #6. The document has been prepared in accordance with a statement of work dated March 5, 2020 between the National Association of Insurance Commissioners (NAIC) and LTCC. They may not be referenced or distributed to any other party without the prior written consent of LTCC. Matthew Morton, FSA, MAAA and Kirill Grin, ASA, MAAA are the actuaries responsible for the findings contained in this document. They are members of the American Academy of Actuaries and meet its Qualification Standards for issuing such findings.
- In developing these results, LTCC relied on information that was supplied by the NAIC and the contributing companies. LTCC staff reviewed the information being relied upon for reasonableness but performed no audits or independent verification of such information. To the extent that there are material errors in the information provided, the results of the analysis will be affected as well.
July 26, 2021

Commissioner Scott A. White, Chair
Commissioner Michael Conway, Vice Chair
Long-Term Care Insurance (EX) Task Force
National Association of Insurance Commissioners (NAIC)

Attn: Jane Koenigsman, Senior Manager, Life and Health Financial Analysis

Re: Exposure Draft: Long-Term Care Insurance (LTCI) Multistate Rate Review Framework

Dear Commissioners White and Conway:

The American Academy of Actuaries\(^1\) Long-Term Care Reform Subcommittee appreciates the opportunity to offer comments on the actuarial sections of the exposure draft \textit{Long-Term Care Insurance Multi-State Rate Review Framework} (Framework) released June 10, 2021.

We previously provided comments on the operational aspects of the Framework in our letter dated May 24, 2021. We appreciate the NAIC LTC Insurance (EX) Task Force’s consideration of our previous comments and the opportunity to discuss them with the LTCI Multistate Rate Review (EX) Subgroup during its June 22, 2021, meeting.

This letter provides our comments on the actuarial aspects of the Framework, grouped into four themes, plus some additional comments at the end. We welcome the opportunity to discuss the comments provided in this letter during any future meetings of the task force or subgroup.

\textbf{Actuarial Judgment}

The actuarial review sections of the Framework address the necessary application of judgement in reviewing rate increase requests. The term is variously modified in the draft document as “regulatory actuarial judgment” or “regulatory judgment.” Qualified actuaries performing an MSA Review would use their professional judgment as defined in Actuarial Standard of Practice (ASOP) No.1:\(^2\)

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\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

\(^2\) Actuarial Standards Board; Actuarial Standard of Practice No. 1, \textit{Introductory Actuarial Standard of Practice}; March 2013.
2.9 PROFESSIONAL JUDGMENT

Actuaries bring to their assignments not only highly specialized training, but also the broader knowledge and understanding that come from experience. For example, the ASOPs frequently call upon actuaries to apply both training and experience to their professional assignments, recognizing that reasonable differences may arise when actuaries project the effect of uncertain events.

We suggest that the Framework consistently adopt the term “professional judgment” when referring to the actuarial work of the MSA Review Team. The actuaries on the MSA Review Team may be guided by ASOP No.41 regarding appropriate communications and disclosures when issuing an actuarial opinion in an MSA Advisory Report. Specifically, disclosures may be necessary where material assumptions or methods are specified by applicable law (statutes, regulations, and other legally binding authority) or selected by another party.

Decision-making Process of the Multi-State Actuarial (MSA) Team

The Framework outlines three main approaches to calculating a justified rate increase: 1) loss ratio approach (including the 58%/85% standard for rate-stabilized business); 2) Minnesota approach; and 3) Texas approach. Other than a statement that the 58%/85% standard would produce the maximum allowable increase for relevant blocks (which is consistent with rate stability regulation), it is unclear how the results from the different approaches will generate the rate recommendation of the MSA Review Team. We suggest that additional information be provided regarding the decision-making process of the MSA Review Team. Some questions and considerations that currently exist are:

- What happens if the Minnesota and Texas approaches are in conflict whether a rate increase is justified or if the approaches produce materially different results? The two approaches differ in their structures, with the Minnesota approach looking at past and future impacts and including non-actuarial provisions through cost-sharing, while the Texas approach is geared toward ensuring only future impacts are captured.

- The discussion of the Texas approach does not explicitly discuss the “catch-up” and “transition” provisions outlined as part of the Prospective Present Value approach in the NAIC LTC Pricing Subgroup document Long-term Care Insurance Approaches to Reviewing Premium Rate Increases, approved by the Long-Term Care Actuarial (B) Working Group in 2018. Was the omission of these provisions (outside of the last paragraph in Appendix C) intentional?

- In both the Minnesota and Texas approaches as specified, it is not clear how a company would account for a prior rate increase which was reduced and/or delayed due to lack of credible experience or for another reason. It can be very difficult in future filings to achieve a requested rate increase after a regulatory reduction in prior years.

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3 Actuarial Standards Board; Actuarial Standard of Practice No. 41, *Actuarial Communications*; December 2010.
• How are past rate increase approvals considered across states? Is the time value of money considered where two states may be at the same current rate level, but one approved prior increases many years earlier than the other state?

• If the MSA Review provides a recommended rate increase (e.g., 40%) and a participating state approves a significantly lower increase (e.g., 10%), for how long may a company and/or a state regulator rely on the original MSA recommendation when submitting or reviewing a follow-up filing to achieve the recommended rate level? What is the process for the company to submit a follow-up filing for the remaining rate increase? Does the follow-up rate increase request go through the MSA Review again? Would the time value of money be considered in the review of the follow-up request?

The subcommittee appreciates the detail provided in the Framework to date and recognizes the significant effort in documenting this information. However, the answers to some of the questions above may be crucial to ensuring that companies and actuaries submitting LTC rate increase filings have the knowledge needed about the MSA Review process to be comfortable using the option.

Industry Standards and Benchmarking

Section V.A indicates that assumptions in a rate increase filing may be “deemed unreasonable or unsupported” by the MSA Review Team. We suggest that the MSA Review Team contact the filing actuary to provide additional support for his or her actuarial assumptions, if necessary, prior to deeming them “unreasonable.” If an actuarial assumption is deemed unreasonable or unsupported, it may have implications for the use of a similar assumption in a company’s asset adequacy testing and/or Actuarial Guideline LI analysis. We note that “Fair and reasonableness considerations” is listed in Section V.F (Non-Actuarial Considerations). This is a broad and not-well-defined category allowing wide latitude in regulatory decision-making regarding the results of an analysis, distinct from the justification of actuarial assumptions.

Section V.C.1(c) cites “concepts discussed in public NAIC LTC pricing subgroup calls from 2015 to 2019,” which provides inadequate documentation to include in a regulatory procedure document. Rate filing actuaries may not be aware of the content of past calls. We suggest citation to particular documents, such as adopted summaries or minutes of the referenced calls, if available.

Section V.C.5(a) refers to “industry-average assumptions at the time of original pricing” for LTC products. Where are these averages reliably to be found? How are variations in product, carrier, distribution channel, and other factors taken into account? What level of deviation from these averages (in one or more assumptions) would be considered “out of line” and trigger the use of “benchmark premium,” rather than actual original premium, in the MSA Review Team’s review process? Recognizing that regulators who approved a company’s original product and rate filings had the opportunity to review all relevant assumptions at the time of filing, and may not have enforced or suggested the use of industry averages at that time, it may not be appropriate to determine benchmark premiums with 20/20 hindsight uniformly for all product filings and company characteristics.
For rate-stabilized business, the draft states that the 58/85 test “would produce the recommended rate increase” if lower than the Minnesota and Texas approaches. Why would these approaches potentially override and reduce the recommended rate increase, when the rate stability model was already intended to address the issues with loss ratio regulation described in the preceding paragraph of the Framework?

Non-Actuarial Considerations

The Framework contains various non-actuarial considerations that may be contemplated as part of the rate recommendation. We believe it is important to recognize that many of these considerations, while listed as non-actuarial, have actuarial aspects or implications.

For example, the phase-in of a rate change over a period of years necessitates a higher cumulative rate increase to have the same financial impact as a single rate increase. Similarly, if limitations are imposed on when a company can file a future rate increase, such as a rate guarantee period, a future request may need to be higher due to the cost of waiting.

Caps or limits on rate increase approvals that are not based on actuarial considerations likewise increase the size of future rate increases. In this situation, where necessary premium rate increases are delayed, policyholders pay higher premiums, and the ultimate necessary premium level increases due to the delays in approvals.

It should also be noted that the Minnesota and Texas approaches, while primarily actuarial in presentation, already include decisions based on non-actuarial considerations, such as specific cost-sharing provisions and disallowing interest rate deviations as a reason for a rate increase.

Finally, we believe that the MSA Review process may ultimately add little value if its actuarial conclusions are frequently overridden at the state level by non-actuarial considerations. The task force may wish to consider the degree of commitment demonstrated by Participating States when evaluating the success of the MSA Review program in meeting the NAIC’s objective of “developing a consistent national approach for reviewing current LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner.”

Additional Items

There is a potential interaction between the NAIC’s Reduced Benefit Options workstream and the MSA Review. Appendix E, “Guiding Principles on LTCI Reduced Benefit Options Presented in Policyholder Notification Materials,” suggests that insurers should consider “disclosing all associated future planned rate increases approved by regulators” in their rate increase notification letters. Will the existence of an MSA Review report with a recommended cumulative rate level impose any obligation on an insurer to disclose the likelihood of future rate increases to reach this level? How would any such disclosure apply to Participating and/or non-Participating states?

The tone of several sections of the document seems to unnecessarily impute suspect motivations to companies who sold and/or currently sell LTC insurance:

- Section V.B.4(b) states that the loss ratio method results in “low incentive for responsible pricing.” Practicing LTC pricing actuaries are responsible for compliance
with all relevant actuarial standards of practice, and a company has incentives to price appropriately. Most companies would prefer to receive premium sooner rather than later. Additionally, there are the costs associated with filing and implementing a rate increase and the impact on policyholders of premium adjustments.

- Section V.C.2(a) refers to “a direction that could be seen as misleading.” Subparagraph (a) could be deleted entirely without affecting the definition of the Minnesota approach.
- Section V.C.5, “anti-bait and switch adjustment,” where we suggest a less pejorative term could be used. In the context of a rate increase review, see our comments above regarding industry standards and benchmarking. The concern regarding potential deliberate underpricing to boost market share, expressed in subparagraph 5(a)(iii), is best addressed in the context of an initial rate review by regulators.

In our May 24 comment letter, the subcommittee reserved comment on Appendix B of the April 9 Framework draft until its information requirements could be considered in context with exposure drafts of the Actuarial Review section. We now offer the following comments:

- Item A.1. should provide clarification for the desired issue state for group products (i.e., master group policy issue state or certificate issue state).
- Some items from subsections A and B are at least partially duplicative. Specifically, items regarding attribution of rate increase, waiver of premium handling, and assumption comparisons to asset adequacy testing are repeated in both locations.
- We encourage Participating States to agree that the listing of information for an MSA Review (as outlined in Appendix B) is exhaustive. If no further requests for information are needed as part of a specific state review, the filing process could be streamlined for both filers and reviewers.

**Conclusion**

Thank you for the opportunity to provide input on the development of the actuarial aspects of the MSA Review process. The subcommittee thanks members who participated in the drafting of this comment letter, including J. Patrick Kinney, MAAA, FSA; Mike Bergerson, MAAA, FSA; Greg Gurlik, MAAA, FSA; Aaron Wright, MAAA, FSA; Ali Zaker-Shahrak, MAAA, FSA; Sisi Wu, MAAA, FSA; P.J. Beltramini, MAAA, FSA; Gordon Trapnell, MAAA, FSA; Jim Glickman, MAAA, FSA, FCA; Zenaida Samaniego, MAAA, FSA; and Perry Kupferman, MAAA, FSA.
We would welcome the opportunity to speak with you in more detail and answer any questions you have regarding these comments or on other topics. If you have any questions or would like to discuss further, please contact Matthew Williams, the Academy’s senior health policy analyst, at williams@actuary.org.

Sincerely,

Andrew H. Dalton, MAAA, FSA
Vice Chairperson, LTC Reform Subcommittee
American Academy of Actuaries

CC: Eric King, Health Actuary, NAIC
July 26, 2021

Commissioner Michael Conway  
Chairman, NAIC LTCI Multi-State Rate Review (EX) Subgroup  
Colorado Insurance Department

Dear Commissioner Conway and Subgroup Members,

The American Council of Life Insurers1 (ACLI) and the American Association of Health Insurance Plans2 (AHIP) strongly support the work of the NAIC Long-Term Care (EX) Task Force in achieving its charge of developing a consistent national approach for reviewing long-term care (LTC) rates and identifying options for consumers to modify benefits when faced with a premium increase on their LTC policy. As stated in our May 24th comment letter on the Operational Section of the LTC Multi-State Rate Review Framework (Framework) document, we recognize the commitment of state insurance commissioners and LTC subject matter experts from state insurance departments and appreciate the time and effort afforded to this critically important work.

The Actuarial Section is the core of the Framework document and worthy of a comprehensive review and robust discussions with all stakeholders to achieve the best possible result. While we are making good progress, we believe that several rounds of exposure, review and discussions will be required to finalize a document that is consistent with the Task Force charge. We have offered only high-level comments on this exposure and anticipate that we will share more detailed comments once our initial questions have been addressed.

Executive Summary
Our comments to this first exposure of the Actuarial Section of the MSSR Framework focus on transparency with respect to the methodologies used by the MSA Team.

It is important to remember that not only will the MSRR process be used to recommend actuarially justified rate increases on existing legacy blocks of business; it will be applied to business that is being sold today.

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1 The American Council of Life Insurers advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. Ninety million American families depend on our members for life insurance, annuities, retirement plans, long-term care (LTC) insurance, disability income insurance, reinsurance, dental, vision, and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States.

2 AHIP is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.
Insurers best protect their policyholders by fulfilling the obligations they made to them. This is accomplished when insurers have some level of predictability in their ability to manage their LTC business over time. At its core, this level of predictability can only be achieved through transparency and consistency within the MSA Review Process, specifically regarding the methodology used to calculate the increase recommended by the MSA Team. When insurers understand the methodology the MSA Team will use to calculate rate increases, they can make informed decisions about their business now that will ensure they can fulfill their obligations to policyholders years into the future.

Our comments are focused on Section V. - Actuarial Review and Appendix C – Actuarial Approach Detail. We have also provided a general comment with respect to Appendix E – Guiding Principles on LTCI RBOs Presented in Policyholder Notification Materials.

Section V Actuarial Review and Appendix C – Actuarial Approach Detail

Our comments to this section of the Framework are guided by the Task Force charge to:

Develop a consistent national approach for reviewing LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization.

Insurers need a clear understanding of how their businesses will be regulated – today and into the future. The Framework must be evaluated based on its impact both on legacy blocks of business and new business that will be developed and sold in the future. The Framework does not currently contain the rationale or criteria that will determine which method the MSA Team will apply to a particular filing. As a result, we request clarification on the following fundamental questions and issues:

1. Will the MSA Team apply just one method based on the characteristics of the block or will all methods be used in the calculation of a rate increase? If all methods will be used, will the MSA Team recommend a blend of the results? Or will they recommend the lowest percentage?

2. What public policy issue is each methodology designed to address (e.g. certain issues with aging or shrinking blocks)?

3. How will each methodology address the inequity between policyholders in states that have routinely capped or delayed increases and those that have not? The MSA’s Actuarial Review standards/recommendations for participating states should include an acknowledgment that the recommendations for rate approvals do not reflect lifetime rate inequalities resulting from inconsistencies in the amount and/or timing of historical rate approvals between states, even on policies that offer identical coverage. We believe that the standards should encourage states to work
with filing companies to address these inequities and that the MSA Team should continue to assess this issue to determine if more specific guidance is appropriate.

4. Will the MSA Team apply their “regulatory actuarial judgement” to recommend an increase percentage that is different (higher or lower) than that produced by the Minnesota or Texas approaches?

5. In the example proposed (where there’s less-than-credible older-age morbidity) what actions would the MSA Team take?

6. The description of the Minnesota methodology includes a focus on underlying assumptions and indicates that the reviews are benchmarking to industry-average assumptions. How are those assumptions calculated? Will they be provided to companies? Similarly, what is the “average corporate yield bond” index that will be used under the Minnesota method?

7. The “anti-bait and switch adjustment” under the Minnesota method appears to suggest the insurers intentionally underpriced LTC products. How would the MSA Team make this determination? How are the “industry-average assumptions at the time of original pricing” determined? Are product and underwriting differences accounted for? How far from the industry average is considered reasonable? Wouldn’t such assumptions only be considered unreasonable in hindsight considering the product was originally approved by the state insurance department?

8. The Minnesota Approach accounts for changes in interest rates; the Texas Approach explicitly does not. How do these conflicting approaches achieve similar results? The same is true in cases of solvency concern – the document states that the cost-sharing formula in the Minnesota Approach can be adjusted. How will the cost-sharing formula be adjusted? How is solvency accounted for in the Texas Approach?

9. Will the MSA Team recommendation reflect any non-actuarial considerations or is the document simply acknowledging their existence?

10. A clear distinction needs to be made between non-actuarial considerations that should inform the MSA Team’s recommendations (like company solvency) and non-actuarial considerations that states might apply to the MSA Team’s recommendation (rate caps, phasing, age limits). The former should be a factor in the MSA Team’s regulatory actuary judgment. To achieve The Task Force’s goal of a consistent national approach to rate actions, the MSA Team should seek to discourage the latter (unless required by a clear state statutory mandate).
11. A primary goal of MSA Review Process is to achieve an adequate rate level for policyholders in all states. As proposed, the process gives states the discretion to continue to apply state-specific non-actuarial restrictions and caps on rate increase amounts. While we recognize the independence of each state’s authority, we note that allowing states to impose artificial rate caps on what the MSA Team has determined to be an actuarially justified rate likely will perpetuate the historical discrepancies between states, which will not address cross-state inequities. It will also undermine the Task Force’s charge to develop “a consistent national approach” to achieve “actuarially appropriate increases.”

12. The Framework states that the MSA Team’s review of rate proposals will resemble a state-specific rate review process utilizing consistent actuarial standards and methodologies. In addition, the MSA Team will apply the Minnesota (Blended If-Knew/Make-Up) and Texas (Prospective Present Value) approaches, as described in the 2018 NAIC LTC Pricing Subgroup’s paper – *Long-term Care Insurance Approaches to Reviewing Premium Rate Increases* (“NAIC Pricing Subgroup’s Paper”), to calculate recommended, approvable rate increases. In reviewing the methodologies, we noticed that specific components of the Texas method are not clearly included. In addition, there were changes or additions to adjustments made to the Minnesota method. The NAIC LTC Pricing Subgroup’s paper was the result of a deliberate and collaborative effort on the part of regulators and industry in 2018, during which each method was fully vetted. We believe that any kind of change to the methods outlined in that document should occur only after the same robust discussion and review. For example:

   a. Under the Texas method, the catch-up and transitional provisions are not clearly included. As outlined in the NAIC LTC Pricing Subgroup’s Paper, we believe these are valid and important adjustments that should be considered when applying the Texas method. The catch-up provision is intended to account for necessary additional premiums in a new rate increase related to assumptions provided to the department at the time of a previous rate increase request that were not approved in conjunction with the prior filing(s). Likewise, the transition provision, for pre-rate stability products and other products where the last rate increase request was voluntarily reduced by the company, provides the ability to make a single filing to provide the full amount of premium necessary to meet the actuarial certification.

   b. With respect to the “anti-bait and switch adjustment” under the Minnesota method, we strongly disagree with the inclusion of this adjustment. We believe the name itself draws a legal conclusion and submit that any reference to this type of adjustment should be categorized as an “original assumption adjustment”.
13. Finally, as mentioned in our previous comment letter, we encourage the subgroup to include a formal trigger to review and amend the Framework annually.

Appendix E – Guiding Principles on LTCI RBOs Presented in Policyholder Notification Materials

We appreciate the subgroup’s acceptance of many of our recommended changes now reflected into Appendix E. However, there are a few suggestions made in our May 24th letter that were not accepted by the subgroup. We welcome the opportunity to discuss further refinements to this document as the work evolves.

CONCLUSION

We share your fundamental objective of ensuring that policyholders receive the benefit of their insurance policies when they need it. Maintaining a guaranteed renewable product, with limited or no rate adjustment flexibility, is not sustainable, so we appreciate the MSRR subgroup’s hard work and analysis to identify and develop key parameters for a process to assess and approve actuarially justified rate increases. Success of this initiative would help to ensure market stability, which will support the willingness of current LTC carriers to stay, and hopefully will motivate others either to return or to join.

Thank you for the opportunity to provide these comments. We will submit more detailed comments once the Framework document is exposed in its entirety.

ACLI/AHIP welcomes the opportunity to discuss our comments with you and would be pleased to participate in additional discussions regarding the issues and perspectives included in this letter.

Sincerely,

Jan M. Graeber
Senior Actuary, ACLI

Ray Nelson
AHIP Consulting Actuary
Response to NAIC’s LTCI MSA Framework document

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“Any business built on non-disclosure of information vital to its customers will not survive - and will not deserve to survive over the long term” -- Joe Belth, The Insurance Forum
Introduction

FinancialMedic, LLC has chosen to respond to NAIC’s LTCI MSA Framework document dated June 10th, 2021. The firm is noted for its work product in the FIRE (Financial Independence Retire Early) field. We develop intellectual property for a holistic, integrated financial planning (FP) systems that includes substantive mathematical modeling over a wide range of personal financial domains.

The firm recognizes Long Term Care (LTC) as a valid risk in FIRE planning and have conducted extensive research in LTC and LTC Insurance (LTCI). The outcome of this research is embedded within our operational FP system. As part of this consumer driven effort, our firm published LTCI Rate Adjudication & Neutrality © Oct 2019, a treatise on LTCI industry pricing practices. This publication along with two years of data mining form the basis of the response within.

Our LTCI knowledge and experience represented here are a thumbnail of our complete industry coverage and only confines itself to subject matter of the Actuarial Review.

Overview

Considering that the LTCI Industry is 3 decades old, one should be shocked to learn of a Draft paper of the industry methods of rate adjudication. What is shocking is to also witness this debate in 2018, a paper from the American Academy of Actuaries (AAA)¹ with no resolution since or sense of urgency. Meanwhile, affected stakeholders² are shocked & angry by the parabolic scaling of rate increases over the past 3 years particularly in certain state jurisdictions. There are spurious claims of industry insolvency without evidence except for isolated cases.

Our firm is very familiar with the Loss Ratio Approach (LRA) discussed in Section V, Actuarial Review. For a client who has legacy LTCI, we are called upon to project its contractual performance within the confines of our FIRE application. Our LTCI Individual Case Basis (ICB) modeling must necessarily include similar logic pieces of morbidity incidence, duration, and situs modeling. A technical paper describes data and methods to the level of programmatic repeatability enabling an ICB decision support system. We believe we are the only firm capable of such analysis.

Historically, our clients have been concerned about premium projections as increases are perceived to know no bounds. Right out of the research gate in June 2019 we noted legacy LTCI’s premium projection toxicity using LRA, such that one could debate whether this product falls within the definition of insurance as a risk hedge. On the contrary, LTCI ownership has become a financial risk to the many seniors on fixed income due to its unfair pricing. We use the term Fair Pricing to mean Repricing In Accordance with Level Premium Precepts, the basis on which this product was sold. The technical definition and methodology is described in the earlier cited paper.

¹ Considerations for Treatment of Past Losses, American Academy of Actuaries, Oct 2018
² We consider primary affected stakeholders are policyholders, state government (Medicaid), federal government (Medicaid), and the Long-Term Support Services (LTSS) sector.
Loss Ratio Approach, the main culprit

Addressing Actuarial Review, Loss Ratio Approach, Section B, point 4, quoting:

“The loss ratio approach, one of the minimum standards in many states’ statutes, is evaluated by the MSA team. However, there is general recognition that this approach produces rate increases that are too high and do not recognize other typical statutory standards such as fair and reasonable rates.

a. The loss ratio approach also does not recognize actuarial considerations such as the shrinking block issue, where past losses being absorbed by a shrinking number of remaining policyholders would lead to unreasonably high-rate increases. This concern was the main driver of the Minnesota, Texas, and other approaches”.

b. The loss ratio approach shifts all the risk to the policyholders. If the company is allowed always to return to the 60% loss ratio, there is low incentive for responsible pricing.

The admission that past losses, known as premiums that were insufficient since inception, confirms our independent findings. We find evidence that some regulators reject the past loss theory without foundation of data science and accounting practices. We add that it is not merely the principal of past underpricing that is subject to recapture. The LRA is based on present value (PV) calculations, thus the shrinking number of policyholders (SNOP) are also charged interest based on the carrier’s discount rates, as though signing an LTCI contract involved a hidden lending arrangement.

Typical example (2021): A recent rate increase for a large carrier expands SNOP premiums to 4.02x original premium though the book remains considerably under-priced using LRA (at an LLR of 111%). Through standard accounting procedures, the new premium is calculable and allocatable to 3 distinct components.

![Rate by Components Illustrating Past Loss Recovery](image)

We do not see recovery of principal and its interest being reported in narratives or financial statements from LTCI actuaries in carrier filings or regulatory final dispositions. This non-disclosure misleads all LTCI stakeholders. We note that the expanding pie in premium growth in rate filings 2020+ are mainly due to the two recovery components while Fair Pricing remains static.
The Texas Approach

Our firm agrees with what the Texas Approach is designed to address, Section D, points 1 and 2, quoting:

1. Past losses are assumed by the company and not by existing policyholders. An approach that considers past claims in the calculation of the rate increase, such as a lifetime loss ratio approach, permits to some extent, the recoupment of past losses.

2. Calculates the rate increase needed to fund the prospective premium deficiency for active, premium-paying policyholders based on an actuarially supported change in assumption(s). This ensures that active policyholders do not pay for the past claims of policyholders who no longer pay premium.

Point 3 describes a general methodology of looking at forward “deltas” (both present value premiums & claims, along with rate history) as the primary drivers of rate changes. Appendix C, Section B provides a formula that allowed our firm to back test with a small code snippet to our LTCI processing subsystem that already had a forensic analysis capability.

We encountered cases where the future claim “delta” was small relative to future premium “delta” such that a premium reduction would be called for. The Texas approach provides a useful filtering mechanism. See example below. The claim “delta” was exactly zero, a perfect overlap, yet the regulatory agency granted a 40% increase. The stock language of the actuarial narrative based the increase on an expected deterioration of future claims. Accounting procedures refute the actuarial narrative but a simple picture tells the story even better absent professional formalities.
The Texas proposal acknowledges that the methodology would not work for a first time increase as no “deltas” exist. Moreover, we discovered the formula by itself is not a complete specification. For example, when measuring future “deltas” from one filing to the next, the specification does not clarify the source of PVs to be used for the baseline (old) filing. In our experience, many rate requests are not granted in full thus a baseline filing would not be a good source of information unless there were a recalculation of PV futures as adjusted by the actual rate increase.

A general concern is that the Texas Approach, being a mere draft or conceptualization, would have to be vetted to fit into the current environment. It is a dramatic change and one that would cause stakeholders to question why is being implemented, after significant economic harm. Our firm has received questions from clients, who: (1) have lapsed, (2) paid more in premiums than they thought they should have, or (3) exercised an RBO – “have we been injured by the Loss Ratio Approach”? Answer is a resounding “yes”!

Summary

The views presented here have already been presented to parties who have a need to know. To date, our work has been well-distributed and has not been refuted.

We ask how the industry came about the LRA method and not Repriced in Accordance with Level Premium Precepts (Fair Pricing) as the product was originally intended and sold to clients.

The Actuarial Review raises fundamental questions as to the technical purity of rate adjudication methods yet the industry appears to be unduly focused on RBO. This is cart before the horse logic in our professional opinion.

Respectfully submitted,

Samuel T Cuscovitch, Research Scientist / Strategist
FinancialMedic, LLC (domiciled in CT)
Email: scuscovitch@financialmedic.com
(860) 942 0929
[Samuel Cuscovitch] [LinkedIn]
[Publications]
ABA MEMBER ID: 05509363
LTC (EX) Multi-state Actuarial Rate Review Framework

On p. 14, in appendix D, Principles for Reduced Benefit Options (RBO) Associated with LTCI Rate Increases, it reads:

*Exploration of innovation, particularly where an outcome of improved health and lower claim costs are possible:*

- *Regulators and interested parties should continue to study the idea of offerings being made by insurers including potentially being tied to rate increases, e.g., providing hand railings for fall prevention in high-risk homes, and identifying the pros and cons of such an approach.*

Rate increases for long-term care policies typically add thousands of dollars to the annual premium paid for the policy. These types of rate increases are significant and may be a hardship to elderly consumers on fixed incomes. Consumers may not be able to consider their own best interest in the face of a significant change to annual expenses. Any offer associated with a rate action, and which involves the collection of data through artificial intelligence should clearly explain how information will be collected and used to avoid profiting and potential discriminator actions on behalf of the insurer. Also, any offer to an insured tied to rate increases should be supported with data showing why and how the rate impact is directly correlated to the offer.

Consider this example:

- A consumer on a fixed income receives notice that long-term care premiums will increase by $3,000 annually.
- That consumer now faces $3,000 of new expenses.
- If the consumer checks a box, they will receive a smart device that will collect data from their home and computer.
- If they select this option, they will not have to pay any rate increase.

The consumer may not be in the position to act in their own best interest and may not be able to consider these options carefully for several reasons. First, the consumer may not fully understand the technology proposed, the data to be collected, and the privacy implications. Second, the consumer may not realize that there may be several other options to modify their policy and reduce premiums besides accepting the new technology option. The technology option may seem like the only choice available.

The MSA subgroup should consider keeping the wellness program offers separate from implementation of large rate increases (greater than 10%). Then, there would be no question that the consumer was coerced, rather than persuaded, to take part in any wellness program.
July 21, 2021

Ms. Jane Koenigsman, Sr. Manager – L/H Financial Analysis  
National Association of Insurance Commissioners  
1100 Walnut St., Suite 1500  
Kansas City, MO 64106-2197  
Email: jkoenigsman@naic.org

RE: Exposure Draft: LTCI MSA Framework Comments

Dear Ms. Koenigsman,

Thank you for the opportunity to provide comments on the Long-Term Care Insurance (LTCI) Multi-State Actuarial (MSA) Rate Review Framework. We strongly support the goal of consistent rate review across all states for LTCI products.

We support a more consistent rate review approach to minimize the differences across states in their application of actuarial and nonactuarial considerations in rate review criteria for LTCI rate filings. While we think there are benefits for states to participate MSA rate review, a few key criteria and issues need to be addressed in order to achieve a maximum value from MSA rate review.

- **Is this binding? If not, limited participation might impact goal of nationwide uniformity and defeat the purposes of MSA rate review.**
  
  Several states have made it clear that they are not willing to participate in or accept the results of the MSA rate review, thus hampering the ability of MSA rate review to achieve its stated goal of nationwide uniformity. In order to achieve a more consistent rate review approach and minimize the differences across states, most states (if not all) need to participate in the MSA rate review program and make use of the final results mandatory.

  If the MSA rate review is not binding on participating states and is instead treated as a recommendation, state actuarial reviewers will use their own actuarial judgement to evaluate the MSA rate review and then apply state-specific laws and rules. The results will be different and therefore inconsistent. Enough state must bind themselves to the MSA rate review results in order for this approach to be effective.

  The current status of LTCI rate review at the Interstate Insurance Product Regulation Compact (IIPRC) informs this concern. At least a half dozen of the IIPRC states have opted out of IIPRC LTC review standards. This lack of uniformity is exacerbated by the IIPRC only being allowed to consider rate increases for policies that the IIPRC originally approved, and only for increases up to 15%. These challenges for the IIPRC suggest similar challenges may exist for MSA rate review.
OFFICE OF THE INSURANCE COMMISSIONER

Ms. Jane Koenigsman
National Association of Insurance Commissioners
RE: Exposure Draft: LTCI MSA Framework Comments
July 21, 2021
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- Can the rate changes recommended by the MSA team be implemented by all states and meet existing state laws and rules? If not, does this invalidate the actuarial work of the MSA team?
  Some states have capped an LTCI rate increase regardless of actuarial justification. If the MSA team recommends a higher rate increase than a particular state’s capped rate increase, the actuarial assumptions may no longer be valid. Also, those states without a rate cap will be continuing to subsidize the states with a rate cap.

- Can the MSA Team review meet the proprietary or confidentiality requirements of the participating States?
  MSA rate reviews will be done by drawing on staff support from various state insurance departments. Can the MSA Team effectively maintain confidentiality and meet individual state’s proprietary information law?

Comments Specific to MSA Actuarial considerations:

- MSA (Advisory) Report: The actuarial requirements in the report should not conflict with various state’s laws, rules, and procedures. The report’s wording will also need to be edited carefully whether it is just a recommendation or if there are conflicts with state regulations. The report should also address that actuarial standards and expectations still apply, since the team members are expected to contribute their actuarial expertise.

- The NAIC should conduct a study to determine whether the “Minnesota” and “Texas” approaches mentioned in the MSA framework are consistent with the state laws and rules. Take our state as an example: we do not automatically calculate and discuss the “Minnesota” or “Texas” rate increase calculations. The proposed MSA rate review procedures are somewhat different from our current rate review, rules, and methodology. In our review, we also require carriers to clearly designate when policies were issued and whether the block is closed or still being sold. Carriers are also required to clearly demonstrate how the policies look in terms of rate stability requirements (e.g., the 58%/85% analysis) and the loss ratio requirements.

Sincerely,

Lichiou Lee
Chief Actuary, Rates, Forms, and Provider Networks

Sent electronically
CC: Molly Nollette, Deputy Commissioner, Rates, Forms, and Provider Networks
    Amy Lopez, Senior Administrative Assistant, NAIC
SPECIAL (EX) COMMITTEE ON RACE AND INSURANCE

Special (EX) Committee on Race and Insurance Aug. 15, 2021, Minutes ................................................................. 4-167
  Special (EX) Committee on Race and Insurance July 21, 2021, Minutes (Attachment One) ........................................4-178
  Special (EX) Committee on Race and Insurance 2021/2022 Proposed Charges (Attachment One-A) .................4-179
  Special (EX) Committee on Race and Insurance July 1, 2021, Minutes (Attachment Two) .................................4-181
The Special (EX) Committee on Race and Insurance met in Columbus, OH, Aug. 15, 2021. The following members participated: David Altmaier, Co-Chair (FL); Dean L. Cameron, Co-Chair (ID); Raymond G. Farmer, Chair Emeritus (SC); Andrew N. Mais, Co-Vice Chair (CT); Chlora Lindley-Myers, Co-Vice Chair (MO); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Alan McClain (AR); Peni Itula Sapini Teo (AS); Ricardo Lara (CA); Karina M. Woods (DC); Trinidad Navarro (DE); Colin M. Hayashida (HI); Doug Ommen (IA); Dana Popish Severinghaus (IL); Amy L. Beard (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon (LA); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Eric A. Cioppa (ME); Anita G. Fox (MI); Grace Arnold (MN); Mike Chaney (MS); Mike Causey (NC); Jon Godfread (ND); Eric Dunning (NE); Marlene Caride (NJ); Barbara D. Richardson (NV); Linda A. Lacewell and My Chi To (NY); Judith L. French (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Larry D. Deiter (SD); Doug Slape (TX); Jonathan T. Pike (UT); Scott A. White (VA); Michael S. Pieciak (VT); Mike Kreidler (WA); Mark Afable (WI); James A. Dodrill (WV); and Jeff Rude (WY).

1. **Adopted its July 21, July 1, and Spring National Meeting Minutes**

The Special Committee met July 21 and July 1. During these meetings, the Special Committee took the following action: 1) heard comments on its 2021/2022 proposed charges; and 2) adopted its 2021/2022 proposed charges.

Commissioner Altman made a motion, seconded by Director Lindley-Myers, to adopt the Special (EX) Committee’s July 21 (Attachment One), July 1 (Attachment Two), and April 12 (see NAIC Proceedings – Spring 2021, Special (EX) Committee on Race and Insurance) minutes. The motion passed.

2. **Received a Status Report on Workstream One**

Executive Deputy Superintendent of Insurance To reported that Workstream One’s initial recommendations were incorporated into the Special Committee’s charges and that the Workstream will move forward with the next phase of its work.

In terms of next steps, Workstream One will reconvene in September to move forward with additional engagement with stakeholders to understand the efficacy of diversity-related programs, how companies measure their progress, and what state insurance regulators can do to support these efforts.

Workstream One will also continue collecting input on any existing gaps in available industry diversity-related data.

Workstream One will continue to do research and analysis to identify issues and develop specific recommendations on action steps state insurance regulators and companies can take to improve the level of diversity and inclusion in the industry.

3. **Received a Status Report on Workstream Two**

Commissioner Clark reported that Workstream Two has been charged with researching and analyzing the level of diversity and inclusion efforts of the NAIC and state insurance departments.

The Workstream recently emailed to commissioners a Best Practices Survey intended to examine, at the zone level, best practices and initiatives state insurance departments can consider promoting diversity, equity, and inclusion (DE&I) in their offices. Once responses have been gathered, the Workstream will meet to discuss and develop a method and forum to share diversity and inclusion information among state insurance regulators.

The NAIC has asked commissioners to share their departments’ diversity contact with Evelyn Boswell, NAIC Director of Diversity and Inclusion, for sharing DE&I information and training. The NAIC has also begun the process of developing a diversity training program for state insurance regulators and will get input from the NAIC membership as it moves forward, likely through Workstream Two.

Birny Birnbaum (Center for Economic Justice—CEJ) asked a question of Workstream Two regarding what metrics, if any, the NAIC is using to evaluate DE&I efforts and if the metrics include DE&I within regulatory processes. Mr. Birnbaum noted he...
asked the question based on the presentation made during the NAIC/Consumer Liaison Committee meeting based on the survey of consumer organizations and their difficulty navigating regulatory processes. Kay Noonan (NAIC) said Workstream Two was not specifically charged with looking at diversity within regulatory processes but was charged with looking at DE&I within state insurance departments. When the Workstream meets again, the NAIC will make sure it receives a copy of the presentation, and the Workstream can talk about whether there is a need to expand that charge. Ms. Boswell described what metrics the NAIC is using for internal DE&I efforts, goals, benchmarks, and implementation. She noted it is a three-year strategy and that going into 2022, the NAIC DE&I Council work will ensure there is continued momentum and progress.

4. **Received a Status Report on Workstream Three**

Commissioner Schmidt reported that Workstream Three recommendations from the initial report were incorporated into the 2021/2022 adopted charges and that the Workstream will move forward with the next phase of its work.

The American Academy of Actuaries (Academy) and the (Casualty Actuarial Society—CAS) have created working groups looking at these issues, and both groups have reached out to the NAIC offering input. The Special Committee will engage with the Academy and the CAS early in the process to see what their research has shown and how it can inform the Special Committee’s next steps.

In terms of next steps, the Workstream will reconvene in September to formulate a work plan and develop priorities and timelines.

Commissioner Mais stated that when looking at the charges related to Workstream Three, the Workstream believes Charge F. will garner immediate attention. Charge F. spreads across the workstreams and calls for continuing research and analysis of insurance, legal, and regulatory approaches to addressing unfair discrimination, disparate treatment, proxy discrimination, and disparate impact.

A subset of Charge F. is Charge F.2, which is specific to Workstream Three and calls for the development of analytical and regulatory tools to assist state insurance regulators in defining, identifying, and addressing unfair discrimination in property/casualty (P/C) insurance.

Workstream Three will work closely with the Special Committee in determining who works on the research and analysis part of insurance, legal, and regulatory approaches. It seems likely that the Workstream may want to take on that part first, with a focus on defining the terms, before the Workstream turns to developing analytical and regulatory tools. Workstream Three will be a key part of creating those definitions, and Workstream members will see that as a high priority within the work plan.

Workstream Three’s other charges have to do with data collection, affordability issues, and nonstandard markets. The Workstream will prioritize those alongside the unfair discrimination charge. The charge in regard to producer issues has been received by the Center for Insurance Policy and Research (CIPR), and the Workstream will oversee that work.

5. **Received a Status Report on Workstream Four**

Commissioner Afable reported that Workstream Four has not met since adopting the Workstream’s initial report and recommendations. Now that the Special Committee has adopted its charges, the Workstream is eager to start meeting and do a deeper dive into the practices and barriers that potentially disadvantage minority and underserved populations in the life insurance and annuity lines of business.

The Workstream plans to meet in September to develop a work plan with concrete deliverables and looks forward to making a positive contribution to an issue that continues to be a critical for all.

6. **Received a Status Report on Workstream Five**

Commissioner Altman reported that Workstream Five met July 8 and June 10. During its July 8 meeting, the Workstream focused on issues related to provider networks, provider directories, and cultural competency. The Workstream asked panelists representing consumers, industry, and providers to respond to several key questions related to these issues, including: 1) Are there ways state insurance regulators can incentivize more diverse, inclusive, and culturally competent provider networks? and 2) How can provider directories be used as a tool to connect patients to culturally competent providers and care? The Workstream also asked if there were specific deliverables the NAIC should work towards to address these issues.
During its June 10 meeting, the Workstream heard responses from a panel of industry representatives and a panel of consumer representatives on several key questions related to demographic data collection. Those questions asked about the benefits of insurer collection of disaggregated demographic data, the risks of collecting such data, and regulatory barriers to the collection of such data. The panelists also were asked what role state insurance regulators should have in collecting this type of data and whether there was a specific deliverable the NAIC should work towards in considering this issue.

Commissioner Altman noted that also during its June 10 meeting, the Workstream prepared and exposed a draft data collection best practices document reflecting the discussion for a public comment period ending Aug. 19. The Workstream anticipates beginning to discuss the comments received on this document during its meeting on Aug. 26.

Commissioner Altman also noted that Workstream Five plans to continue meeting at least once a month to: 1) work on the data collection best practices document; 2) work on a future network/directory document; and 3) collect additional information on issues the Workstream identified in its report to the Special Committee.

Workstream Five will consider the following topics and actions in the remaining meetings in 2021: 1) during its September meeting, the Workstream plans on receiving consumer presentations, as well as further consideration of the data best practices document; 2) during its October meeting, the Workstream plans on receiving additional presentations regarding equity issues in provider networks and provider directories, as well as discussion of next steps in framing a policy document for networks and directories. Also, if time permits, the Workstream will further discuss the data best practices document; and 3) during its November meetings, the Workstream proposes to receive presentations regarding the equity lessons of the COVID-19 pandemic, approve the data best practices document, and release a network/directories equity issues policy document for stakeholder comment.

7. Heard a Presentation on the Availability and Affordability of Insurance for Minority Consumers from Robert W. Klein and Associates

Robert W. Klein (Robert W. Klein and Associates) reported on the availability and affordability of insurance for minority consumers. He noted that empirical research indicates that some consumers (e.g., African Americans, low-income households) tend to pay higher premiums and may have less adequate coverage. He asked: Is this due to unfair discrimination or other factors or a combination of both?

Mr. Klein said as an economist specializing in insurance, unfair discrimination could be explicit or implicit. Insurers may not intend to treat certain consumers unfairly, but certain rating factors (e.g., credit scores) could have a “disparate impact” on these consumers.

What constitutes “unfair” discrimination depends on the standard for “fair” discrimination. There is the actuarial standard, which is embodied in most, if not all, state rating laws. Pricing/underwriting are “fair” if factors used are commensurate with an insured’s risk. There are other standards that may be applied, such as insurance prices should be the same for all insureds or based on an insured’s ability to pay.

Mr. Klein discussed the issue of “disparate impact,” which refers to practices that have adverse effects on certain protected groups that do not appear discriminatory on their face but are discriminatory in their application or effects. He said there is this “business necessity” defense in which the challenged practice serves a legitimate purpose that cannot be served by an alternative practice with a less discriminatory effect. This is something that a company or firm that is accused of disparate impact might offer in defense of what it is doing.

Mr. Klein noted that he continues to be involved in insurance issues and follows activities regarding unfair discrimination and other aspects of insurance. He said he recognizes the concerns and is sympathetic to availability and affordability problems. He said he believes allegations of unfair discrimination warrant careful and rigorous investigation and public policies that improve market efficiency and equity. Regardless of whether insurers engage an unfair discrimination, there are measures that could improve the availability and affordability of insurance for minority and low-income consumers. He said good policy should be based on sound research and careful consideration of the trade-offs associated with different measures.

Mr. Klein next briefed the Special Committee on economic principles. There are three conditions for economic price discrimination: 1) the seller must have some control over prices; 2) the price discriminator must be able to segregate consumers into groups with different elasticities of demand or reservation prices; and 3) there is no opportunity for arbitrage—resale by low-price to high-price consumers, which really does not apply to insurance. He said an economist named Gary Becker in 1993...
proposed that economic price discrimination should seek to determine whether firms’ profits on minority consumers are higher than they are for non-minority consumers.

For actuarially unfair discrimination to occur, there needs to be some form of market failure that enables insurers to acquire market power or that otherwise impairs efficient market functioning. Also, insurers would need to be able to segregate low-income/minority consumers and charge them higher premiums. While most economists believe that auto and home insurance markets generally meet the conditions for workable competition, there are problems, and Mr. Klein said the most significant problem is in auto and home insurance. Both insurers and consumers have imperfect information. Many consumers have a poor understanding of insurance, and some may find it difficult to shop for it.

Mr. Klein asked what the literature says. He said studies by consumer groups conclude that insurers engage in unfair discrimination, whether it is explicit or implicit against minority and low-income consumers. The most rigorous studies by insurance economists have not found evidence of unfair discrimination in pricing in auto and home insurance. He said that does not mean it does not exist and said that these studies, for the most part, are about 20 years old. These economists are more guarded in their conclusions regarding the effects of insurers’ underwriting/marketing practices on availability of coverage for minority/low-income consumers. The economists have not been able to rule out the possibility that these underwriting and marketing practices may have effects on availability and may result in certain consumers having less than adequate coverage. Findings of studies by state insurance regulators tend to be consistent with academic studies, such as a study performed by the Missouri Department of Insurance (DOI) in 2018. There are some exceptions. For example, some older studies by the Texas Insurance Department found evidence of unfair discrimination. Differences in findings appear to be due to different methodologies used by different researchers.

Mr. Klein formed a study commissioned by the National Association of Mutual Insurance Companies (NAMIC) earlier this year that analyzed data published in the NAIC’s 2020 Private Passenger Auto Study. This report contained tables/figures showing average premiums, pure premiums, and loss ratios by income quartile for each state. Underlying data was at a ZIP code level. Mr. Klein’s principal objective was to determine how these insurance metrics varied with income. He found that average premiums, pure premiums (average loss costs), and loss ratios tend to be higher in low-income areas, but this pattern was not consistent across all states.

Mr. Klein’s study indicates that loss ratios tend to be higher in low-income areas, but this pattern is not consistent across all states. Where loss ratios are higher or the same in low-income areas, this suggests (but does not prove) that insurers are not charging low-income drivers “excessive” rates. Then there are a number of states where there is the opposite case, so it does suggest that drivers in those states are being charged excessive rates.

Mr. Klein said his analysis was at a high level and not rigorous. He could not access nor analyze data at a ZIP code level. While income may serve as a proxy for race/ethnicity, it is not the same thing. He was unable to analyze how premiums, claims, and loss ratios varied with race/ethnicity and other variables that could affect or be associated with insurance premiums and availability.

Mr. Klein said there is a need for more rigorous research that would provide a much better understanding of what minority and low-income consumers face with respect to the price and availability of auto and home insurance and what factors drive their experience. This research could take various forms, such as: 1) analysis of ZIP code-level data coupled with economic and demographic data; 2) surveys of consumers; and 3) examination of insurers’ rating models, underwriting guidelines, marketing, etc. Mr. Klein said he is interested in whether certain consumers are at a disadvantage with respect to their ability to shop for insurance. He said this definitely could have an effect on what consumers pay for insurance and the quality of coverage consumers receive.

Mr. Klein noted that good ZIP code-level data for auto insurance is available for every state to the NAIC Tableau application. The statistical agents and advisory organizations (e.g., the Insurance Services Office [ISO] and Verisk Analytics) have even better data at a transaction level. J.D. Power has good survey data, but it is reluctant to share it for this kind of research. He said academic researchers need data as well as financial support to conduct this kind of research.

Mr. Klein noted that good policy requires good research. These are not simple problems with simple explanations that are easy to solve. Banning certain rating factors (e.g., credit scores) may seem like a good idea, but it could backfire. He said if the nature, extent, and causes of availability and affordability problems could be understood, then appropriate welfare-enhancing “solutions” could be designed. They could involve restrictions on certain insurer practices, reducing risk and claim costs for minority consumers, improving consumer information and the ability to shop for insurance, and other measures (e.g., taxpayer-funded subsidies).
Commissioner Ridling asked how the quartiles are identified. He asked if it is IRS data or housing data. Mr. Klein responded he believes the NAIC used census data to divide ZIP codes into these income quartiles. So, it was linking the census data to identify the ZIP codes, and then the NAIC, with the help of the statistical agents, have the insurance data for those ZIP codes. There were some ZIP codes for which income data was not available, so that creates that fifth category.

Commissioner Ridling asked if it was basic income data from the IRS. Mr. Klein said it was not the IRS. He said it was basically the U.S. Census Bureau and not necessarily the 10-year census. There are also other surveys the Census Bureau does every one or two years. He said he believes that was a source of the income data for those ZIP codes, but the NAIC just used either a mean or median income for a ZIP code to determine where they fit within which quartile.

Eric Ellsworth (Consumers Checkbook) asked Mr. Klein his thoughts on the impact of difficulty in shopping for consumers in terms of potentially increased premiums. Mr. Klein replied it is a great concern and said he is not aware of any research. His concern stems from the fact that it is generally known that if consumers shop for insurance and they are well informed about it, they often can get a better price and a better-quality coverage for what they pay. The concern is there might be low-income groups and, to the extent that minorities tend to have lower incomes or live-in certain areas, they are not able to shop as well. It may have more to do with access to the Internet or access to insurance agents. All these issues have been raised in the past, but Mr. Klein said he is not aware that anyone has really studied this.

8. Heard a Presentation on Testing for Racial Bias in Insurance from the CEJ

Mr. Birnbaum discussed testing for racial bias in insurance. He noted that provisions regarding fair and unfair discrimination are generally found in two parts of insurance statutes. Unfair discrimination is generally defined in two ways: 1) actuarial. There must be an actuarial basis for distinction among groups of consumers; and 2) protected classes. Distinctions among groups defined by certain characteristics—race, religion, national origin—is prohibited regardless of actuarial basis.

Mr. Birnbaum asked why race is a prohibited factor for underwriting or pricing. He said for some lines of insurance, race is predictive of insured loss, so he asked why life insurers are prohibited from using race as an underwriting pricing factor. He asked if race were predictive of auto insurance claims, then why should insurers be unable to use that or any other factor that is predictive of claims. He said Mr. Klein’s report suggests it should be.

Mr. Birnbaum said one reason race is prohibited could be that people have no control over their race; they are born with it. However, he said there are plenty of pricing factors based on characteristics that consumers have little or no control over like age or gender. Religion is a prohibited factor, but consumers can change their religion. Mr. Birnbaum asked again why state and federal laws declare that racial discrimination is unfair discrimination in insurance.

Mr. Birnbaum said he suggests the reason race and protected class characteristics are carved out regardless of actuarial fairness is there is a history of discrimination that, at best, has left a legacy of outcomes that are embedded in the data used for actuarial analysis and, at worst, continues today with racist practices, whether intentional or unintentional, that are unrelated to risk or cost of insurance. Unfair discrimination in insurance regulation recognizes that historic discrimination has long-lasting effects that disadvantage these groups. The shorter life expectancy of Black Americans is not caused by their skin color, but by the historic and ongoing discrimination in housing, health care, and policing. Mr. Birnbaum said this is why U.S. federal civil rights and anti-discrimination laws on employment, credit, housing, and insurance have always been understood to prohibit not just intentional discrimination, but practices, intentional or unintentional, that result in disparate outcomes. Federal laws and every court that has opined on the issue recognize both disparate treatment and disparate effect as unfair discrimination.

Mr. Birnbaum noted that systemic racism refers to policies, practices, or directives that result in advantages or disadvantages to individuals or communities based on race, including harm caused by infrastructures that determine access and quality of resources and services.

Mr. Birnbaum went on to identify three ways systemic racism can manifest in any aspect of the insurance lifecycle—whether for marketing, pricing, or claims settlement. One would be disparate intent, which is the intentional use of race. Mr. Birnbaum said for this presentation, he will focus on two types of unintentional forms of racial bias: 1) proxy discrimination, a factor predicting race and not the intended outcome. This is the use of non-prohibited factors that, due in whole or in part to a significant correlation with a prohibited class characteristic, causes unnecessary, disproportionate outcomes on the basis of prohibited class membership. The result is unnecessary racial bias because the predictive factor is not in fact predicting the outcome. For example, he said to consider the use of criminal history information in Ferguson, MO. Using criminal history as a predictive variable would simply be a proxy for racist policing practices; and 2) disparate impact, which means disproportionate outcomes tied to historic discrimination embedded in insurance outcomes. Mr. Birnbaum said it is important
to distinguish between proxy discrimination and disparate impact. With proxy discrimination, insurers have or should have interest in stopping this unnecessary discrimination.

Disparate impact, however, requires a policy decision based on equity considerations—specifically, prohibiting the use of a particular data source or consumer characteristic that compromises the cost-based and risk-based foundation of insurance. Equity-based decisions have been made, and that is why intentional use of race is prohibited. In the big data/artificial intelligence (AI) era, it is essential for insurers to test their algorithms and for state insurance regulators to test actual consumer market outcomes for proxy discrimination and disparate impact. While there is an important distinction between disparate impact and proxy discrimination, there is a common methodology to test for both consistent with predictive analytic methods that insurers use.

Mr. Birnbaum said to explain how current analytic methods in insurance can be used to test for racial bias, he will explain the difference between analyzing one variable at a time and analyzing multiple variables simultaneously. He noted that in the past 30 years, insurers have moved away from univariate analysis to multivariate analysis—from analyzing the effects of one risk characteristic at time to simultaneous analysis of many risk characteristics.

Mr. Birnbaum explained the problem with univariate analysis. He said if the relationship of age, gender, and credit score is analyzed—each individually—to the likelihood of a claim, the individual results for each risk characteristic are likely capturing some of the effects of the other risk characteristics. This is because age, gender, and credit score (or other risk classifications) may be correlated to each other as well as to the outcome variable.

To address this problem, insurers have developed multivariate analysis techniques, which simply means that several predictive factors are analyzed simultaneously. By analyzing these predictive variables simultaneously, the model removes the correlation among the predictive variables. If another predictive variable or a control factor were added, such as geographic location, then it would be possible to identify whether age, gender, or credit score were correlated with location and better identify the unique contributions of age, gender, and credit score to predicting the outcome.

Mr. Birnbaum reviewed a number of slides showing disparate impact as both a standard and methodology. Using a multivariate model and race as a control variable, he noted that “the impact of race can be seen on both the outcome—is the algorithm itself racially biased—and the impact on the predicted variables themselves because adding race removes the correlation between race and the other predictive variables.” Mr. Birnbaum noted this is one common method of testing for racial bias, but there are a variety of methods that generally seek to do the same thing: identify the correlations between predictive variables and race (or other protected class factors) and evaluate the impact of that correlation on the predictive capability of the model. After reviewing a number of examples, Mr. Birnbaum said the one key takeaway is that disparate impact analysis improves cost-based pricing and is entirely consistent with the cost base foundation of insurance.

Mr. Birnbaum said a regulatory regime requiring testing and related actions by insurers is a holistic approach to identifying and addressing systemic racism in insurance and avoids historical debates over banning selected rating factors. By testing their algorithms, insurers test not just individual predictive variables, but the algorithm as whole. The holistic testing approach avoids three key issues with efforts to ban selected factors because those selected factors are considered proxies for race: 1) testing confirms and distinguishes between proxy discrimination and disparate impact; 2) avoids shifting proxy discrimination and disparate impact from a now-prohibited factor to a remaining permitted factor; and 3) identifies problematic factors previously unknown to the state insurance regulator and the public.

Mr. Birnbaum next discussed insurer testing of algorithms and state insurance regulator testing of market outcomes. He said the least insurers can do to address systemic racism in insurance is to test their practices for and seek to remove racial bias. Mr. Birnbaum noted that state insurance regulator testing of actual consumer market outcomes should accompany insurer testing of their algorithms. State insurance regulators must collect and analyze granular consumer market outcome data for racial bias for several reasons: 1) algorithms do not always work as intended. An insurer’s good intentions are not a guaranty of intended consumer market outcomes; 2) even if individual insurers’ algorithms work generally as expected, industry aggregate consumer outcomes may produce racial bias; 3) it enables regulators to evaluate claim settlement, anti-fraud, and marketing practices—parts of the insurance product cycle for which algorithms are not filed and reviewed by state insurance regulators; and 4) it is a more efficient and effective use of regulatory resources compared to upfront review of insurers algorithms. The market outcome review represents an independent review of objective data. With today’s complex insurer algorithms, upfront review relies on insurer representations.
Director Cameron said he understands Mr. Birnbaum is asking for the NAIC and insurers to do testing on algorithms if an insurer or its algorithm had data on race, ethnicity, sex, or sexual orientation. He asked Mr. Birnbaum if he considers that to be discriminatory or some sort of proxy discrimination on its face.

Mr. Birnbaum responded no, but he said insurers cannot measure racial bias without considering race. Insurers have to include consideration of sensitive characteristics in order to evaluate whether the algorithm is biased towards those characteristics. Racial bias in lending has been tested for four decades by specifically including consideration of race in those tests. The fact that insurers collect data on race and use it for testing for racial bias does not mean they are required to use it in their algorithms that they actually deploy in the marketplace. Mr. Birnbaum said he pointed out in his comments the use of race is simply to make their algorithms more accurate and devoid of racial bias, not to use race in the marketplace.

Director Cameron asked if an insurer did not have that data, would that not lead Mr. Birnbaum to believe that the insurer was not using that sort of data for any sort of racial discrimination. Mr. Birnbaum responded by saying the theory behind that question is that if insurers do not consider race in their algorithms, then they cannot possibly be discriminating on the basis of race. He said every data scientist knows that is not true, and the reason is that because of systemic racism, racial bias is baked into almost all of the data that is used. Mr. Birnbaum said the other aspect is that there are many sources of data on race that insurers could use to append to their existing data sets in order to do the kinds of testing that he mentioned.

Mr. Birnbaum said there is no reason to stop insurers from collecting data on race with clear consumer protections. He said that even if they are not collecting data on race, which Mr. Birnbaum said he assumes they are not, there are tools and methods in which insurers can get information that serves as a proxy for race that they can append to their individual consumer transaction data in order to do the types of analysis. Mr. Birnbaum said that what he is suggesting is not new or novel; these are techniques that have been in place and used for decades.

Commissioner Mais asked the difference between what Mr. Birnbaum proposed and what the federal government requires mortgage bankers to do when collecting race information to the best of their ability and making decisions if that information is not provided, even though they cannot use it, but it has to be used in order to analyze whether there is discriminatory impact. He asked if there is a difference between that and what Mr. Birnbaum is suggesting.

Mr. Birnbaum replied that lenders test for racial bias from the ground up because they know that federal laws prohibit discrimination on the basis of race. Mr. Birnbaum said he can point to text for developing lender models that show exactly the type of methodology he presented. The federal government says here are the laws and regulations about racial bias and that it is also going to collect granular data. So, the federal Home Mortgage Disclosure Act (HMDA) has been recorded for 40 years for all types of lending, which not only gets information on loans that were given but on applications. To do that, lenders ask the consumers if they are willing to identify their race and, if the consumers willing, they collect it.

Mr. Birnbaum said what he is sharing is a practice that has been in place for decades in the U.S., but it is also the type of testing that is done in Europe now because gender is a prohibited factor in Europe in insurance.

Commissioner Conway noted Colorado passed a law in the last legislative session doing in part what Mr. Birnbaum was talking about, asking the insurance companies to step up and test their algorithms for unfair proxy discrimination. He said Colorado had lots of conversations about the data component and whether it was requiring insurance companies to collect data on race or other protected classes that it may not be otherwise collecting. The companies and their trades tried to make the argument that because they may not have the data, they could not test for it. Commissioner Conway said while that might be true with some protected class information, it is certainly not true with race.

Commissioner Conway reiterated the point Mr. Birnbaum made about how the tools that are out there have been out there for a long time, they are well known, and they have been tested. Commissioner Conway continued saying that he thinks state insurance regulators are in good stead to start doing that work and requiring the carriers to actually test their algorithms and test their machine learning systems to make sure they are not having unintended consequences.

Commissioner Conway said he wants to extrapolate or compare and contrast Mr. Birnbaum’s presentation with Mr. Klein’s presentation. He said Mr. Klein made the argument that if just pure income is looked at, there may not be an issue in play. Commissioner Conway pointed to a comment in the chat, which he said is a good one, that incomes may not be a good proxy for race at all. Commissioner Conway continued by saying that Mr. Birnbaum’s presentation makes it clear that a complete look at the algorithms and testing is needed in order to really see if there is unfair discrimination and that trying to do it just based on one simple proxy is probably not going to work. Commissioner Conway asked for Mr. Birnbaum’s thoughts on if testing for proxy discrimination by looking at just one simple factor like income can be done.
Mr. Birnbaum said it cannot be done using the methodology that the Mr. Klein used in this report on behalf of NAMIC. He said that while Mr. Klein’s report is interesting, it does not really have any relevance for the work of this Special Committee because NAMIC and Mr. Klein simply assume structural racism has no impact on insurance and that race has no impact, intentional or unintentional, on insurance outcomes. The logical extension of the conclusions in Mr. Klein’s report is that insurers should be permitted to use race because it could be predictive of insurance claims and stopping insurers from using any predictive characteristic will destroy risk-based pricing.

Mr. Klein responded that he made it clear what his study indicated and what it did not show. He said he fully indicated the limitations of the study. The study by itself should not be interpreted as a finding that insurers do not engage in unfair discrimination or that everything is fine. He said he worked with the data he had, which was limited and at a high level. He said the best studies have been done by him and others 20 years ago, which used much more granular data and much more rigorous analysis. He said even those studies were subject to limitations. Mr. Klein said he does not agree that his report or presentation shows or proves that insurers’ practices are perfectly fine or there are not problems with availability/affordability for minority consumers.

9. Heard a Presentation on the ACLI’s Racial Equity Initiative

Bruce Ferguson (American Council of Life Insurers—ACLI) commented on the ACLI’s economic empowerment and racial equity initiative and the commitment of its board of directors to make DE&I, financial security, and investing in improving the upward mobility of underserved communities a long-standing priority for the ACLI.

He noted the Special Committee put in motion a significant effort on the part of the NAIC. The ACLI’s board of directors approved that economic empowerment and racial equity initiatives align between what the ACLI is working on and the NAIC workstreams.

Mr. Ferguson noted three things that are the ACLI’s priorities: 1) corporate governance and diversity; 2) financial inclusion, which also includes algorithmic accountability and the barriers to licensure and employment in the insurance industry; and 3) racial equity impact investment, which is where the industry is looking at ways to aggregate to move the needle further and faster.

Mr. Ferguson also reported that ACLI board members have all signed the CEO action pledge. It is something that brings to the forefront ways in which corporate diversity happens in the corporate level. One of the key elements of that CEO action pledge is finding a way for the CEO leadership to report to the corporate board of directors a diversity plan. About two-thirds of the NAIC commissioners have adopted the NAIC Corporate Governance Annual Disclosure Model Regulation (#306) and in it requires the CEO to report the corporate diversity applied to its board of directors. That confidential information allows all state insurance regulators to ask the progress that is being made by the corporation with respect to diversity within the corporation.

Mr. Ferguson said the next issue is financial inclusion. He said life insurers are committed to digital financial inclusion that provides a gateway for all companies to be able to protect their family's financial future no matter their gender, race, or economic status.

Mr. Ferguson thanked Commissioner Godfread for the work that he has done to advance the AI principles that were adopted last summer. Mr. Ferguson said the ACLI supported and adopted a road map for taking advantage of new and innovative ways to reach a broader segment and close the racial wealth gap within the industry.

Mr. Ferguson noted that regarding the discussion of what an overall framework should look like, the ACLI had a cadre of member company data scientists, actuaries, lawyers, and a lot of groups daily, if not weekly, for the past year looking at recommendations that the ACLI might be able to make as to how to test algorithmic data to implement measures avoiding unintentional racial bias. Not every company is the same, and the ACLI has adopted and has some initial ideas about how it might share that with state insurance regulators going forward.

Mr. Ferguson said he listened to Mr. Birnbaum and has talked to him in the past about some of the CEJ’s ideas about correlation versus causation. Mr. Ferguson said none of that is easy to figure out it, and it all certainly depends on what this group will be looking at going forward.

Mr. Ferguson thanked Commissioner Mais for his work at how he will address the issue going forward. He said it is looking at what companies are doing now so that further discussion can be based on what additional action might be needed.
Mr. Ferguson also thanked Commissioner Conway for his work over the past few months on legislative session.

10. Heard a Presentation on Fairness in Auto Insurance from Root Insurance

Alex Timm (Root Insurance) stated that insurance has never really been about data sets; it has always been about people and the obligation owed to each other. It is recognition that at some point, everyone falls down and needs help picking themselves up. At a basic level, fair insurance underwrites a fair society. He said that is why many of us are passionate about this industry today.

Mr. Timm noted if success is measured by the distance between ideals and reality, unfortunately, industry has a big problem. He said years in the industry have made it clear to him that fairness is not always considered a virtue. Fairness and profitability are often seen as mutually exclusive at best, and irreconcilable at worst. It does not have to be that way. He said he started Root six years ago based on the idea that insurance can be fairer. He said Root’s goal is to make insurance fair and more equitable by harnessing modern technology and data science, enabling providers to offer personalized policies. To accomplish this, industry needs to transition away from premium price based on demographics.

Mr. Timm said leading among these unfair demographic-based systems is credit-based scoring in auto insurance. Credit-based scoring is currently used by every major auto insurer in the country as the main factor to price policies. Under the system, those with lower credit scores are often forced to pay more, even if they are the safest drivers on the road.

Mr. Timm said more than anything else, credit scores entrench bias into pricing, and its effects are not felt equally. For those who are not wealthy or have a thin file, the system means paying more because of who they are rather than how they drive, which is a controllable factor. An unfair system becomes more unfair when race becomes a factor. According to the urban institute, 50% of white households have FICO credit scores above 700, while only 21% of Black households do. He said he does not know how industry can have a system with those kinds of basic facts that does not in some way perpetuate racial injustice.

Mr. Timm said those who did not happen to grow up in the right place or those who are young and do not have a credit history are negatively affected by the use of credit score in insurance pricing.

As an entrepreneur, Mr. Timm said America can still offer the reality that people can build the dream and build their life, but it is hard to do that when there are limits to the possibilities of that dream, limits that are well outside of an individual's control. As an example, Mr. Timm cited Pedro Montenegro, who has a phenomenal driving record. He has never been in a car accident, nor has he been issued a ticket for a moving violation. He also never in his adult life qualified for affordable car insurance. He is a 30-year-old Guatemalan American living in Washington, DC, and he has suffered at the hands of the credit system. He is saddled with student loans, and he had some irresponsible spending in his younger years, so his credit score is in the low 500s. His auto insurance premiums and the quotes he is eligible for are $350 a month, and this is for a government-mandated purchase product. The only ticket he has ever had was for a broken taillight. His rates should not be that high.

Mr. Timm said the difference between cause in correlation is everything, and the truth is that credit is a proxy for race and income, not risk. He said this was supported by the evidence from Mr. Klein’s study that showed loss ratios essentially being flat by income group, which effectively means insurers are using income to price.

Mr. Timm said industry needs to build a better system of auto insurance now, but it will not happen on its own. He said the good news is that viable alternatives are already readily available. He said Root has seen what this can look like. He said Root has never used occupation and has never used education level to determine rates. When drivers have control of what affects their premium, that is when insurance becomes fair. He said Root does this by measuring real driving behavior through telematics. Based on this data, Root calculates a rate that more accurately reflects how someone drives rather than how likely they are to file a claim.

Mr. Timm said he rejects the notion that reform is a zero-sum game and said that Root is proof that inequality can be combatted. By making risk assessment fairer, Root can make car insurance more accessible and encourage the nearly 13% of uninsured U.S. motorists to enter the market, creating benefits for drivers and auto insurance alike. He said he knows industry can create a fairer world, one where insurance protects and supports rather than burdens and suppresses.

Mr. Timm said he has worked in the industry and has seen firsthand how comfortable many of the players are with how things currently work even as they know that there is better and more fair way. He said he would like to see a world where industry
does not use demographic factors that are beyond a driver’s control to set their car insurance rate. He said he would like to see drivers priced individually on their behavior and risk, not as part of a group because of where they work or their education level.

Mr. Timm said the work the Special Committee is doing to investigate the source of bias in insurance is essential and that he supports what it is doing. He urged the Special Committee to not settle with the way things are but rather focus on the way things should be. He said his hope for the Special Committee is that its research and its tough conversations will result in the creation of a model law that can guide commissioners and legislators to bridge the gap between today’s unfair reality and the fairer ideal that industry is so close to. By opening a dedicated investigation into the role that credit-based scoring plays and perpetuating inequality, Mr. Timm said the NAIC can further its goals of creating “fair competitive in healthy insurance markets to protect consumers.” He said industry should take this opportunity to do things the right way and drop the credit score.

Commissioner Donelon asked one question relative to adverse selection. He said in Louisiana about five or six years ago, an insurer failed in large part because it failed to use credit and the rest of the industry was using it. He asked how Root addressed that problem relative to competition with the rest of the national carriers.

Mr. Timm stated there are multiple states in the country where insurers are profitably writing today where credit score is not allowed. When the state insurance regulators move, he said industry has lots of examples of companies that can certainly become profitable and make it work. The second is using modern techniques like driving behavior and measuring the causal effects of why someone gets into an accident. Mr. Timm said Root has proven through its data—which has been validated by Milliman and is now in the public light—that it is far more predictive than really any of those other variables. He said Root believes that through the advent of machine learning and technology, it can actually build a system that puts control back into the consumers hands and rewards them for doing the right things. By doing so, he said Root will not have the level of adverse selection that Commissioner Donelon is referring to. But most importantly, Mr. Timm said Root believes that it is most important for state insurance regulators to act to entirely eliminate it in markets, which has been done. He said in those markets, there are profitable, healthy, and competitive insurance environments.

Commissioner Donelon said Louisiana has been debating this issue back to his time in the ‘90s, as chair of the House Committee on Insurance. He said his understanding is only five states now—California, Colorado, Maryland, Massachusetts, and Washington—ban the use of credit, and two of those are just recently added to the original three. So, he said it is still quite uncommon. He said Louisiana has seen the result of adverse selection on a local company that has a good business along the lines of what Root does.

11. Heard Remarks from the APCIA

Phillip L. Carson (American Property Casualty Insurance Association—APCIA) commented that it is important to get more involved with this Special Committee’s work as it moves forward on its financial charges. He said that he would like to think that industry and state insurance regulators can work together to find policy options that improve diversity and inclusion within the insurance industry while also addressing, to the extent it can, some of the most intransient problems that continue to disadvantage minority communities. As a core foundation, he said insurance is built on risk-based pricing, meaning that insurance is priced according to the risk of loss based on past loss experience and other objective factors of loss potential. The risk-based pricing framework also encourages risk mitigation and safety, which in turn can lower the cost of insurance.

Mr. Carson said risk-based pricing is just the beginning of a conversation. He said the APCIA has been listening closely to the Special Committee and is not tone deaf to its concerns about addressing the disproportionate impact of the cost of insurance, specifically auto and homeowners’ insurance. Mr. Carson said to state for the record, the APCIA is committed to working with this Special Committee on next steps. The APCIA is committed to expanding availability and affordability of insurance for treating all consumers fairly. He also said the APCIA is committed to maintaining a healthy and competitive insurance market, and its members are committed to always being there for all policyholders when worst events happen. Mr. Carson said the APCIA and its members have been working on analyzing and understanding various concerns such as affordability, explain ability, and fairness, as well as issues associated with intentional or unintentional discrimination.

Mr. Carson continued by summarizing the internal discussion that the APCIA has been having on framing these concerns and identifying potential solutions to those concerns. He began with intentional discrimination. This area of concern ought not to be an industry problem. Offering insurance with the intent to discriminate against protected class is illegal.

Mr. Carson said proxy discrimination is another form of intentional discrimination and, therefore, also requires more scrutiny. Evidence of intentional discrimination is more appropriately addressed to the regulatory apparatus. Understanding and
addressing unintentional discrimination, however, is more problematic. Identifying intentional discrimination requires a deeper loss analysis. There have been studies, including some done by the NAIC, that found that loss ratios for various income groups and groups living in primarily minority areas are not on average significantly lower than other groups. He said, however, if a protected class does appear to be charged a rate disproportionately higher than the expected cost for other groups, then unintentional discrimination may be present. Further analysis would be warranted about the causes and impacts that create that disconnect so that appropriate remedies can be provided.

With respect to concerns about affordability, Mr. Carson said the APCIA has been discussing alternatives to reduce the cost burden placed on low-income communities. These alternatives could include low-cost auto programs, potential subsidies, and initiatives to improve inadequate infrastructure investments that create adverse cost drivers. Regarding “explain ability”, he said the APCIA knows that the mechanics of insurance rating and underwriting are complex, so the challenge for industry and policymakers is to create plain language mechanisms to help consumers better understand the use of risk factors. People sometimes ask why auto insurers use non-driving rating factors. Auto insurance is not only about was an individual’s driving efficiency; it also involves factors such as bad weather conditions, bad roads, or poor maintenance of a car. Therefore, all those types of factors should be considered in the writing process.

Mr. Carson said industry may need to do a better job of explaining rating factors to consumers so they can make more informed choices about their insurance needs and about which insurers best meet those needs.

Mr. Carson said the issue of fairness is often raised, but it is rarely well-defined. For regulatory purposes, unfair discrimination means charging different rates for the same risk. Some outcomes may still appear to be unjust or may appear to contribute or perpetuate historic social inequities. Addressing that current disparity will be difficult. Nevertheless, he said the APCIA hopes policymakers and industry participants can agree on specific outcomes for achieving fairness. Getting to fairness would necessarily involve uncomfortable conversations as they must deal with sensitive issue about race, ethnicity, life experiences, and wealth, or, more appropriately, a lack of wealth.

If the underlying concern of this Special Committee is that certain insurance risk factors are inaccurate, then Mr. Carson said industry needs to work together to find other inputs with less adverse effects. If the risk factors are accurate, but industry does not like the inequitable outcome, it may be necessary to work outside of risk-based pricing to reduce unfair cost drivers. Coming out with fairness solutions will be an incredibly complex undertaking. He said that means industry must be willing to have the difficult conversation about prioritizing what needs to be changed.

In closing, Mr. Carson provided a quick summary of some issues that the APCIA and its members have been discussing and will continue to discuss. The APCIA will continue its evaluation of its concerns with its board working group on social equity and inclusion. In the meantime, he said the APCIA welcomes constructive suggestions from the regulatory community. The insurance industry cannot solve all the problems by itself, and the APCIA knows that it must be part of this solution. He said the APCIA wants to collaborate with state insurance regulators and the rest of industry to address unintentional discrimination and develop potential solutions.

Mr. Carson said the APCIA believes it is possible to develop policy options that address unintentional disparities without compromising the risk-based foundation of its business. He said he will continue to be involved in the work of the Special Committee and that he hopes it will reach out to him and the APCIA with its concerns, questions, and suggestions.

Having no further business, the Special (EX) Committee on Race and Insurance adjourned.
The Special (EX) Committee on Race and Insurance met July 21, 2021. The following members participated: David Altmaier, Co-Chair (FL); Dean L. Cameron, Co-Chair (ID); Raymond G. Farmer, Chair Emeritus (SC); Andrew N. Mais, Co-Vice Chair (CT); Chlora Lindley-Myers, Co-Vice Chair (MO); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Alan McClain (AR); Ricardo Lara represented by Bruce Hinze (CA); Michael Conway (CO); Karima M. Woods (DC); Colin M. Hayashida (HI); Doug Ommen (IA); Dana Popish Severinghaus (IL); Amy L. Beard represented by Claire Szpara (IN); Vicki Schmidt (KS); Sharon P. Clark represented by Rob Roberts (KY); James J. Donelon represented by Tom Travis (LA); Gary D. Anderson (MA); Eric A. Cioppa (ME); Kathleen A. Birrane (MD); Anita G. Fox represented by Karin Gyger (MI); Grace Arnold represented by Galen Benshoof (MN); Mike Chaney (MS); Mike Causey represented by Jackie Obusek (NC); Jon Godfred (ND); Eric Dunning (NE); Marlene Caride (NJ); Barbara D. Richardson (NV); Linda A. Lacewell represented by My Chi To (NY); Judith L. French represented by Tynesia Dorsey (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer represented by Matt Gendron (RI); Doug Slape (TX); Jonathan T. Pike represented by Tanji J. Northrup (UT); Scott A. White (VA); Michael S. Pieciak (VT); Mike Kreidler (WA); Mark Afable represented by Sarah Smith (WI); James A. Dodrill (WV); and Jeff Rude (WY).

1. **Adopted its 2021/2022 Proposed Charges**

Commissioner Altmaier reported that the Special Committee met July 1 and April 12 to discuss its charges and received two sets of written comments from a broad range of stakeholders. He said the Special Committee appreciates the interest in its work and that it hopes for a shared commitment to addressing any inequities in the marketplace and market practices.

Commissioner Altmaier also reported that the Special Committee made several changes based on the commentary received, as well as for clarity and consistency. He said the Special Committee also proposed that this set of charges carry over through 2022, as well as the remainder of 2021. Commissioner Altmaier explained that with all charges, these can be amended during that period as work is completed or as other priorities arise. He said these charges also anticipate that the existing established workstreams will continue their work as described in the charges in addition to the tasks assigned at the Special Committee level.

Director Farmer made a motion, seconded by Director Lindley-Myers, to adopt the Special Committee’s 2021/2022 proposed charges (Attachment One-A). The motion passed unanimously.

Having no further business, the Special (EX) Committee on Race and Insurance adjourned.
The mission of the Special (EX) Committee on Race and Insurance is to serve as the NAIC’s coordinating body on identifying issues related to: 1) race, diversity, and inclusion within the insurance sector; 2) race, diversity, and inclusion in access to the insurance sector and insurance products; and 3) practices within the insurance sector that potentially disadvantage people of color and/or historically underrepresented groups.

Ongoing Support of NAIC Programs, Products or Services

1. The Special (EX) Committee on Race and Insurance will:
   A. Serve as the NAIC’s coordinating body on identifying issues related to: 1) race, diversity, and inclusion within the insurance sector; 2) race, diversity, and inclusion in access to the insurance sector and insurance products; and 3) practices within the insurance sector that potentially disadvantage people of color and/or historically underrepresented groups.
   B. Coordinate with existing groups such as the Big Data and Artificial Intelligence (EX) Working Group and the Casualty Actuarial and Statistical (C) Task Force and encourage those groups to continue their work on issues affecting people of color and/or historically underrepresented groups, particularly in predictive modeling, price algorithms, and artificial intelligence (AI).
   C. (Workstream One) Continue research and analysis to identify issues and develop specific recommendations on action steps state insurance regulators and companies can take to improve the level of diversity and inclusion in the industry, including:
      1. Seek additional engagement from stakeholders to understand the efficacy of diversity-related programs, how companies measure their progress, and what state insurance regulators can do to support these efforts.
      2. Collect input on any existing gaps in available industry diversity-related data.
   D. (Workstream Two) In coordination with the Executive (EX) Committee, receive reports on NAIC diversity, equity, and inclusion (DE&I) efforts. Serve as the coordinating body for state requests for assistance from the NAIC related to DE&I efforts.
   E. (Workstream Two) Research best practices among state insurance departments on DE&I efforts and develop forums for sharing relevant information among states and with stakeholders, as appropriate.
   F. Continue research and analysis of insurance, legal, and regulatory approaches to addressing unfair discrimination, disparate treatment, proxy discrimination, and disparate impact. Make recommendations for statutory or regulatory changes and additional steps, including:
      1. (Workstream Four) The impact of traditional life insurance underwriting on traditionally underserved populations, considering the relationship between mortality risk and disparate impact.
      2. (Workstream Three) Developing analytical and regulatory tools to assist state insurance regulators in defining, identifying, and addressing unfair discrimination in property/casualty (P/C) insurance, including issues related to:
         a. Rating and underwriting variables, such as socioeconomic variables and criminal history, including:
            1. Identifying proxy variables for race.
            2. Correlation versus causation, including discussion of spurious correlation and rational explanation.
            3. Potential bias in underlying data.
            4. Proper use of third-party data.
         b. Disparate impact considerations.
      G. (Workstreams Three, Four, and Five) Consider enhanced data reporting and record-keeping requirements across product lines to identify race and other sociodemographic factors of insureds, including consideration of legal and privacy concerns. Consider a data call to identify insurance producer resources available and products sold in specific ZIP codes to identify barriers to access.
   H. Continue research and analysis related to insurance access and affordability issues, including:
      1. (Workstream Four) The marketing, distribution, and access to life insurance products in minority communities, including the role that financial literacy plays.
2. (Workstream Four) Disparities in the number of cancellations/rescissions among minority policyholders.
3. (Workstream Five) Measures to advance equity through lowering the cost of health care and promoting access to care and coverage, with a specific focus on measures to remedy impacts on people of color, low income and rural populations, and historically marginalized groups, such as the LGBTQ+ community, individuals with disabilities, and Alaska Native and other Native and Indigenous people.
4. (Workstream Five) Examination of the use of network adequacy and provider directory measures (e.g., provider diversity, language, and cultural competence) to promote equitable access to culturally competent care.
5. (Workstream Five) Conduct additional outreach to educate consumers and collect information on health and health care complaints related to discrimination and inequities in accessing care.
6. (Workstream Three) Whether steps need to be taken to mitigate the impact of residual markets, premium financing, and nonstandard markets on historically underrepresented groups.
7. Make referrals for the development of consumer education and outreach materials, as appropriate.

I. Direct NAIC and Center for Insurance Policy & Research (CIPR) staff to conduct necessary research and analysis, including:
   1. (Workstream Three) The status of studies concerning the affordability of auto and homeowners insurance, including a gap analysis of what has not been studied.
   2. (Workstream Three) The availability of producer licensing exams in foreign languages, steps exam vendors have taken to mitigate cultural bias, and the number and locations of producers by company compared to demographics in the same area.
   3. (Workstream Five) Aggregation of existing research on health care disparities and the collection of insurance responses to the COVID-19 pandemic and its impact across demographic populations.

LIFE INSURANCE AND ANNUITIES (A) COMMITTEE – NEW CHARGES

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

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

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

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

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

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

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

NAIC Support Staff: Andrew J. Beal/Michael F. Consedine

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The Special (EX) Committee on Race and Insurance met July 1, 2021. The following members participated: David Altmaier, Co-Chair (FL); Dean L. Cameron, Co-Chair (ID); Raymond G. Farmer, Chair Emeritus represented by Michelle Proctor (SC); Chlora Lindley-Myers, Co-Vice Chair (MO); Andrew N. Mais, Co-Vice Chair (CT); Jim L. Ridling represented by Yada Horace (AL); Alan McClain (AR); Evan G. Daniels (AZ); Ricardo Lara represented by Bruce Hinze (CA); Michael Conway represented by Peg Brown (CO); Karima M. Woods (DC); Trinidad Navarro (DE); Colin M. Hayashida (HI); Doug Ommen (IA); Dana Popish Severinghaus (IL); Amy L. Beard (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon (LA); Gary D. Anderson (MA); Eric A. Cioppa (ME); Kathleen A. Birrane (MD); Anita G. Fox (MI); Grace Arnold (MN); Mike Chaney (MS); Mike Causey represented by Jackie Obusek (NC); Jon Godfrey (ND); Eric Dunning (NE); Marlene Caride (NJ); Barbara D. Richardson (NV); Linda A. Lacewell represented My Chi To (NY); Judith L. French represented by Tynesia Dorsey (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Larry D. Deiter (SD); Doug Slape (TX); Jonathan T. Pike (UT); Scott A. White represented by Don Beatty (VA); Tregenza A. Roach (VI); Michael S. Pieciak represented by Kevin Gaffney (VT); Mike Kreidler (WA); Mark Afable (WI); and Jeff Rude (WY).

1. Discussed its 2021/2022 Proposed Charges and Heard Comments from Interested Parties

Commissioner Altmaier introduced the interested parties who submitted comments and requested to comments on the 2021/2022 proposed charges of the Special Committee (Attachment One-A).

A. Academy

Laura Hanson (American Academy of Actuaries—Academy) noted that the Academy continues to support the Special (EX) Committee’s efforts pertaining to diversity and inclusion concerns in insurance coverages and in particular to identify and address unfair discrimination. The Academy submitted two comment letters to the Special (EX) Committee in recent months. The first letter underscored the Academy’s commitment to supporting the work of the Special (EX) Committee and provided information about the Academy’s current efforts related to diversity, equity and inclusion (DE&I). The second letter provided comments on the draft charges.

Ms. Hanson noted that the research and analysis described in charge F.2 and charge I.2 for the casualty practice area would be equally relevant research and analysis for the life practice area. Second, she said the Academy noted that the research and analysis relating to disparities among minority policyholders described in charge H.2 may be difficult to accomplish until the Special (EX) Committee has considered enhanced data reporting and record-keeping requirements as described in charge G.

Next, Lauren Cavanaugh (Academy) reported that with respect to the property/casualty (P/C) matters, the Academy was pleased to see many of the comments provided in its Nov. 12, 2020, letter to Workstream Three were included in the charges. In its May 14, 2021, letter, the Academy focused on charge F and charge G. For charge F, it recommended that the NAIC define all important terms, including “disparate treatment,” and that the NAIC develop methods of identifying unfair discrimination prior to developing methods to address it.

With respect to charge F.2, Ms. Cavanaugh said the Academy suggests that any tools developed to focus on unfair discrimination should consider the inputs, such as a rating and underwriting variables, separate from the outputs, such as disparate impact. With respect to those underwriting and rating variables, the Academy recommends including concepts of spurious correlation and the term “rational explanation” in the sub-bullet on correlation versus causation. “Rational explanation” is the term used in the Casualty Actuarial and Statistical (C) Task Force’s Regulatory Review of Predictive Models white paper.

Finally, Ms. Cavanaugh said the Academy thinks it is important to add the principles of cost-based pricing as a consideration in addressing unfair discrimination as these principles are fundamental to P/C rate making. With respect to charge G, related to enhanced data reporting and record keeping, she said the Academy suggests the Special (EX) Committee define the term “resources” and create a governance structure for any data collection effort to protect privacy and prevent misuse.
Director Altmaier noted that a number of commenters from industry and consumers recommended that the Special (EX) Committee consider deleting the discussion of causation versus correlation and asked for the Academy’s thoughts on that recommendation.

Ms. Cavanagh stated that correlation and causation continue to come up in these discussions, and it is important to consider them. The reason the Academy suggests the concepts of spurious correlation and rational explanation be included is to address the notion that this is not a binary either/or, accept all variables that are correlated or only accept variables that can be established to have a causal relationship. She said a successful plan has to consider a more broad spectrum of rating variables and how those concepts apply.

B. ACLI

Brian Bayerle (American Council of Life Insurers—ACLI) thanked the NAIC for its leadership on the effort to address systemic inequalities. The ACLI is aligned with the goal to help address systemic inequalities and is encouraged by the discussions taking place at the NAIC to address this critical societal issue. The ACLI is committed to working with the NAIC at all levels to address concerns of fairness and improve accessibility of insurance products to all communities.

Regarding the specific charges, Mr. Bayerle said the ACLI supports the spirit of the proposed charges. Thinking about the direction over the next year, the ACLI believes the Special (EX) Committee should maintain as much centralized control over the efforts as possible while bringing in technical expertise as deemed appropriate. The ACLI believes a centralized approach will help maintain the big-picture view of this critical issue and address any fragmentation that may exist in this process if various subgroups come up with conflicting recommendations moving forward.

Mr. Bayerle said the ACLI recommends the inclusion of charges to the Life Actuarial (A) Task Force and the Health Actuarial (B) Task Force that would ensure both Task Forces are involved in actuarial and risk classification issues emanating from any Special (EX) Committee workstreams related to life insurance and health insurance, respectively.

C. AITC

J.P. Wieske (Horizon Government Affairs on behalf of American InsurTech Council—AITC) stated that the AITC is the independent voice of InsurTechs in support of the development of technology-based innovation in insurance. The AITC supports the proposed charges and noted this work is vital to ensuring regulation of these issues by the states. Furthermore, the proposed charges strike the right balance, ensuring consumer access and thoughtful regulation without overburdening the industry. He said the AITC believes the proposed charges will set the table for state insurance regulators and the insurance industry to promote innovation and provide measured and appropriate growth of InsurTechs by setting new regulatory standards.

D. APCIA

Angela Gleason (American Property Casualty Insurance Association—APCIA) reemphasized APCIA’s commitment to being collaborative partners.

Ms. Gleason noted that APCIA understands the state insurance regulators’ concerns with unintentional discrimination, explainability, and transparency. APCIA is willing to work with the NAIC to think through these issues and concerns, but it strongly suggests building a foundation of common understanding from which productive and action-driven conversation can emerge. For instance, the charges blur distinctions between the definitions of well-established legal terms, like “proxy discrimination” and “unintentional discrimination.” These terms have different measurements and potential remedies. State insurance regulator concerns can be addressed with new and distinct terms that do not confuse existing law and protected classes. APCIA recommends the charges establish a framework for conversation that identifies the current state of the law and articulates the specific gaps to be addressed so everyone is speaking from the same page and same dialogue and that dialogue can begin to center on solutions. With a common foundational understanding, the conversation can more readily develop consensus solutions.

Ms. Gleason said APCIA noted at least four different issues state insurance regulators and policymakers have raised, and APCIA has been developing solutions to address or explain each separate concern. The concerns APCIA has heard include: 1) intentional discrimination, which includes proxy discrimination; and 2) unintentional discrimination, which includes disparate
impact, and reducing disparate outcomes and explainability. APCIA would like to hear from commissioners if the identified issues are incorrect as APCIA wants to work collaboratively to address these issues.

Ms. Gleason said the importance of identifying and articulating the distinct concerns and not conflating solutions into a single existing term that upends well-established case law cannot be understated. APCIA believes taking this deliberate and methodical approach leverages the expertise of the NAIC, staff, state insurance regulators, industry, and consumer advocates. This approach does not slow down or delay the process, but rather it ensures that together meaningful solutions are developed.

Ms. Gleason noted that most of edits submitted in APCIA’s comment letter are intended to focus on defining the category of problems state insurance regulators want to address and then creating a framework within which to consider those issues and potential solutions separately.

Ms. Gleason said in addition to outlining a framework for discussion, APCIA’s markup of the proposed charges also identifies two new charges that address important considerations. The first identifies opportunities to develop materials, partnerships, and programs that promote economic empowerment. This has been a topic and objective of many presentations to the Special (EX) Committee, and APCIA believes it is an important area of exploration. The second identifies opportunities to address the underlying causes of intentional disparities that are due to circumstances unrelated to insurance, which APCIA says is a holistic approach not different from how state insurance regulators think about other issues like natural catastrophes.

Ms. Gleason said advancing DE&I within the insurance community is a shared objective, and there has been a lot of great work from state insurance regulators and industry. APCIA suggests the charge for Workstream Two, sharing best practices among state insurance regulators, be expanded to include sharing those best practices with industry to emphasize that the exchange of ideas on DE&I are important and can benefit all.

Commissioner Altmaier noted that APCIA’s comments focused on the existing legal and regulatory framework for unfair discrimination and asked if APCIA and its members are open to discussions about those existing frameworks and the need to possibly change those if that is where the analysis and data leads us.

Ms. Gleason stated that APCIA is open to all those conversations and needs to understand and come to agreement on what it is and find those gaps.

Director Cameron asked Ms. Gleason to reiterate on charge B; APCIA seems to be taking out work on predictive modeling and prior algorithms. Director Cameron asked what is APCIA’s concern with the Special (EX) Committee continuing to work in that space.

Ms. Gleason stated that it is not a concern but adding clarity. Ms. Gleason stated that these issues are not the only ones those groups are working on, so the suggested change was clarification about not preventing other work from moving forward.

Commissioner Altman commented on a particular objection to the proposed deletion, from APCIA and as a preview of the National Association of Mutual Insurance Companies (NAMIC) as well, of the charge to consider collection of demographic information. Commissioner Altman noted the charge has the word “consider” in it and said the charge is to have a conversation about whether that is the thing we should or should not do and is not meant to negate a conversation about barriers or concerns about what that means. She said Pennsylvania has a particular interest in this question, Workstream Five has had some really robust initial conversations about this, and the health insurance industry has had some important organic conversations talking about equity and disparities in the health insurance space. Commissioner Altman said she wants to make sure to note that Pennsylvania and members of Workstream Five feel quite strongly about keeping that reference in the charges. California, Colorado, Connecticut, District of Columbia, and Maryland indicated agreement with Commissioner Altman’s comments.

E. **BCBSA**

Randi Chapman (Blue Cross and Blue Shield Association—BCBSA) stated that BCBSA is committed to a sustained effort to reduce racial health disparities in America and to addressing health and equity in a thorough comprehensive way. She said BCBSA appreciates the work that the NAIC is doing and developing these proposed charges. Ms. Chapman noted that BCBSA has established a national health equity strategy in addition to developing health equity policy recommendations outlined in the BCBSA Issue Brief, *Addressing Health Disparities and Inequities in Communities of Color*, which align with the Special (EX) Committee’s proposed 2021 charges and efforts to promote improved access to quality, affordable coverage, and culturally competent care.
Ms. Chapman said BCBSA is committed to being a supportive and collaborative partner to the NAIC and appreciates the collaborative spirit in which this work has been approached. She encouraged commissioners to see BCBSA as a resource and collaborative partner as the Special (EX) Committee develops recommendations and considers these charges.

Ms. Chapman commented on the proposed charges from BCBSA’s April and May comment letters. With respect to data in charge G, BCBSA understands and agrees that accuracy in demographic data is key to improving health equity outcomes in all communities across the country. BCBSA understands that there are many overlapping and complex state and federal laws that govern collection of demographic data in the health sector and suggests the NAIC, when considering how to address data, know there are a number of laws that address these issues and a degree of inconsistency in how data is collected and used. BCBSA will continue to work closely with the NAIC to meet that mutual goal of ensuring the industry and state insurance regulators are best positioned to address the need for better data that will ultimately improve health equity outcomes.

Ms. Chapman stated that with regard to provider diversity and culturally competent care in charge H.4, BCBSA shares the Special (EX) Committee’s goal of promoting equitable access to high-quality care through improving the racial and ethnic diversity of providers in addition to addressing the language diversity needs and cultural competency challenges.

Ms. Chapman said to meaningfully address existing barriers in access to diverse providers and providers offering linguistically and culturally competent care, BCBSA believes the focus needs to be on the root causes: a lack of diversity within the health care system and health education pipelines; limited availability of providers in areas that are predominantly communities of color, communities where English is not the primary language spoken, and rural communities; and the critical need to promote cross-cultural and implicit bias training within health professions.

Director Cameron noted that BCBSA comments mentioned the lack of nationwide standards and that there are conflicting state and federal standards. Director Cameron asked Ms. Chapman to elaborate on where those conflicts are and also to elaborate as to BCBSA discussing or working on nationwide standards and what the state insurance regulators’ role would be in developing those standards.

Ms. Chapman said that BCBSA and industry are working on addressing these barriers and conflicts they see in existing state and federal laws, thinking through recommendations on how to enable the industry to collect the data they need, and using that data in a way that is sensitive and appropriate to the needs of their members. Ms. Chapman said the federal Affordable Care Act (ACA) includes language that suggests there is an ability to collect race and ethnicity data using Office of Management and Budget (OMB) and U.S. Department of Health and Human Services (HHS) standards, but it is subject to discrimination laws in the federal Civil Rights Act. There are a lot of state laws that pertain to data collection on health insurance applications, and there are some states that require a strict use purpose for data collection. Ms. Chapman said the bottom line is this is an area that needs to be delved into a bit more deeply so it is clear what the laws are saying, what the laws allow and what the laws prevent. She said once there is an understanding, work can move forward determining what the best ways are to collect and use data in a way that is sensitive to members’ needs and make sure insurers are respecting privacy so they are not in a position where they are collecting data and their members are wondering and questioning how that data is being used.

Ms. Chapman noted that state insurance regulators are in a great position to get a better picture of what the landscape looks like in terms of the legal parameters regarding demographic data collection and also to get a sense of what can be communicated with industry and consumer partners.

Commissioner Mais raised a question in terms of the comments that Ms. Chapman had focusing on network care standards and communities that are underserved with provider shortages. He said BCBSA suggested that focusing on that issue would not necessarily help improve access to care. Commissioner Mais said there are some longer-term solutions BCBSA suggested, but BCBSA also said the NAIC should consider opportunities to inform patients of currently available providers. Commissioner Mais asked Ms. Chapman to expand how that would work within the current system.

Naomi Senkeeto (BCBSA) noted that BCBSA recognizes there are pipeline issues and diversity issues within the system. She said BCBSA is undertaking efforts to think through what the role is for health insurers and as the NAIC continues to work through recommendations in this space, BCBSA wants to partner on that work. BCBSA provided high-level recommendations in the Addressing Health Disparities and Inequities in Communities of Color issue brief regarding providing access to linguistically and culturally competent care. Ms. Senkeeto said BCBSA recognizes that there is a concern around network adequacy, but at its core, she thinks the foundational question is more on the access and the availability of providers both from a diversity perspective and from the perspective of traditionally underserved areas and workforce pipelines. She said BCBSA
is committed to an ongoing conversation and a concerted effort to move forward. She said BCBSA wants to partner with the NAIC in this effort.

F. CEJ

Birny Birnbaum (Center for Economic Justice—CEJ) continues to urge the Special (EX) Committee to develop a more systematic approach to examining issues of race and insurance by first setting the foundation defining what is fair and what is unfair discrimination. The CEJ says without this foundation, the workstreams have no guidance or principals against which to evaluate the variety of issues that are raised. Therefore, a solid definition of unfair discrimination that articulates principles of discrimination and disparate impact is essential to meaningfully consider the issues raised in charge 2.F.

Mr. Birnbaum said the CEJ wants to stress the urgency of this first step. The NAIC adopted its principles for artificial intelligence (AI) more than a year ago. These principles included responsibility of insurers to avoid proxy discrimination yet there has been no action of the NAIC to develop the guidance for insurers to implement those principles.

In contrast, the National Council of Insurance Legislators (NCOIL) quickly discussed and adopted the definition, at the urging of industry, of “proxy discrimination” that would not only stop any meaningful efforts to address systemic racism and insurance, but also would limit state insurance regulators’ current authority to even examine practices that raise concern about racial bias. Mr. Birnbaum said the NAIC should consider it a top priority to move quickly to develop meaningful definitions of “proxy discrimination” and “disparate impact” in insurance to counter the NCOIL action.

Mr. Birnbaum said the second step is for insurers to test their algorithms and practices for proxy discrimination and disparate impact. Eliminate proxy discrimination and minimize disparate impact; the problem cannot be fixed if it cannot be measured. Establishing a regulatory framework for insurers to test their processes, whether for marketing, pricing, claim settlement, or antifraud requires a collaborative approach between state insurance regulators, insurers, and stakeholders.

Mr. Birnbaum said the testing paradigm overcomes the current impasse the CEJ sees in states that have tried to address systemic racism by prohibiting the use of certain factors. Those efforts have failed because they evolved into a debate of pricing accuracy versus racial justice. The testing approach overcomes this either/or choice by looking at a holistic review by insurers of racial impact of their practices within the cost-based framework of insurance. Testing for proxy discrimination and disparate impact improves risk and cost-based practices by eliminating spurious correlations in which the factors are predicting race and not the outcome.

Mr. Birnbaum noted that the testing approach is holistic. This means that by analyzing the racial impact of an algorithm, the problems created when prohibiting one factor, only to find that racial bias has shifted to some other existing or new data source, are avoided. Mr. Birnbaum said related to a requirement for insurers to test for racial bias in their marketing, pricing, claim settlement, and antifraud efforts is developing regulatory guidance to: specify what type of testing is acceptable; assist in identifying sources of information on protected class characteristics; specify the actions insurers must take on certain testing outcomes; specify reporting of test results and related actions; and provide a safe harbor for insurers that follow regulatory guidance.

Mr. Birnbaum said the CEJ’s third step to a more systematic approach is in developing a more robust and comprehensive data collection system for state insurance regulators and the public to evaluate actual consumer outcomes, including the outcomes of communities of color. Auditing an algorithm is not a sufficient consumer protection for at least two reasons. First, an algorithm may not produce the intended results. Second, state insurance regulators are seriously overmatched by insurers when it comes to the technical expertise involved in designing and auditing big data/AI models. Mr. Birnbaum said it is only by collecting and analyzing actual consumer market outcomes at a granular level that state insurance regulators and the public can measure progress in the fight against systemic racism.

At a recent hearing of Workstream Five, there was no disagreement over the need to collect this aggregated, granular data on consumer outcomes to help assess racial disparities. Mr. Birnbaum said if the property/casualty (P/C) trades continue their historical opposition to such data collection, it will obstruct the Special (EX) Committees’ efforts. There should be a systematic approach to examining regulatory and public policies that reflect and perpetuate systemic racism. There are practices that clearly fall under commissioners’ current statutory authority, but there are also public policies regarding insurance that reflect and perpetuate historic discrimination outside of your authority, but not outside of your influence.

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Mr. Birnbaum urged the Special (EX) Committee to pick up the pace, saying concrete actions are needed to address the structural biases and disadvantages of communities of color. Mr. Birnbaum urged the Special (EX) Committee to adopt some charges and put as much energy into these issues as state insurance regulators did into changing the anti-rebating law, updating the annuity suitability model, and developing the group capital calculation (GCC). It is only by this type of energy that communities of color will see the concrete steps that improve their lives.

Director Fox asked Mr. Birnbaum to expand on the safe harbor idea. She said she understands the need for some kind of certainty, but putting the regulatory imprint on what the insurer has developed has consequences, obviously.

Mr. Birnbaum noted that the safe harbor is related to any kind of liability the insurer would face for unfair discrimination based on proxy discrimination or disparate impact. If the insurer has followed the regulatory guidance to test for or to eliminate proxy discrimination and minimize disparate impact, then if it turns out that there is still some disparate impact or proxy discrimination, that insurer should have a safe harbor in the CEJ’s view. Any follow-up should be limited to repairing the problem and providing restitution for consumers. Additionally, there should not be penalties involved with unintentional consequences, despite following the best regulatory guidance.

Director Fox noted the information in the regulatory system would only be as good as the information going in and the regulators’ ability to understand whether those things were really done to the certain standards. Director Fox wondered if it is workable to have a safe harbor where the guidance is detailed enough, company-specific enough and deep-dive enough to allow a safe harbor. She asked if that is a necessary component to get compliance.

Mr. Birnbaum said whether it is necessary is going to be up to the NAIC. The CEJ certainly suggests that it is worthy of discussion. He said the CEJ wants insurers to be forthcoming with state insurance regulators and for insurers to test their practices with conscious effort to root out the impact of systemic racism. If insurers need some certainty in terms of liability for doing that, then the CEJ thinks that it is a fair trade-off to get that type of honest appraisal.

**G. NPFA**

Jeffrey M. Klein (McIntyre & Lemon on behalf of the National Premium Finance Association—NPFA) stated that the NPFA is a national trade association representing premium finance companies. The association is supportive of the NAIC’s efforts to research, review, and develop solutions regarding DE&I, as well as issues surrounding access and affordability of insurance to disadvantaged individuals and underserved communities.

Mr. Klein commented on charge H.6. with regard to premium financing. Premium finance loans provide short-term financing to help businesses and consumers purchase insurance for property, casualty, and liability risk. Many small businesses, sole proprietors, and individuals cannot afford the upfront premium expense, lack access to traditional sources of credit, and therefore, need access to insurance premium financing in order to obtain adequate coverage.

Mr. Klein also noted that while the NPFA has no specific comment on the language of the charge itself, the NPFA wants the Special (EX) Committee to be aware of its status and interest. The NPFA stands ready to provide insight, relevant input, and assistance at the appropriate time, through testimony and/or submission of materials, with regard to the premium finance mechanism and the services provided by the premium finance companies.

**H. NAIC Consumer Representatives**

Katie Keith (NAIC Consumer Representative) stated that the NAIC consumer representatives are supportive of the work of the Special (EX) Committee. The Special (EX) Committee has served as a powerful forum that needs continued executive-level commitment and support to help keep state insurance regulators and industry focused on addressing systemic racism, bias, and discrimination, and increasing diversity and inclusion in the insurance sector. The Special (EX) Committee should continue to play this role going forward in addition to ensuring that the NAIC takes concrete actions and adopts meaningful changes. An executive-level committee will remain crucial to ensuring that state insurance departments and the NAIC develop and adopt consistent policies throughout the organization.

Ms. Keith noted the NAIC consumer representatives’ comments primarily focus on Workstream Five and on health care in particular. Among the proposed charges, she said the consumer representatives urge the Workstream to prioritize: 1) enhanced data reporting and record-keeping requirements for demographic data based on race, ethnicity, language, sexual orientation, gender identity, and disability status; and 2) the use of plan network standards to advance health equity. As a starting point, she
said they urge the NAIC to develop white papers on these topics that summarize the existing literature, identify best practices, and discuss the need for consumer guardrails (such as privacy protections and training requirements). The exercise of developing white papers on these two issues will help inform stakeholder approaches, provide guidance to industry, and serve as an evergreen NAIC resource upon which to build a strong foundation.

In response to the question Commissioner Mais raised about provider adequacy, Ms. Keith said that pipeline issues and provider shortages are all known challenges that need to be overcome, but the NAIC consumer representatives also think there are tools insurance companies are underutilizing like access to essential community providers and other ways to extend care to people of color, people with disabilities, and LGBTQ people.

Ms. Keith said there is incredible urgency for the work of the Special (EX) Committee. She said the Special (EX) Committee has started a much-needed dialogue, but that is not enough to address the generations of mistreatment people of color and other historically underserved populations have faced by the insurance industry. Ms. Keith encouraged the Special (EX) Committee to focus on what the legacy of the Committee’s could be and what results actually came of the work.

I. **NAIFA**

Winona S. Havir (National Association of Insurance and Financial Advisors—NAIFA) represents the Horace Mann Companies, which is a company that was founded by educators for educators. A key component of NAIFA’s mission is to serve as an industry expert on DE&I by attracting and nurturing members from diverse backgrounds. NAIFA remains committed to this mission and has recently undertaken several leading DE&I initiatives.

With respect to charge H.1, Ms. Havir said there are opportunities to address these issues by removing the barriers that stand in the way for minorities to enter the producer workforce. She said the insurance industry must work with managers, recruiters, and executives to hire, develop, and promote candidates from all backgrounds. The insurance industry should look like the marketplace it represents, which is a diverse one. She said that underserviced communities are more receptive to agents and advisors who come from similar backgrounds and can relate to and understand their life circumstances.

With respect to charge H.7, Ms. Havir said NAIFA strongly supports the notion of financial security for all and understands that the expansion of financial education and literacy are critical. Insurance agents and producers play an enormous role in educating consumers. NAIFA is developing tools to encourage its members to take into their communities and help connect the importance of insurance and financial security. She said NAIFA looks forward to contributing our insights and expertise to this effort.

With respect to charge I.2, Ms. Havir said NAIFA has recommended expanding on this charge by addressing the need for access to producer licensing education and exams in languages other than English. She said NAIFA thinks this is an important component to increasing diversity among producers and encouraging a workforce to serve diverse consumers and communities.

J. **NAMIC**

Tony Cotto (NAMIC) noted that NAMIC remains engaged, ready and willing to discuss work on any and all proposals as they are developed.

Mr. Cotto said for the purposes of this meeting, he will start with a broad comment about the charges. The issues the Special (EX) Committee wishes to address should be specifically identified prior to coordinating and responding to alleged or perceived problems. The Special (EX) Committee and other bodies around the NAIC first needs to establish whether issues exist rather than starting with assumptions or broad mandates about potential problems or potential harms, particularly in the absence of concrete data or facts. NAMIC believes such an approach will improve and better focus the Special (EX) Committee’s work today and into the future. Mr. Cotto said as several committee members have noted, this will not be a short or easy process. Additionally, the failure to develop such foundational building blocks and establish the answers to threshold questions will undermine the credibility of any future work by the Special (EX) Committee and the NAIC.

Mr. Cotto noted a couple of specifics regarding the proposed charges and said first that NAMIC wants to commend the Special (EX) Committee’s charges related to enhancing the insurance talent pipeline. He said NAMIC continues to believe this is the most valuable area for the Special (EX) Committee’s focus and efforts. The looming retirement cliff and accompanying talent crisis in insurance is an existential problem for the industry and for state insurance regulators. Mr. Cotto said the insurance industry must work together on charge C, charge D and charge E to identify smart ways to invest in future insurance
professionals by cultivating the talent pool with an appropriate focus on students and other professionals from diverse backgrounds. He said that in addition to being more attractive employers, diverse companies are more innovative, more profitable and have better retention rates.

Mr. Cotto said second, NAMIC feels obligated to continue raising questions about proposed charges that seem to embrace outcome-oriented analysis rather than the bedrock insurance principle of risk-based pricing, the effort to match rate to risk. He said that charge F and charge G, regarding research and analytical tools to address alleged unfair discrimination and enhance data collection, appear focused on unsubstantiated notions of ongoing, unfair discrimination and the potential collection of socioeconomic and sociodemographic data that insurers do not collect, are not interested in collecting, and consumers do not want to provide. Mr. Cotto said that it is impractical, invasive, and immaterial to how P/C rates are determined and that current laws already prohibit discrimination against protected classes. Mr. Cotto noted the perspective pushed by the charges ignores the fundamental truth about fairness and economic efficiency. They are achieved best when the prices charged to individuals are irrespective of race, national origin, income, or religion and are matched as close to risk as can be made possible.

Mr. Cotto said that NAMIC recommends the Special (EX) Committee expand the dialogue to include consideration of its recently commissioned study, Matching Rate to Risk: Analysis of the Availability and Affordability of Private Passenger Automobile Insurance, conducted by Dr. Robert Klein, Senior Research Fellow with Temple University (Philadelphia, PA) Emeritus Professor of Risk Management and Insurance at Georgia State University (Atlanta, GA), and the NAIC’s former Director of Research. This study made use of the data collected by the Property and Casualty Insurance (C) Committee and Market Regulation and Consumer Affairs (D) Committee over an eight-year period and published in the NAIC’s 2020 Private Passenger Automobile Insurance Study. Dr. Klein’s analysis found, among other things, that insurers have no incentive to engage in unfair discrimination and that the NAIC’s own data does not support allegations that insurers are discriminating unfairly again low-income drivers or the areas where they live. NAMIC encourages the Special (EX) Committee to invite Dr. Klein to discuss his findings at its next meeting.

Mr. Cotto commented that Dr. Klein’s study makes clear that rather than a sole focus on the risk-based pricing structure of insurance, there are other avenues that should be studied and can contribute meaningfully to the important work of this Special (EX) Committee, and NAMIC recommends exploring them. For example, to the extent the Special (EX) Committee finds gaps in the availability or affordability of insurance and develops proposals for addressing them, NAMIC recommends that state insurance regulators consider ideas like consumer subsidies, re-distribution of premium taxes for identified communities, systematic review of historical loss ratios, and third-party vendor and algorithm transparency requirements. NAMIC is committed to substantive and meaningful action on these salient issues.

Director Fox asked if NAMIC was suggesting the Special (EX) Committee not focus at all on disparate impact and only look to intentional discrimination in rate setting? Is NAMIC suggesting that as long as it is risk-based, it does not matter if there is disparate impact?

Mr. Cotto noted that disparate impact is a very specific legal framework set up outside of the insurance mechanism and to the extent it is imported into the insurance mechanism, that is a conversation that needs to involve legislators. There has to be an acknowledgment that it would upend the entire framework of underwriting and rate-making.

Director Lindley-Myers noted that she feels an obligation to hold many of the CEOs’ to the commitment that companies need to do more and reevaluate longstanding practices that affect protected classes. In addition, regarding Mr. Birnbaum’s comments, she asked that Mr. Birnbaum please submit to the Special (EX) Committee any real-world use of the methodology he proposed insurers use to examine and identify proxy discrimination and disparate impact.

Commissioner Altmaier asked NAIC staff to revise the draft charges based on the comments heard today.

Commissioner Altman commented that she is most interested in moving forward on adopted charges so work can start on deliverables for the workstreams and the Special (EX) Committee. She urged the Special (EX) Committee to keep the process moving and adopt charges during the Special (EX) Committee’s next meeting.

Having no further business, the Special (EX) Committee on Race and Insurance adjourned.
The Information Systems (EX1) Task Force met July 27, 2021. The following Task Force members participated: Ricardo Lara, Chair, represented by David Noronha (CA); Kathleen A. Birrane, Vice Chair, represented by Paula Keen (MD); Lori K. Wing-Heier represented by Anna Latham and Alida Bus (AK); Michael Conway represented by Damion Hughes and Rolf Kaumann (CO); Trinidad Navarro represented by Tim Li (DE); Colin M. Hayashida represented by Kathleen Nakasone (HI); Grace Arnold represented by Matthew Vatter (MN); Chlora Lindley-Myers, Cynthia Amann, and Jo LeDuc (MO); Russell Toal (NM); Barbara D. Richardson (NV); Judith L. French represented by Tynesia Dorsey (OH); Glen Mulready represented by Diane Carter (OK); Doug Slape represented by Nancy Clark (TX); and Scott A. White represented by Vicki Ayers and Trish Todd (VA). Also participating were: Bud Leiner and John Kittelsrud (AZ); Rebecca Smid (FL); Tate Flott (KS); Chandra Thames (MS); Charlie Mudrick (OR); and Scott Kast (PA).

1. **Adopted its March 24 Minutes**

Ms. Keen made a motion, seconded by Mr. Toal, to adopt the Task Force’s March 24 minutes (see NAIC Proceedings – Spring 2021, Information Systems (EX1) Task Force). The motion passed unanimously.

2. **Adopted its 2022 Proposed Charges**

Ms. Ayers made a motion, seconded by Ms. Nakasone, to adopt the Task Force’s 2022 proposed charges, which remain unchanged from its 2021 charges (Attachment One). The motion passed unanimously.

3. **Received an IT Operational Summary Report**

Scott Morris (NAIC) highlighted several sections included in the Information Technology (IT) Operational Report received by the Task Force members. The report provides updates on technology initiatives at the NAIC, upcoming improvements, impacts to state technology, new offerings from the NAIC, and general updates on the activities of the NAIC technology team.

   a. **Product Highlights**

The State Based Systems (SBS) team is focusing on new state implementations. Five states are currently licensed for SBS implementation, with four currently active: 1) Vermont (August 2021); 2) Connecticut (November 2021); 3) Kansas (January 2022); and 4) Massachusetts (February 2022). Hawaii is a future implementation (third-quarter 2022).

Other key product highlights include:

- The first phase of the System for Electronic Rate and Form Filing (SERFF) Modernization project is underway. This phase is an assessment of needs and tools that can be integrated to SERFF to provide the functionality needed by state insurance regulators, such as a document management solution and a rules engine. Many states have provided input on current and future needs. Key outputs of this phase include a future state architectural diagram and an implementation plan. This phase is expected to finish by year-end.

- The Online Premium Tax for Insurance (OPTins) development team focused on improvements to Entity Management. The team implemented changes to prevent all user types from creating duplicate entities on OPTins accounts and deactivated 17,594 duplicate entity entries through database cleanup.

   b. **Innovation and Technology**

Filing Solutions and Operations helped the Interstate Insurance Product Regulation Commission (Compact) reviewers manage and have visibility of their pre-submission work. The teams decided JIRA best met the needs of the Compact reviewers, allowing workflow, communication, transparency, and reporting to occur within the same tool. After minimal training, the Compact reviewers were able to use this new tool to help organize and view their work.
NAIC teams continue the important work to migrate system applications and databases from the NAIC’s data center to Amazon Web Services (AWS) Cloud and Oracle Infrastructure Cloud (OCI). Cloud migrations are complete for two of the five environments and are operating fully in the cloud. The remaining migrations are targeted later this year.

The IT Operations team has been rolling out the Microsoft 365 services, which enable NAIC staff and external state insurance regulators to share files and collaborate in more ways than ever before. The team is working on SharePoint team sites for internal staff and has set up several external sharing sites, including Property/Casualty (P/C) Model Database, Consumer Rep Applications, SERFF Modernization, Market Regulation Collaboration, and Center for Insurance Policy and Research (CIPR) Collaboration. Additionally, 142 sites have been created and as teams complete their migration to SharePoint, more external collaboration sites will be developed.

The NAIC recently completed the 2021 Service Organization Control (SOC) 1 and SOC 2 audits for on-premises with good results. A few exceptions were found, and the team is working to correct them. The cloud SOC 2 audit is currently in progress for a shortened review period. The auditors are currently reviewing evidence and will determine if any follow-up is needed.

4. Received a Portfolio Update and Project Status Reports

Sherry Stevens (NAIC) reported on the project portfolio. As of July, the NAIC’s technical project portfolio includes 23 active technical projects. One project completed since the last report.

Having no further business, the Information Systems (EX1) Task Force adjourned into regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings.
2022 Proposed Charges

INFORMATION SYSTEMS (EX1) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

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

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Date: 8/20/21

Life Insurance and Annuities (A) Committee
Columbus, Ohio
August 16, 2021

The Life Insurance and Annuities (A) Committee met in Columbus, OH, Aug. 16, 2021. The following Committee members participated: Marlene Caride, Chair (NJ); Glen Mulready, Vice Chair (OK); Jim L. Ridling and Mark Fowler (AL); Karima M. Woods represented by Philip Barlow (DC); Doug Ommen (IA); Dean L. Cameron (ID); Vicki Schmidt (KS); James J. Donelon (LA); Barbara D. Richardson (NV); Linda A. Lacewell represented by Mark McLeod (NY); Judith L. French represented by Jana K. Jarret (RI); Elizabeth Kelleher Dwyer (RI); Carter Lawrence and Toby Compton (TN); and Mark Afable and Richard Wicka (WI).

1. **Adopted its July 19 Minutes**

Commissioner Schmidt made a motion, seconded by Commissioner Mulready, to adopt the Committee’s July 19 minutes (Attachment One). The motion passed unanimously.

2. **Adopted the Reports of its Working Group and Task Force**

Commissioner Mulready made a motion, seconded by Director Cameron, to adopt the following reports: the Accelerated Underwriting (A) Working Group, including its July 29 minutes (Attachment Two); and the Life Actuarial (A) Task Force. The motion passed unanimously.

3. **Discussed Guidance for the Life Insurance Illustration Issues (A) Working Group**

Mr. Wicka explained the history of the Life Insurance Illustration Issues (A) Working Group. He explained that the Working Group was given its charge back in 2016 to “[e]xplore how the narrative summary required by Section 7B of the Life Insurance Illustrations Model Regulation (#582) and the policy summary required by Section 5A(2) of the Life Insurance Disclosure Model Regulation (#580) can be enhanced to promote consumer readability and understandability of these life insurance summaries, including how they are designed, formatted and accessed by consumers.”

Mr. Wicka explained that early on in the process, the Working Group agreed to work on a one- to two-page consumer-oriented policy overview document to achieve its charge of improving the understandability of the life insurance policy summaries already required in Section 7B of Model #582 and Section 5A(2) of Model #580.

Mr. Wicka said the Working Group’s progress has been slow, and in 2019, it became clear that there was disagreement within the Working Group and among interested parties about the timing of the delivery of the policy overview document. At the suggestion of the then-chair of the Committee, the Working Group developed two alternate versions of revisions to Model #580 and two corresponding sample policy overviews for term life insurance policies. Mr. Wicka said one version keeps the delivery timing requirements currently in the model for delivery of the life insurance buyer’s guide; i.e., at the time of application or at the time of policy delivery if there is a free look period. He said a second version mirrors the buyer’s guide delivery timing requirements in the Annuity Disclosure Model Regulation (#245); i.e., delivery at or before the time of application.

On April 30, the Working Group voted to send to the Committee these two alternate versions of revisions to Model #580 and the sample policy overviews and ask the Committee for guidance on how to proceed (Attachment Three).

Mr. Wicka said a request for comments by Aug. 11 was emailed to Committee members, interested state insurance regulators, and interested parties. The request for comments, comments received, and a comment chart summarizing feedback were included in the materials. Mr. Wicka said the email requested comments on two issues: 1) whether the Working Group should continue working on a policy overview document to achieve its charge; and 2) what the timing for delivery of the policy overview should be if the answer to 1) is yes. He said the comments that had been received were included in the meeting materials and showed that there were state insurance regulators and interested parties that supported continuing with the model revisions and state insurance regulators and interested parties that said the Working Group had completed its charge and should disband.

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Superintendent Dwyer said it is her understanding that: 1) there is not consensus on the work product within the Working Group, and there is not likely to be consensus at the Committee level; and 2) there is a preliminary work product that had been developed by the Working Group for term life products that a state could use if it wanted to. She said these two issues lead her to question whether the Working Group should continue.

Commissioner Afable said it appears that this project has lost steam. He said the Committee needs to be practical and recognize how difficult it would be to pass model revisions out of the Executive (EX) Committee and Plenary that do not have the support of all the states or the industry that will be charged with implementing it. He said while he believes simplified disclosures could benefit consumers, he is hesitant to ask Mr. Wicka or any other state insurance regulator to spend what could be another five years on a task that may not ultimately lead to an adopted model.

Commissioner Afable suggested that Mr. Wicka should draft a “chair report” for the Committee for the Fall National Meeting, and the Committee agreed. The report will outline the work that the Working Group has accomplished and how the comments it has received over the years have been addressed. Commissioner Afable said the report will provide the information the Committee needs to decide if it should continue to pursue revisions to the model, and if not, the work product that the Working Group has accomplished so far will be part of the report and readily available for states that would like to pursue the revisions and policy overview.

Commissioner Oommen asked Mr. Wicka about the lack of consensus in the Working Group, recognizing that there has likely been membership turnover. Mr. Wicka said the Working Group has been divided on the delivery requirements, but there has not been opposition by state insurance regulators to the concept of developing a policy overview to achieve its charge. He said the comments submitted by the Aug. 11 deadline expressed sentiments that had not been raised at the Working Group level previously.

Birny Birnbaum (Center for Economic Justice—CEJ) said it does not make sense for the Working Group to abandon its task. He said there are only a few states participating on the Working Group, and to reach the conclusion that the project is not sufficiently supported does not make sense. He said the Committee is supposed to balance disparate interests and should provide the necessary support for the project and not stop work just because the industry is not supportive. He said the Committee has revisited the issue of what the Working Group’s charge should be several times and affirmed its charge. He said the CEJ supports this project, which is a modest, yet necessary, response to life insurance disclosures that were complicated. He said this is the only effort that remains at the NAIC that is seeking to improve life insurance disclosures for consumers.

Commissioner Mulready confirmed that no motion is needed to ask Mr. Wicka to develop a chair report. Director French also expressed support for this approach. No one opposed the idea. Commissioner Caride confirmed that the Committee will plan to review Mr. Wicka’s report and reach a final decision at the Fall National Meeting.

4. Received an Update on the Special (EX) Committee on Race and Insurance Workstream Four’s Work

Commissioner Afable, co-chair of the Special (EX) Committee on Race and Insurance Workstream Four, provided an update to the Committee. He explained that the Special Committee met Aug. 15 and took the following action: 1) received oral reports from its workstreams; and 2) heard a few presentations. He explained that the Special Committee charges will be officially adopted by the NAIC during the Executive (EX) Committee meeting on Aug. 17.

Commissioner Afable said Workstream Four plans to start meeting within the next month and develop a work plan to achieve its charges. He said Workstream Four is eager to start meeting in earnest to delve into the practices and barriers that potentially disadvantage minority and underserved populations in the life insurance and annuity lines of business.

Having no further business, the Life Insurance and Annuities (A) Committee adjourned.
The Life Insurance and Annuities (A) Committee met July 19, 2021. The following Committee members participated: Marlene Caride, Chair (NJ); Glen Mulready, Vice Chair, represented by Andrew Schallhorn (OK); Karima M. Woods represented by Philip Barlow (DC); Doug Ommen (IA); Dean L. Cameron represented by Michele Mackenzie (ID); Vicki Schmidt (KS); James J. Donelon represented by Tom Travis (LA); Barbara D. Richardson (NV); Linda A. Lacewell represented by Bill Carmello (NY); Judith L. French, Tynesia Dorsey, and Michelle Brugh Rafeld (OH); Elizabeth Kelleher Dwyer represented by Matt Gendron (RI); Carter Lawrence represented by Brian Hoffmeister (TN); and Mark Afable (WI). Also participating was: Mike Boerner (TX).

1. **Adopted its June 30 and Spring National Meeting Minutes**

Mr. Travis made a motion, seconded by Commissioner Afable, to adopt the Committee’s June 30 (Attachment One-A) and April 12 (see NAIC Proceedings – Spring 2021, Life Insurance and Annuities (A) Committee) minutes. The motion passed unanimously.

2. **Adopted a FAQ Guidance Document on the Best Interest Revisions to Model #275**

Commissioner Ommen explained that late last year, the Annuity Suitability (A) Working Group began development of a frequently asked questions (FAQ) guidance document to assist the states as they move forward with adopting the revisions to the Suitability in Annuity Transactions Model Regulation (#275), which added a best interest standard of conduct for insurers and producers.

Commissioner Ommen said the FAQ guidance document is part of the work the Working Group plans to do this year to complete the second part of its charge to “[c]onsider how to promote greater uniformity across NAIC-member jurisdictions.” He explained that the Working Group has been meeting since the 2020 Fall National Meeting to discuss the draft FAQ guidance document and consider revisions to the document.

During these meetings, the Working Group had robust discussions among all the stakeholders on the proposed FAQ questions and answers, particularly on those FAQ concerning the revised model’s producer training provisions. He said although the Working Group anticipates resuming its work on the FAQ guidance document sometime this fall to add additional questions related to the model’s safe harbor provision, the Working Group met May 10 (Attachment One-B) and adopted the FAQ guidance document so that it would be available to the states as soon as possible. He said 15 states have adopted the revisions to Model #275, and an additional four states are considering the revisions.

Commissioner Ommen made a motion, seconded by Mr. Gendron, to adopt the FAQ guidance document. (Attachment One-C) The motion passed unanimously.

Ms. Rafeld suggested that the FAQ be shared with the Producer Licensing (D) Task Force. Commissioner Ommen said the Working Group had discussed sharing the FAQ with the Task Force, and he agreed that this is a good idea. Commissioner Richardson asked how the guidance might apply to states that have not yet adopted the revisions. Ms. Rafeld explained that states had questions about how producer training is intended to operate under the revisions, and the FAQ guidance document is helpful to provide that uniform interpretation as states move forward. Jolie H. Matthews (NAIC) and Jennifer R. Cook (NAIC) offered to reach out to the Task Force and follow up with Ms. Rafeld and Commissioner Richardson regarding how best to share the FAQ guidance document.

3. **Adopted Valuation Manual Amendments**

Commissioner Caride said a package of 15 Valuation Manual amendments was included in the materials for the Committee’s consideration. These amendments have all been adopted by the Life Actuarial (A) Task Force. Mr. Carmello said New York objects to the mortality improvement amendment, and as a result, it will not be voting for adoption of the package.
Commissioner Afable made a motion, seconded by Commissioner Ommen, to adopt the *Valuation Manual* amendments (see *NAIC Proceedings – Summer 2021, Executive (EX) Committee and Plenary, Attachment Two*). The motion passed with New York dissenting.

Having no further business, the Life Insurance and Annuities (A) Committee adjourned.
Life Insurance and Annuities (A) Committee
E-Vote
June 30, 2021

The Life Insurance and Annuities (A) Committee conducted an e-vote that concluded June 30, 2021. The following Committee members participated: Marlene Caride, Chair (NJ); Glen Mulready, Vice Chair (OK); Jim L. Ridling (AL); Karima M. Woods (DC); Trinidad Navarro (DE); Doug Ommen (IA); Vicki Schmidt (KS); James J. Donelon (LA); Barbara D. Richardson (NV); Linda A. Lacewell (NY); Judith L. French (OH); Elizabeth Kelleher Dwyer (RI); Carter Lawrence (TN); and Mark Afable (WI).

1. Appointed the Index-Linked Variable Annuity (A) Subgroup

The following proposed charge, adopted by the Life Actuarial (A) Task Force on June 17, was emailed on June 22 to the Life Insurance and Annuities (A) Committee for adoption via e-vote:

The **Index-Linked Variable Annuity (A) Subgroup** will:

1. Provide recommendations and changes, as appropriate, to nonforfeiture or interim value requirements related to index-linked variable annuities.

An explanation for the new charge was attached to the e-vote request. The explanation provided that a design of an annuity product has emerged over the past several years that does not fall neatly into existing regulations. They are commonly referred to as index-linked variable annuities (ILVAs) or registered index-linked annuities (RILAs). These products are exclusively filed in the states as variable annuities and are funded through non-unitized separate accounts. The Life Actuarial Task Force has discussed developing a draft standard for minimum interim values for these products and providing direction for implementing the standard.

The Life Actuarial Task Force proposed the establishment of a new Indexed-Linked Variable Annuity (A) Subgroup and provided an accompanying charge to develop the interim value standard. The Committee is asked to consider approval of the Subgroup and the adoption of its proposed charge.

The following states voted to adopt the proposed charge: Alabama, Delaware, District of Columbia, Iowa, Kansas, Louisiana, Nevada, New York, Ohio, Rhode Island, Tennessee, and Wisconsin. The motion passed.

Having no further business, the Life Insurance and Annuities (A) Committee adjourned.
The Annuity Suitability (A) Working Group of the Life Insurance and Annuities (A) Committee met May 10, 2021. The following Working Group members participated: Doug Ommen, Chair (IA); Amanda Baird, Vice Chair, and Michelle Brugh Rafeld (OH); Jodi Lerner (CA); Fleur McKendell (DE); Dean L. Cameron (ID); Tatt Flott and Shannon Lloyd (KS); Renee Campbell (MI); Martin Swanson and Tom Green (NE); Keith Nyhan (NH); Andrew Schallhorn (OK); Elizabeth Kelleher Dwyer and Matt Gendron (RI); Brian Hoffmeister (TN); and Richard Wicka (WI).

1. **Adopted an FAQ Guidance Document**

Commissioner Ommen said during its March 25 meeting, the Working Group asked a small drafting group to work on a frequently asked questions (FAQ) guidance document on the producer training requirements in the revised Suitability in Annuity Transactions Model Regulation (#275), which added a best interest standard of conduct for insurers and producers. The Working Group is developing an FAQ guidance document to assist the states as they move forward with adopting the revised model as one way for it to complete its work on the second part of its 2021 charge to “[c]onsider how to promote greater uniformity across NAIC member jurisdictions.” Commissioner Ommen directed the Working Group’s attention to the small drafting group’s proposed producer FAQ (Attachment One-B1).

Ms. Rafeld said herself, Mr. Gendron, Birny Birnbaum (Center for Economic Justice—CEJ), Jason Berkowitz (Insured Retirement Institute—IRI), Kim O’Brien (Federation of Americans for Consumer Choice—FACC), Maegan Gale (National Association of Insurance and Financial Advisors—NAIFA) and Wes Bissett (Independent Insurance Agents & Brokers of America—IIABA) developed 12 proposed producer FAQ based on the Working Group’s discussion during its March 25 meeting. She explained and touched on the key points in the proposed producer FAQ. The Working Group discussed the proposed producer FAQ. The Working Group also discussed Mr. Berkowitz’s suggestion to uniformly refer to the 2020 revisions to Model #275 as the “2020 version” throughout the FAQ document. After discussion, the Working Group directed NAIC staff to revise the FAQ document to consistently refer to the 2020 revisions to Model #275 as the “2020 version.” The Working Group also agreed without any objections to add the small drafting group’s proposed producer FAQ to the FAQ document.

The Working Group next discussed the proposed new FAQ on conflict of interest explaining why cash and non-cash compensation is not considered a material conflict of interest. Commissioner Ommen noted the discussion of this proposed new FAQ during the Working Group’s March 25 meeting. He explained that since that meeting, a couple Working Group members—Ohio and Rhode Island—had reviewed Mr. Birnbaum’s suggested language and decided to offer their own suggested language, which NAIC staff distributed prior to the Working Group meeting (Attachment One-B2). Ms. Rafeld said the proposed language for this new FAQ is aimed at trying to make it clearer and more concise. She said the other consideration in developing this new language is to make it more understandable to the average layperson. The Working Group discussed the proposed language.

Mr. Bissett suggested deleting the first sentence in the proposed answer to the FAQ because he believes the first sentence could be interpreted to impose a general obligation to act in a consumer’s best interest. He said FAQ Question 4 explains that there is no general obligation to act in one’s best interest, and the revised model requires the core four obligations to be satisfied. Given this, the first sentence does not add anything substantively and can be deleted. Mr. Birnbaum said he believes the language in his version of the FAQ, which includes a description of the definition of “material conflict of interest,” is important information to be included in the FAQ because it clearly explains what a “material conflict of interest” is. He said such a description provides important context to the FAQ and why “cash” and “non-cash” compensation are not considered material conflicts of interest. He said having that definition from the revised model frames the issue of why cash and non-cash compensation are excluded from something that would influence the impartiality of the recommendation. He also suggested deleting the first sentence because the fact that someone is required to act in the best interest is a non-sequitur when it comes to a material conflict of interest because if all that is needed is a requirement for an individual to act in the best interest, then there would be no need for a “material conflict of interest” definition or the inclusion of provisions in the revised model on “material conflict of interest.” He said the proposed FAQ also does not explain why cash and non-cash compensation is excluded from the definition of “material conflict of interest” and suggests that disclosures address any issues related to compensation and potential “material conflicts of interest.” The Working Group discussed Mr. Birnbaum’s and Mr. Bissett’s
comments, particularly whether the first sentence in the proposed answer to the FAQ should be deleted. After additional discussion, the Working Group decided to include Ohio’s and Rhode Island’s proposed language for the new FAQ.

The Working Group next discussed whether it should include additional FAQ on the revised model’s safe harbor provisions. Mr. Berkowitz said the Joint Trades—the American Council of Life Insurers (ACLI), the Committee of Annuity Insurers (CAI), the Financial Services Institute (FSI), the Indexed Annuity Leadership Council (IALC), the IRI, and the National Association for Fixed Annuities (NAFA)—had submitted suggested FAQ on the safe harbor provisions, which the Working Group discussed, but it deferred making a decision to include the suggested language. After additional discussion, the Working Group agreed that it would be important to include such FAQs; however, it decided to defer discussion of specific language to include in the FAQ on the safe harbor provisions until a later date in order to have the FAQ document available to the states as soon as possible as they move forward with adoption and implementation of the revised model.

Ms. Baird made a motion, seconded by Mr. Nyhan, to adopt the FAQ guidance document (see NAIC Proceedings – Summer 2021, Life Insurance and Annuities (A) Committee, Attachment One-C) and forward it to the Life Insurance and Annuities (A) Committee for its consideration. The motion passed unanimously. The Working Group also committed to continue its work and review and discuss potential FAQ on the safe harbor provisions to include in the FAQ document following the Life Insurance and Annuities (A) Committee’s adoption of this current version of the FAQ document.

Having no further business, the Annuity Suitability (A) Working Group adjourned.
SMALL DRAFTING GROUP PRODUCER TRAINING FAQs (FINAL)

Q: Are there new producer training obligations under the revised model?
A: Yes, all producers must complete a one-time training course that covers general annuity principles – including the types and uses of annuities, how annuity contract features affect consumers, and tax implications – as well as information about the new standard of conduct and the other requirements of the revised model. The specific training required depends on what prior training the producer has completed.

Q: How can a producer satisfy the training requirements in the revised model?
A: A producer who has completed the annuity training requirements under the prior version of the model must complete either a new four-credit training course that meets the requirements of the revised model or the one-credit training course that focuses on the new sales practices, replacement and disclosure requirements established by the revised model. Courses must be approved by the insurance department.

A producer who has NOT completed the annuity training requirements under the prior version of the model must complete the four-credit training course that meets the requirements of the revised model. Producers who have not completed the annuity training requirements under the prior version of the model may not satisfy the training requirement by taking only the one-credit training course.

Q: Does the training requirement apply to producers who are registered with FINRA?
A: Yes, all producers who engage in the sale of annuities, including those registered with FINRA, must complete the training required by the revised model.

Q: When must producers complete the training requirements in the revised model?
A: A producer who has completed the annuity training requirements under the prior version of the model has six months to take the required training. Such producers may continue to recommend and sell annuities during the six-month grace period.

A producer who has NOT completed the annuity training requirements under the prior version of the model must complete the required training before engaging in the sale of annuities.

Q: What are the consequences of failing to satisfy the training requirements of the revised model?
A: A producer who fails to satisfy the training requirements is not permitted to recommend or sell annuities. A producer who recommends or sells annuities without completing the required training may face enforcement action by the insurance department.

Q: Can a producer requalify to recommend and sell annuities after failing to satisfy the training requirements of the revised model within the six-month grace period?
A: Yes, a producer who has completed the training required under the prior version of the model can requalify to recommend and sell annuities by completing the new four-credit training course prior to recommending or selling annuities.

Q: If a producer already completed the new training in another state, will they have to retake the training in every state where they may recommend or sell annuities?
A: No, completion of substantially similar training in one state satisfies the training requirement in other states. Producers are not required to take the new training multiple times.
Q. Do producers have to wait for the revised model to take effect in a particular state before taking the new required training?

A. No, a producer can take the training at any time as long as the course they take has been approved by the insurance department in a state where the producer is licensed.

Q. Will a producer get CE credit for taking the new training?

A. A producer who completes the required training will receive CE credit only if the course was approved by their resident state prior to the date the course was taken and the course provider submits a roster and all applicable fees to the insurance department in the producer’s resident state.

Q. Can a producer satisfy the training requirements by taking a longer course that covers the required training plus additional content?

A. Yes, the revised model states that a producer can also satisfy the training requirement by completing any course that is approved by the insurance department and includes components that are substantially similar to the one-credit or four-credit training course.

Q. Will completion of a course that meets the requirements of the revised model also satisfy the training requirement under the prior version of the model in a state which has not yet adopted the revised model?

A. Yes, completion of the new four-credit training course (but not the one-credit training course) will satisfy the training requirements under the prior version of the model. The new course includes all of the topics that were required to be covered under the prior version of the model (with information on the new requirements established by the revised model). A producer who has completed this course is not required to also complete a course that satisfies the prior version of the model in states that have not yet adopted the revised model.
**SEVERAL STATES PROPOSED FAQ QUESTION 9 LANGUAGE**

**Question 9:** Why did the NAIC determine that "cash and non-cash compensation" is not a material conflict of interest (as defined in Section 5I(2))? 

**Answer:** Under the revised model, a producer is required to act in the best interest of the consumer without placing their or the insurer’s financial interest ahead of the consumer’s interest. In addition, the revised model now contains a disclosure requirement in which producers must prominently disclose to a consumer, using a disclosure form (similar to Appendix A), their relationship with the consumer, the role they will play in the transaction and a description of the cash and non-cash compensation they will receive. In light of these robust disclosures, and the fact most consumers recognize producers will be compensated for their work, the NAIC determined that compensation is not a material conflict of interest.

The NAIC also determined that general incentives regarding production levels with no emphasis on any particular product do not create an unanticipated conflict of interest. However, the NAIC did conclude that sales contests, sales quotas, bonuses and non-cash compensation based on sales of specific annuities within a limited time frame should be avoided. Accordingly, the revised model requires insurers to identify and eliminate these arrangements.
This Frequently Asked Questions (FAQ) document is intended to specifically address those questions that are likely to arise as the states work to adopt the revised Suitability in Annuity Transactions Model Regulation (#275) and to assist in the uniform implementation and enforcement of its provisions across all NAIC member jurisdictions. No provision of this FAQ document is intended to supersede the specific language in Model #275.

This FAQ document is offered to any state that chooses to use it. It is not intended to expand the content of the model regulation but provides interpretive guidance regarding certain aspects of its provisions.

For purposes of this FAQ document, references to “revised model” refer to the 2020 version of Model #275.

GENERAL

Q1. Why did the NAIC decide to revise the model to include a best interest standard of conduct?

A1. The revised model was developed, in part, in response to the U.S. Department of Labor’s (DOL) fiduciary rule, which was finalized in April 2016 but vacated in its entirety in March 2018. The DOL fiduciary rule would have expanded the scope of who is considered a fiduciary to federal Employee Retirement Income Security Act of 1974 (ERISA) retirement plans and individual retirement accounts (IRAs) to include a broader set of insurance agents, insurance brokers and insurers. Separately, the U.S. Securities and Exchange Commission (SEC) released a proposed rule package in May 2018, which included Regulation Best Interest (Reg BI). The SEC finalized Reg BI in June 2019. The final Reg BI establishes a best interest standard of conduct for broker-dealers beyond the existing suitability obligation that applies to federally registered variable annuities. Recognizing the SEC’s and the DOL’s role in the regulatory landscape and believing that consumers are better protected when, to the extent possible, there is compatibility with the regulations enforced by the states, the SEC and the DOL, the NAIC revised the model to establish a framework for an enhanced standard of conduct that is more than the model’s current suitability standard but not a fiduciary standard.

Q2. How does the Harkin amendment, Section 989J of the Dodd-Frank Act apply to the revised model?

A2. Section 989J confirms state authority to regulate the sale of fixed and fixed indexed annuities and provides an exemption for such annuities from federal securities regulation when certain conditions are met, including when the state in which the contract is issued or the state in which the insurer issuing the contract is domiciled: 1) has adopted requirements that “substantially meet or exceed the minimum requirements” established by the 2010 version of the NAIC’s Suitability in Annuity Transactions Model Regulation (#275); and 2) “adopts rules that substantially meet or exceed the minimum requirements of any successor modifications to the model regulation[]” within 5 years of the adoption by the NAIC. The only exception to this requirement is if the product is issued by an insurance company that adopts and implements practices on a nationwide basis that meet or exceed the minimum requirements established by the NAIC’s Model #275, “and any successor thereto,” and is therefore subject to examination by the State of domicile or by any other State where the insurance company conducts sales of such products.

The NAIC considers the 2020 version to be a successor modification to the model that exceeds the requirements of the 2010 version, which is reflected in a drafting note to Section 1—Purpose:

“Section 989J of the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (“Dodd-Frank Act”) specifically refers to this model regulation as the “Suitability in Annuity Transactions Model Regulation.” Section 989J of the Dodd-Frank
Act confirmed this exemption of certain annuities from the Securities Act of 1933 and confirmed state regulatory authority. This regulation is a successor regulation that exceeds the requirements of the 2010 model regulation.”

As such, states need to work toward adopting the 2020 version within 5 years after its adoption by the full NAIC membership in February 2020, which, in this case, would require state adoption of the 2020 version by February 2025, to maintain the status of fixed and fixed indexed annuities meeting the requirements of Section 989J as outside the scope of federal securities regulation.

EXEMPTIONS

Q3. What is the intent of the exemption to the revised model’s provisions under Section 4A to allow a consumer in response to a direct response solicitation to purchase an annuity product where no recommendation is made based on information collected from the consumer?

A3. This exception from the rule was in the 2010 version and was not changed in the 2020 version. A direct-response solicitation is a solicitation through a sponsoring or endorsing entity solely through mails, the Internet, or other mass communication media that does not involve a communication directed to a specific individual.

BEST INTEREST STANDARD OF CONDUCT

Q4. What is the best interest standard of conduct and how would a producer or insurer satisfy it?

A4. To satisfy the best interest obligation, a producer or an insurer must satisfy four obligations: 1) care; 2) disclosure; 3) conflict of interest; and 4) documentation.

To satisfy the four obligations, when making a recommendation, producers must:
- Know the consumer’s financial situation, insurance needs and financial objectives;
- Understand the available recommendation options;
- Have a reasonable basis to believe the recommended option effectively addresses the consumer’s financial situation, insurance needs and financial objectives;
- Communicate the basis of the recommendation to the consumer;
- Disclose their role in the transaction, their compensation, and any material conflicts of interest; and
- Document, in writing, any recommendation and the justification for such recommendation.

Q5. What types of recommendations fall under the best interest standard of conduct?

A5. All recommendations made by a producer or insurer to purchase, exchange or replace an annuity product must comply with the best interest standard of conduct. Specifically, as defined in Section 5M, a “recommendation” is advice provided by a producer to an individual consumer that was intended to result or does result in a purchase, an exchange or a replacement of an annuity in accordance with that advice. A recommendation does not include general communication to the public, generalized customer services assistance or administrative support, general educational information and tools, prospectuses, or other product and sales material.

Q6. Does the best interest standard of conduct apply to a producer who never meets the client, but assists a producer in making a recommendation to the client?

A6. Yes, the standard can apply, if under Section 6A(5), a producer who has exercised material control or influence in the making of a recommendation and has received direct compensation as a result of the recommendation or sale, regardless of whether the producer has had any direct contact with the consumer. Activities such as providing or delivering marketing or educational materials, product wholesaling or other back office product support, and general supervision of a producer do not, in and of themselves, constitute material control or influence.
CARE OBLIGATION

Q7. What is the intent of language in Section 6A(1)(c), which states “Producers shall be held to standards applicable to producers with similar authority and licensure?”

A7. The intent of this language is to help to ensure that in any compliance or enforcement action, a producer’s recommendation is compared only to other producers as opposed to being compared to investment advisers or possibly higher-level fiduciaries, such as trust officers or plan sponsors under the federal Employee Retirement Income Security Act of 1974 (ERISA) for compliance and enforcement purposes.

DISCLOSURE OBLIGATION

Q8. To satisfy the disclosure obligation, Section 6A(2)(a) requires a producer to provide the completed “Insurance Agent (Producer) Disclosure for Annuities” form in Appendix A prior to a recommendation or sale of an annuity. Can a producer provide the form at the initial client meeting?

A8. Yes, a producer can satisfy the disclosure obligation by providing a completed form during the initial client meeting.

Q9. Is the producer required to update the “Insurance Agent (Producer) Disclosure for Annuities” form in Appendix A and provide it again or can the producer provide it once and satisfy this obligation?

A9. Yes, if, after the completed form is provided to the client, the information on the completed form becomes out-of-date prior to a recommendation or sale, the producer is expected to provide the consumer with an updated form.

CONFLICT OF INTEREST OBLIGATION

Q10. Why did the NAIC determine that "cash and non-cash compensation" is not a material conflict of interest (as defined in Section 5I(2))?

A10. Under the revised model, a producer is required to act in the best interest of the consumer without placing their or the insurer’s financial interest ahead of the consumer’s interest. The revised model contains a disclosure requirement in which producers must prominently disclose to a consumer, using a disclosure form (similar to Appendix A), their relationship with the consumer, the role they will play in the transaction and a description of the cash and non-cash compensation they will receive. In light of these robust disclosures, and the fact most consumers recognize producers will be compensated for their work, the NAIC determined that compensation is not a material conflict of interest.

The NAIC also determined that general incentives regarding production levels with no emphasis on any particular product do not create an unanticipated conflict of interest.

However, the NAIC did conclude that sales contests, sales quotas, bonuses and non-cash compensation based on sales of specific annuities within a limited time frame should be avoided. Accordingly, the revised model requires insurers to identify and eliminate these arrangements.

Q11. As defined in Section 5I(2), a material conflict of interest does not include cash compensation or non-cash compensation. What other type of financial interest would be considered a material conflict of interest? Is it only an ownership interest as referenced in Section 6A(3)?

A11. The revised model defines material conflict of interest as “a financial interest of the producer in the sale of an annuity that a reasonable person would expect to influence the impartiality of a recommendation.” Cash and non-cash compensation are not considered to be material conflicts of interest, though the revised model does require disclosure about producer compensation and impose restrictions on certain types of non-cash compensation, as described in Q14/A14 below. An ownership interest (such as where a producer has a material ownership interest in an insurance company whose products the producer is authorized to recommend) is one example of a material conflict of interest that would be subject to the revised model’s conflict of interest obligation. Depending on the particular facts and circumstances, a producer could also be deemed to have a material conflict of interest if, for example, he or she borrowed funds directly from a certain insurer (except for loans taken by a producer under his or her own personal insurance policy or contract) or has a spouse, partner or a close relative who works as a senior executive for a particular insurer.
Q12. Under Section 6A(3), to satisfy the conflict of interest obligation, what must a producer do to identify and avoid or reasonably manage and disclose a material conflict of interest? Examples?

A12. The appropriate steps to satisfy the obligation to identify and avoid or reasonably manage and disclose material conflicts of interest will depend on the specific facts and circumstances. In some cases, material conflicts of interest can be effectively managed by a producer by informing his or her client of the conflict and answering any questions the client may have regarding the conflict and confirming that the client is willing to continue working with the producer. In other instances, informed disclosure alone may be insufficient and is not in the client’s best interest or that puts the producer’s own financial interests ahead of the client’s interest. In such instances, a producer could, for example, consult with his or her manager, supervisor or agency principal to assess whether a conflict is inappropriately influencing the impartiality of the producer’s recommendations. Finally, there may be material conflicts of interest that cannot be effectively mitigated through informed disclosure and additional measures. In those situations, the producer would have to avoid engaging in the activity or relationship that would give rise to the conflict, or, alternatively, abstain from making the recommendation. In all cases, the producer must ultimately and before making a recommendation have a reasonable basis to believe the producer's professional relationship or capacity along with any related annuity recommendation effectively addresses the consumer's financial situation, insurance needs and financial objectives.

SUPERVISION SYSTEM

Q13. Does the revised model require insurers to set up new supervision systems to ensure producer compliance with this new standard of conduct?

A13. No, but the revised model does add additional insurer supervision requirements by requiring insurers to establish and maintain reasonable procedures in three additional areas:

- To assess whether a producer has provided to the consumer the information required by the revised model.
- To identify and address suspicious consumer refusals to provide consumer profile information.
- To identify and eliminate any sales contests, sales quotas, bonuses, and non-cash compensation that are based on the sales of specific annuities within a limited period of time.

Q14. Section 6C(2)(h) requires an insurer as part of its supervision system to identify and eliminate sales contests, quotas, bonuses, and non-cash compensation based on the sale of specific annuities within a limited period of time. What type of business practices is provision intended to address?

A14. As the provision states, insurer business practices involving sales contests, quotas, bonuses and non-cash compensation based on the sale of a specific annuity or annuities within a specified or limited period of time are prohibited and should be identified and eliminated. For example, this provision would apply where a producer’s eligibility for a particular bonus is tied to his or her sales of a particular annuity product during a particular month. However, the requirements of Section 6C(2)(h) are not intended to prohibit general incentives regarding sales of an insurance company’s products where there is no emphasis on the sale of specific annuities within a limited period of time. Section 6C(2)(h) reflects the efforts for these revisions to be compatible with other financial service rule updates, such as the recent prohibition on most sales contests, quotas and bonuses tied to the sales of particular offerings that the SEC and FINRA have implemented. See Reg. BI and FINRA Rules, including Rules 2111, 2320, 2341 and 5110.

PRODUCER TRAINING

Q15. Are there new producer training obligations under the revised model?

A15. Yes, all producers must complete a one-time training course that covers general annuity principles – including the types and uses of annuities, how annuity contract features affect consumers, and tax implications – as well as information about the new standard of conduct and the other requirements of the revised model. The specific training required depends on what prior training the producer has completed.
Q16. **How can a producer satisfy the training requirements in the revised model?**

A16. A producer who has completed the annuity training requirements under the prior version of the model must complete either a new four-credit training course that meets the requirements of the revised model or the one-credit training course that focuses on the new sales practices, replacement and disclosure requirements established by the revised model. Courses must be approved by the insurance department.

A producer who has NOT completed the annuity training requirements under the prior version of the model must complete the four-credit training course that meets the requirements of the revised model. Producers who have not completed the annuity training requirements under the prior version of the model **may not** satisfy the training requirement by taking only the one-credit training course.

Q17. **Does the training requirement apply to producers who are registered with FINRA?**

A17. Yes, all producers who engage in the sale of annuities, including those registered with FINRA, must complete the training required by the revised model.

Q18. **When must producers complete the training requirements in the revised model?**

A18. A producer who has completed the annuity training requirements under the prior version of the model has six months to take the required training. Such producers may continue to recommend and sell annuities during the six-month grace period.

A producer who has NOT completed the annuity training requirements under the prior version of the model must complete the required training before engaging in the sale of annuities.

Q19. **What are the consequences of failing to satisfy the training requirements of the revised model?**

A19. A producer who fails to satisfy the training requirements is not permitted to recommend or sell annuities. A producer who recommends or sells annuities without completing the required training may face enforcement action by the insurance department.

Q20. **Can a producer requalify to recommend and sell annuities after failing to satisfy the training requirements of the revised model within the six-month grace period?**

A20. Yes, a producer who has completed the training required under the prior version of the model can requalify to recommend and sell annuities by completing the new four-credit training course prior to recommending or selling annuities.

Q21. **If a producer already completed the new training in another state, will they have to retake the training in every state where they may recommend or sell annuities?**

A21. No, completion of substantially similar training in one state satisfies the training requirement in other states. Producers are not required to take the new training multiple times.

Q22. **Do producers have to wait for the revised model to take effect in a particular state before taking the new required training?**

A22. No, a producer can take the training at any time as long as the course they take has been approved by the insurance department in a state where the producer is licensed.
Q23. Will a producer get CE credit for taking the new training?

A23. A producer who completes the required training will receive CE credit only if the course was approved by their resident state prior to the date the course was taken, and the course provider submits a roster and all applicable fees to the insurance department in the producer’s resident state.

Q24. Can a producer satisfy the training requirements by taking a longer course that covers the required training plus additional content?

A24. Yes, the revised model states that a producer can also satisfy the training requirement by completing any course that is approved by the insurance department and includes components that are substantially similar to the one-credit or four-credit training course.

Q25. Will completion of a course that meets the requirements of the revised model also satisfy the training requirement under the prior version of the model in a state which has not yet adopted the revised model?

A25. Yes, completion of the new four-credit training course (but not the one-credit training course) will satisfy the training requirements under the prior version of the model. The new course includes all of the topics that were required to be covered under the prior version of the model (with information on the new requirements established by the revised model). A producer who has completed this course is not required to also complete a course that satisfies the prior version of the model in states that have not yet adopted the revised model.
Accelerated Underwriting (A) Working Group
Virtual Meeting (in lieu of meeting at the 2021 Summer National Meeting)
July 29, 2021

The Accelerated Underwriting (A) Working Group met July 29, 2021. The following Working Group members participated: Mark Afable, Chair (WI); Grace Arnold, Vice Chair (MN); Jason Lapham (CO); Russ Gibson (IA); Cynthia Amann (MO); Chris Aufenthie (ND); Laura Arp (NE); Lori Barron (OH); and Lichou Lee (WA).

1. Discussed the Latest Draft of the Accelerated Underwriting Educational Report

Commissioner Afable explained that the purpose of the meeting was to discuss the latest draft accelerated underwriting educational report dated July 8 (Attachment Two-A). He said the Working Group exposed the report on July 9 for a 21-day public comment period ending July 30. He added that the report is available on the Working Group’s web page.

Commissioner Arnold gave some procedural background on the draft and provided a few highlights on the substance of the draft. She said that a small regulator-only drafting group has been meeting on a weekly basis to develop a draft report. So far, two parts of what is intended to be a five-part paper have been exposed for comment. She explained that this is an iterative process and that comments are invited on the entire draft with every release of a new part. She explained that the group intends to collect and review comments throughout the process and that there will be an opportunity to revise earlier sections as new sections are developed.

Commissioner Arnold made a few comments about the content of the paper. She said that after the release of the first part of the paper, there had been quite a few comments submitted on the definition of accelerated underwriting. She explained that the drafting group had spent a lot of time on the definition and considering definitions from a number of sources, in addition to the comments. She said that the drafting group concluded that the existing definition was largely in the middle of all the options offered and decided to hold off making any changes at this point. She said the drafting group acknowledges that once the rest of the paper is drafted, there may be a need to reconsider the definition.

Commissioner Arnold explained that the drafting group tried to keep the tone of the paper neutral. She said that the presentations the Working Group heard said a lot about the advantages and disadvantages of accelerated underwriting, but the drafting group tried to stay away from that in the report. She said the focus on the report is on what accelerated underwriting is, what accelerated underwriting does, and what the regulatory structure is or should be in the context of current laws.

Commissioner Arnold said they received several suggestions to create a glossary. She explained that the drafting groups decided not to develop a glossary at this point for a few reasons, but largely because some terms are defined differently in different contexts and in different states. She said the drafting group would prefer to have clarity directly in the report and that any suggestions on how to achieve that are welcome.

Commissioner Arnold also said that there were a number of comments suggesting that the report build on other, existing documents. She said that the drafting group agrees and has made an effort to use terminology that builds on and is consistent with the Artificial Intelligence (AI) Principles and the Casualty Actuarial and Statistical (C) Task Force white paper, in particular. She said she welcomes comments on places where there could be additional consistency.

Commissioner Arnold said the drafting group is specifically requesting comments on the parts of the paper addressing, from a legal and practical perspective, the data used in accelerated underwriting programs. Feedback on the kinds of data being used—whether data sources or the scores that come from the sources, feedback on what those terms mean, what kinds of obligations flow from them, and what a consumer sees or should see—would all be welcome. She explained that the drafting group did its best, but feedback to improve the clarity of this section regarding the distinctions between the types of data and what that means for state insurance regulators, companies, and consumers will be key.

Birny Birnbaum (Center for Economic Justice—CEJ) said he plans to submit written comments, but he wanted to get a sense of where the drafting group’s thinking was on a few issues. He wondered why the report seems to conclude that state insurance regulators have all the tools they need to regulate accelerated underwriting and address consumer protection concerns when accelerated underwriting uses new third-party sources, AI and predictive modelling not used in traditional underwriting. He said the AI Principles were specifically created to address new insurer practices like accelerated underwriting, so he asked why
the paper does not include implementation of the principles in life insurance. Commissioner Arnold explained that the report has not reached the conclusion section yet, and specific recommendations have not been formulated. She said some of the preliminary recommendations do incorporate the AI Principles and specifically use language from the AI Principles document, especially with respect to transparency.

Mr. Birnbaum asked specifically how the report incorporates the AI Principle “to avoid proxy discrimination against protected classes.” Commissioner Arnold encouraged specific suggestions regarding things that might be missing. She said this is the kind of feedback they are looking for as they continue to add sections to the paper and move towards the development of more specific recommendations in the report.

Mr. Birnbaum said that the paper talks about the consumer protections afforded under the Fair Credit Reporting Act (FCRA), and he wondered why the report did not recommend the extension of those protections to non-FCRA data. He said many states have laws that regulate the use of consumer credit information and require the filing of models with the insurance commissioner. Commissioner Afable reminded the Working Group that Commissioner Arnold had identified this section, which discusses the different sources of data used in accelerated underwriting, as an area where the drafting group was hoping to receive feedback from interested parties with expertise in data subject to the FCRA. He suggested that Mr. Birnbaum include this issue in his comment letter. Commissioner Arnold said that the drafting group spent a lot of time discussing what kind of data is subject to the FCRA and how that translates to credit scores or insurance scores developed using certain data. She said additional feedback in this area will help the drafting group figure out how to make recommendations that are in line with federal and state law and the AI Principles.

Matthew Wulf (Swiss Re) said he appreciates the overview from Commissioner Arnold and that the drafting group is taking a broad approach to developing the report. He said Swiss Re plans to submit written comments. He said one of the things that Swiss Re identified Commissioner Arnold already mentioned, which is consistency throughout the paper and among the different NAIC work products and workstreams. He said one example is the accelerated underwriting definition. He said the definition of accelerated underwriting acknowledges that not all accelerated underwriting programs use advanced algorithms or machine learning, but subsequent sections seem to assume that they do. He said that Swiss Re comments will point out some of these issues, but he added that he now understands the process and that the drafting group contemplates some reconciliation of these kinds of issues once the paper is complete.

Mr. Wulf also said that the Swiss Re comments will touch on the data sources versus data sets issue that Commissioner Arnold touched on. He said the distinction between data sources and data sets, especially when it comes to identifying the origin of unfair bias, is especially critical. He said another issue Swiss Re plans to focus its comments on is the issue of causation versus correlation. He said this is another area where clarity is critical.

Having no further business, the Accelerated Underwriting (A) Working Group adjourned.

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Resources
New York Circular No. 1
Abbreviated Summary of Presentations
Introduction

In 2019, the NAIC established an accelerated underwriting working group to consider the use of external data and data analytics in accelerated life insurance underwriting, including consideration of the ongoing work of the Life Actuarial (A) Task Force on the issue and, if appropriate, draft guidance for the states. A more detailed procedural background can be found in the appendix. This paper is the output of over a year’s work by regulators to understand the current state of the industry and its use of accelerated underwriting. It summarizes what has been learned over the past year, contextualizes that learning and the topic of accelerated underwriting within other NAIC work and standard regulatory product evaluation processes, and makes recommendations for regulators and insurers when evaluating accelerated underwriting.

Accelerated underwriting in life insurance may provide potential benefits to both consumers and insurers if applied in a fair and non-discriminatory manner. In order to fairly deliver the benefits of more convenient and cost-effective processes, regulators and insurers should be guided by current law related to fair trade practices and unfair discrimination.

What is Accelerated Underwriting?

Throughout this paper, we use the term accelerated underwriting in life insurance. We propose the following as a definition:

Accelerated underwriting in life insurance is a process to replace traditional underwriting and allow some applications to have certain medical requirements (such as paramedical exams and fluid collection) waived. The process generally uses predictive models or machine learning algorithms to analyze data pertaining to the applicant, which includes both traditional and non-traditional underwriting data that comes from both the applicant and external sources.

To understand accelerated underwriting in life insurance, it helps to understand underwriting in general and how it functions. Life insurance underwriting is the process of determining eligibility and classifying applicants into risk categories to determine the appropriate rate to charge for transferring the financial risk associated with insuring the applicant. Traditional life insurance underwriting involves assessing the applicant’s physical health, usually through answers to questions on an application, blood work, urine analysis, doctor’s notes, medical records and a physical exam. Once this information is collected, an underwriter determines whether an applicant is eligible for coverage and the risk class to which that individual belongs. In addition to traditional underwriting and accelerated underwriting, there is also a process called simplified underwriting, or simplified issue. Simplified underwriting relies on very limited information (typically the applicant’s sex and age) and little, if any, additional information. Generally, there is no risk classification beyond age, gender, and possibly smoker status. Due to the limited
information collected about an applicant with simplified underwriting, the expected mortality is higher than with traditional or accelerated underwriting, and the price reflects that mortality.¹

In addition to collecting an applicant’s medical history, the types of data typically collected for use in accelerated underwriting rely upon multiple variables that are components or data points in predicative models or machine learning algorithms. Examples of the variables used by some accelerated underwriting models include: credit data, medical information bureau (MIB) data, public records, motor vehicle reports, smart phone apps, consumer activity wearables, claim acceleration tools, individual consumer risk development systems, purchasing history, behavior learned through cell phone usage and social media. An insurer may, or may not collect all this data from an applicant.

Accelerated underwriting may be limited to certain applicants applying for certain life insurance products. The exact parameters of the application of accelerated underwriting varies by insurer.

Presentations made to the Working Group indicated that life insurers use accelerated underwriting in two primary ways: 1) Accelerated underwriting is used to “triage” applicants, where unsuccessful applicants are re-routed to traditional underwriting, and successful ones continue through the accelerated underwriting process; or 2) Accelerated underwriting is used to create a score for an applicant to then be put into different risk categories. Accelerated underwriting employs a predictive model or machine learning algorithm, which is tested and modified via back-testing. The program learns from its mistakes to improve itself, using an underwriter’s feedback. It evolves over time. In fact, most accelerated underwriting algorithms used in life insurance are in their second or third generation. The COVID-19 pandemic sped up the adoption of accelerated underwriting in the industry as both consumers and insurers looked for options to purchase and write policies that relied more on technology and involved less in-person contact.

Presentations made to the Working Group indicated that adverse underwriting decisions would be reviewed by human underwriters. While some accelerated underwriting programs would issue policies based solely on the accelerated underwriting recommendation.

Companies presenting to the Working Group stated that the accelerated underwriting process is less cumbersome and costs less than traditional underwriting. By improving the underwriting experience for consumers, life insurers also benefit from quicker policy issue times with higher policy acceptance rates. ²

**General Discussion of Issues and Recommendations**

Accelerated underwriting is using multiple variables that are components or data points in an advanced algorithm. This increasing automation of life insurance underwriting presents new regulatory challenges. As is typical, the technology has moved ahead of state regulation. While differences in process have evolved, the concern the regulators have is the same as with all underwriting -- whether or not the process is **fair, transparent and secure**. With regard to accelerated underwriting in life insurance, this pertains to input data, output data, the algorithm and the results of the process.


Insurers’ increasing use of consumer data in accelerated underwriting presents regulatory challenges. One particular challenge is the potential for unfair discrimination. Some companies believe a person’s behavior has a strong correlation with mortality risk. This behavioral data includes gym membership, one’s profession, marital status, family size, grocery shopping habits, wearable technology and credit scores. Although medical data may have scientific linkage with mortality, behavioral data may lead to questionable conclusions as correlation may be confused with causation.

For example, a high-income individual may statistically be likely to receive excellent medical care. However, a high-income individual may also have the resources for illegal drug use or other dangerous habits or hobbies. A healthy young couple, on the other hand, may not have the disposable income to join a gym, however, they may exercise on their own. In either case, the lack of a gym membership or lower income may not indicate an increased mortality risk.

Recommendations

Consistent with the artificial intelligence principles approved by the NAIC in 2020, the use of accelerated underwriting in life insurance should be fair and transparent, companies should be accountable for operating in compliance with applicable laws, and the process and data used needs to be secure. To accomplish these objectives, regulators should dialogue with life insurers and third-party vendors to determine if consumer data is being used in problematic or unfair ways, or generating unfair outcomes, as is currently prohibited under most state laws.

Insurers and other parties involved in accelerated underwriting in life insurance should:

- Take steps to ensure data inputs are transparent, accurate and reliable.
- Ensure that the external data sources, algorithms or predictive models are based on sound actuarial principles with a valid explanation or rationale for any claimed correlation and causal connection.
- Be able to provide the reason(s) for any adverse underwriting decision to the consumer and all information upon which the insurer based its adverse underwriting decision.
- Take steps to protect consumer privacy and ensure consumer data is secure.
- Have a mechanism in place to correct mistakes if found.
- Produce information upon request as part of regular rate and policy reviews or market conduct examinations.

The remainder of this paper delves into some specific topics and provides more detailed recommendations about those topics.

Input data

Data typically collected for use in accelerated underwriting rely upon multiple variables that are components or data points in predicative models or machine learning algorithms. Examples of the variables used by some accelerated underwriting models include: credit data, medical information bureau data, public records, motor vehicle reports, smart phone apps, consumer activity wearables, claim acceleration tools, individual consumer risk development systems, purchasing history, behavior learned through cell phone usage and social media. A life insurer may, or may not, collect all this data from an applicant. The use of this data may have the potential for disparate impact. This section categorizes data used in accelerated underwriting programs into three buckets: traditional data, Fair Credit Reporting Act (FCRA) data, and non-traditional data. We use these buckets to articulate considerations when each type of data is used in an accelerated underwriting program. Presentations made to
the Working Group indicated that accelerated underwriting programs may use information from each of these buckets in their predictive modelling.

**Drafting Note:** The Ad Hoc Drafting Group had lengthy discussions about how best to describe the distinctions between data collected by credit bureaus, the credit scores produced by those credit bureaus, insurance scores and data used in accelerated underwriting models. We seek comment on how to accurately describe these concepts and the application of the Fair Credit Reporting Act (FCRA) to this data.

### Traditional Data

Traditional data used in life insurance underwriting includes data collected through a traditional “full”, as opposed to “simplified”, underwriting process. This data may include the following:

- Application data (e.g., medical records, prescription questions, vocation questions, financial profile).
- Tele-interview.
- Data from the Medical Information Bureau (MIB).[^3]
- Data from Motor Vehicle Records.
- Prescription drug history.
- Paramedical or medical exam, including EKG’s in some instances.
- Fluids (blood, urine, swab/spit test to determine tobacco usage).
- Financial and tax information.

### Considerations for use of Traditional Data

- Traditional data has a long and established history in the life insurance industry. Carriers, producers, and consumers are generally familiar with the process.
- Traditional data has a history of usage by insurance carriers. Trained underwriters and producers have years of experience and often understand the process well.
- The relationship of the traditional data elements to the risk seems reasonable, the consumer understands how the element impacts their risk classification or premium charged.
- State statutes and case law were developed based on the use of traditional data and so contain consumer protections created under the assumption that this was the type of data collected or reviewed during an underwriting process.
- Presentations made to the Working Group represented that time and costs associated with obtaining and reviewing traditional data are significant.

### FCRA Data

Data is subject to the federal Fair Credit Reporting Act (FCRA), which means applicants:

1. Should have a right to be told if this information is used to deny insurance, and
2. Have the ability to request the data a consumer reporting agency is providing to an insurer.

### Considerations for use of FCRA Data

- FCRA data is readily available.
- FCRA data is updated regularly.
- FCRA data is already used in property/casualty lines of business.

[^3]: This data is subject to the Fair Credit Reporting Act (FCRA).

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There is existing regulation and oversight by FCRA and Consumer Financial Protection Bureau (CFPB).
Not all FCRA data is useful/relevant to life insurance underwriting.
If there is a dispute about findings, a consumer will have to obtain additional information and formally dispute these findings.
FCRA data is extensive and accessing such data may result in access to non-usable credit attributes. In other words, significantly more data than is needed to determine risk may be collected.
As additional rating factors are introduced via insurance scores or with specific data elements, disparate impact may be introduced or amplified.
FCRA data may be used to predict mortality, but there may not be a reasonable explanation for that correlation.

Nontraditional Data

Nontraditional data used in life insurance underwriting may include the following:
- Public records (e.g., assessor data, genealogy records, criminal records, court filings, voter information).
- Property/casualty data from adjacent carrier(s).
- Marketing and social data (e.g., shopping habits, mortgage amount/lender, occupation and education, and social media, etc.).
- Professional licenses.
- Voice recognition used to determine smoking status.
- Facial recognition.
- Wearable devices.

Considerations for use of Nontraditional Data
- Nontraditional data may be used to predict mortality, but there may not be a reasonable explanation for that correlation.
- As additional rating factors are introduced via insurance scores or with specific data elements, disparate impact may be introduced or amplified.
- Nontraditional data does not have the same consumer protections as FCRA and traditional data. For example:
  - There may not be a clear path for consumers to know how data affected their application and may be corrected.
  - The type and purpose of data accessed is not required to be disclosed to the consumer.
  - There may be privacy concerns about the extent of the use of nontraditional data.

Recommendations

For Regulators
As stated above, general insurance law applies to accelerated underwriting programs in the same way it does traditional underwriting programs. State Departments of Insurance (DOIs) have broad regulatory authority to make inquiries into the processes and procedures of life insurers in order to investigate potential unfair trade practices. Complaints about underwriting practices are opportunities for DOIs to review a life insurer’s use of accelerated underwriting and data collection methods. Additional DOI actions may include market conduct and on-site examinations as appropriate under existing authorities.
• Specifically, examiners may: Review the life insurer’s underwriting practices and underwriting guidelines during an examination or upon initial submission of the policy rates and forms and confirm the proper use of the data elements.
• Request that explanation provided to the consumer for any negative action taken by the life insurer is succinct and adequately informs the consumer as to why a particular action was taken without the consumer having to make additional inquiries.
• Request information about source data regardless of whether the data or score is provided by a third party.

Form and rate reviewers may:
• Request that the life insurer provide information about how a model or algorithm will be used.
• Regulators may consider requiring filing of models used to analyze data.
• Regulators may consider questioning the extent to which data elements correlate to applicant risk.
• Request information about source data regardless of whether the data or score is provided by a third party.

For Industry
Life insurers have a responsibility to know and to understand the data they are using. To accomplish this, life insurers may choose to use tools such as post-issue audits and data analysis. For example, analyses such as evaluating claims and lapse rates may be helpful. Life insurers and third-party vendors should also take steps to ensure data inputs are accurate and reliable.

Life insurers and third-party vendors should ensure that the external data sources, algorithms or predictive models are developed with sufficient internal controls and oversight and based on sound actuarial principles with a valid explanation or rationale for any claimed correlation and causal connection.
Appendix: Additional Procedural Background
At the 2019 NAIC Summer National Meeting, the Life Insurance and Annuities (A) Committee discussed a referral it had received from the Big Data (EX) Working Group. The Big Data Working Group had discussed the use of predictive models in accelerated underwriting in life insurance, instead of medical examinations and the collection of fluids. The Big Data Working Group agreed that the issue would be most appropriately addressed by the life insurance subject matter experts and voted to refer the issue of the use of external data and data analytics in accelerated underwriting in life insurance to the Life Insurance and Annuities (A) Committee (Committee).4

The Committee discussed the referral and acknowledged that there are a multitude of issues surrounding insurers use of data models and data analytics; issues that extend into many areas of insurance and overlap with the work of several groups at the NAIC. In addition to the Big Data (EX) Working Group, there is the Innovation and Technology (EX) Task Force, the Artificial Intelligence (EX) Working Group, the Casualty Actuarial and Statistical (C) Task Force and the Privacy Protections (D) Working Group. The Life Actuarial Task Force was also looking at the use of accelerated underwriting in life insurance from an actuarial perspective, including looking at any potential impact on insurer solvency.

The Committee agreed that an effort to delve into accelerated underwriting in life insurance would need to be narrowly focused, while taking into account the work of these other NAIC groups touching on the same topic.

Robert Muriel (IL) chaired the Working Group and Grace Arnold (MN) was the vice chair. The following were Working Group members: Jason Lapham (CO); Russ Gibson (IA); Rich Piazza (LA); Cynthia Amann (MO); Rhonda Ahrens and Laura Arp (NE); Ross Hartley and Chris Auffenthe (ND); Lori Barron (OH); Elizabeth Kelleher Dwyer (RI); Lichiou Lee (WA); Mark Afable (WI). In January 2021, Commissioner Afable became chair of the Working Group and the rest of the membership remained the same.

The Working Group met for the first time on Oct 2, 2019 and developed a work plan to accomplish its charge. The work plan contemplated the Accelerated Underwriting (A) Working Group progressing through three phases with the goal of completing its charge by the 2020 Fall National Meeting. The first phase was focused on information-gathering. The second phase focused on identifying the issues and deciding on a work product, with the final phase devoted to drafting.

During the information gathering phase the Working Group heard 15 presentations from varying stakeholders, including an academic (Professor Patrick Brocket5), insurance companies, consulting firms (Deloitte and Milliman), a consumer advocate (Birny Birnbaum—CEJ), the American Academy of Actuaries, lawyers from 2 Illinois law firms (Foley & Lardner and Edelson), a machine learning assurance company (Monitaur), and a data analytics company (Verisk). Several of the presentations were held in regulator-only meetings when requested by presenters in order to share proprietary and confidential company-specific information.

Regulators from the Working Group volunteered to participate in two ad hoc groups to tackle the second and third phases of its work plan: There was an ad hoc NAIC liaison group to ensure awareness of and coordination with any work, including guidelines or protocols, developed by other NAIC groups, past and present, that related to the Working Group. There was also an ad hoc drafting group that agreed to take the information gathered, identify issues, recommend and draft a work product for review and approval by the Working Group.

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4 See NAIC Proceedings – Spring 2019, Innovation and Technology (EX) Task Force, Attachment Two.
5 Gus Wortham Chair in Risk Management and Insurance at the University of Texas at Austin and Editor, North American Actuarial Journal.
In November 2020, the ad hoc drafting group shared with the Accelerated Underwriting (A) Working Group, a proposed draft outline for an educational report exploring accelerated underwriting in life insurance to provide guidance to regulators, industry, and consumer advocates and other stakeholders. In February 2021, the ad hoc groups merged.
The Life Insurance Illustration Issues (A) Working Group of the Life Insurance and Annuities (A) Committee met April 30, 2021. The following Working Group members participated: Richard Wicka, Chair (WI); Jodi Lerner (CA); Chris Struk (FL); Teresa Winer (GA); Mike Yanacheak (IA); Jana Jarrett (OH); Brian Hoffmeister (TN); and John Carter (TX). Also participating were: Denise Lamy (NH); Sarah Neil (RI); John Carter (TX); James Young (VA); and David Hippen (WA).

1. Referred Policy Overview Revisions to the Life Insurance and Annuities (A) Committee for Feedback on the Timing Issue

Mr. Wicka reminded the Working Group that that the issue of timing for the delivery of the policy overview is an issue that the Working Group had not resolved and that two alternate versions for term life insurance policies have been developed and revised by the Working Group during its two previous meetings. He said that the purpose of this meeting is to consider sending draft alternate versions of revisions for term life insurance policies to the Life Insurance Disclosure Model Regulation (#580) (Attachment Three-A and Attachment Three-B), as well as sample policy overview documents reflecting the different timing for delivery (Attachment Three-C and Attachment Three-D), to the Life Insurance and Annuities (A) Committee. He said that having alternate versions showing how the model and sample policy overview would look if delivery was required pre-underwriting and post-underwriting will enable the Committee to provide guidance to the Working Group on how to proceed with revising Model #580 and developing sample policy overviews for whole life and universal life insurance policies.

Mr. Wicka reiterated that there would still be an opportunity to revise Model #580 and the policy overview as it pertains to term life insurance policies after guidance comes back from the Committee. He explained that the Working Group is not actually adopting these versions, but rather it is voting on whether to refer them to the Committee. He explained that the alternate versions will provide the Committee with context as it considers whether the policy overview should follow the timing requirements currently in the model for the Life Insurance Buyer’s Guide (delivery at the time of application or at the time of policy delivery if there is a free look period) or delivery at the time of application.

Birny Birnbaum (Center for Economic Justice—CEJ) said he is comfortable with sending the sample policy overviews to the Committee, but he said he does not want to send the draft revisions to Model #580. He said he is concerned that the Model #580 revisions do not track what is in the sample policy overview documents and that including them may confuse the timing issue about which the Working Group is requesting guidance. Mr. Birnbaum said that Model #580 talks about what needs to be included in the policy overview in general terms, like an explanation or a summary of certain topics, while the sample policy overview includes specific sample language that has been thoroughly discussed and refined. As a result, the Model #580 language needs to be revised to more closely mirror what the Working Group has spent time discussing and revising—which is the language in the sample policy overview. Mr. Wicka said that there is a balance between the directions in Model #580 and the sample, which is an example of one way that the requirements in the model could be displayed. He said after the Working Group receives direction from the Committee on the timing, the Working Group will need to discuss the issues of language and layout and how specific the directions in Model #580 should be.

Patrick Reeder (American Council of Life Insurers—ACLI) said that the ACLI and its members share the goal of the Working Group—to protect consumers. He said that life insurers have great insights into how consumers think and react and added that the ACLI and its members want to continue to partner with the Working Group as it finishes up this important project.

Mr. Yanacheak made a motion, seconded by Ms. Winer, to send to the Life Insurance and Annuities (A) Committee, alternate versions of revisions to Model #580 and the sample policy overview for term life insurance policies for the purpose of obtaining direction for the Working Group on timing for delivery of the policy overview. The motion passed unanimously.

Having no further business, the Life Insurance Illustration Issues (A) Working Group adjourned.
LIFE INSURANCE DISCLOSURE MODEL REGULATION

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Section 1. Authority

This rule is adopted and promulgated by the commissioner of insurance pursuant to [insert state equivalent to Section 4A(1) of the Unfair Trade Practices Act] of the Insurance Code.

Drafting Note: Insert title of chief insurance regulatory official wherever the term “commissioner” appears.

Section 2. Purpose

A. The purpose of this regulation is to require insurers to deliver to purchasers of life insurance information that will improve the buyer’s ability to select the most appropriate plan of life insurance for the buyer’s needs and improve the buyer’s understanding of the basic features of the policy that has been purchased or is under consideration.

B. This regulation does not prohibit the use of additional material that is not a violation of this regulation or any other [state] statute or regulation.

Section 3. Scope

A. Except for the exemptions specified in Section 3B, this regulation shall apply to any solicitation, negotiation or procurement of life insurance occurring within this state. Section 5B shall apply only to an existing nonexempt policy held by a policyowner residing in this state. This regulation shall apply to any issuer of life insurance contracts including fraternal benefit societies.

B. This regulation shall not apply to:

(1) Individual and group annuity contracts;

(2) Credit life insurance;

(3) Group life insurance (except for disclosures relating to preneed funeral contracts or prearrangements; these disclosure requirements shall extend to the issuance or delivery of certificates as well as to the master policy);

(4) Life insurance policies issued in connection with pension and welfare plans as defined by and which are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. Section 1001 et seq. as amended; or
Variable life insurance under which the amount or duration of the life insurance varies according to the investment experience of a separate account.

Section 4. Definitions

For the purposes of this regulation, the following definitions shall apply:

A. “Buyer’s Guide” means the current Life Insurance Buyer’s Guide adopted by the National Association of Insurance Commissioners (NAIC) or language approved by the commissioner.

B. “Current scale of nonguaranteed elements” means a formula or other mechanism that produces values for an illustration as if there is no change in the basis of those values after the time of illustration.

C. “Generic name” means a short title that is descriptive of the premium and benefit patterns of a policy or a rider.

D. “Illustration” means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years that is subject to [insert state equivalent to Life Insurance Illustrations Model Regulation (#582)].

E. “Nonguaranteed elements” means the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these, that are subject to company discretion and are not guaranteed at issue. An element is considered non-guaranteed if any of the underlying non-guaranteed elements are used in its calculation.

F. “Policy data” means a display or schedule of numerical values, both guaranteed and nonguaranteed for each policy year or a series of designated policy years of the following information: illustrated annual, other periodic, and terminal dividends; premiums; death benefits; cash surrender values and endowment benefits.

G. “Policy summary Overview” means a written statement describing the elements of the policy, including, but not limited to brief summary of the policy prepared in accordance with this regulation and an example may be found in Appendix A.

G. “Guaranteed Premium and Benefit Patterns Summary” is a separate document that accompanies the Policy Overview where the insurer has identified the policy as one that will not be marketed with an illustration.

G. “Preneed funeral contract or prearrangement” means an agreement by or for an individual before that individual’s death relating to the purchase or provision of specific funeral or cemetery merchandise or services.

Section 5. Duties of Insurers

A. Requirements Applicable Generally

(1) The insurer shall provide a Buyer’s Guide to all prospective purchasers, prior to accepting the applicant’s initial premium or premium deposit. However, if the policy for which application is made contains an unconditional refund provision of at least ten (10) days, the Buyer’s Guide may be delivered with the policy or prior to delivery of the policy.

(2) The insurer shall provide a Policy Overview to all prospective purchasers. Delivery of the Policy Overview shall be consistent with the time for delivery of the Buyer’s Guide as specified in Paragraph (1). Insurers should endeavor to limit the length of the Policy Overview to the minimum length necessary to reasonably inform consumers of the information required to be included in the Policy Overview. The Policy Overview is not required to be in a specific format beyond the requirements of this Section. The Policy Overview must be prepared in language and in a format...
that would be understood by a typical person within the segment of the public to which the policy is directed. A sample Policy Overview that meets the requirements of this Section is provided in Appendix A. A Policy Overview shall include the following topics with appropriate headings:

(a) An introductory section containing the following language: “This document lists this product’s key features, and benefits and costs. You can get a similar summary of key product features from other insurance companies to help you compare similar product policies. If you have questions about life insurance generally or other types of policies, the National Association of Insurance Commissioners has useful information at https://content.naic.org/consumer/life-insurance.htm/. If you have questions about this particular life insurance policy, ask the agent, broker, advisor, or a company representative offering this product for clarification. If you have questions about life insurance products generally or about company or agent licensing, contact [insert reference to state department of insurance].”

(b) “Company [and Agent Information]” which shall contain the name, address, email address and phone contact information of the insurance company and insurance agent, if an agent is involved and the name of the insured for whom the Policy Overview was prepared and the email and phone contact information of the insurer and insurance agent.

(c) “Information We Use to Determine Your Premium” which shall include the following information about the policy owner and insured, as applicable:

   (i) A brief description of the data elements that the insurer collects from the applicant and other sources that are used to determine an applicant’s premium;

   (ii) A brief description of the policy features that will affect the amount of premium such as the amount of the death benefit and optional riders;

   (iii) How Risk class or the estimated risk class is assessed used to generate the quote, if applicable;

(d) “Cost Information” which shall include the following information, as applicable:

   (i) An explanation of how much the life insurance policy costs or is estimated to cost at the time of application, including initial premium or the estimated premium quoted at the time of application and an explanation of differences in costs based on premium mode selected;

   (ii) A brief description summary of the available options for funding the policy and the minimum funding needed to maintain the policy in force;

   (iii) An yes or no indication explanation of whether the premium can vary and, if so, a brief explanation as to how the premium will be determined;

   (iv) An yes or no indication explanation of whether there are surrender charges and any costs associated with cancelling the policy (i.e. surrender charges) and, if yes, the period of time the charges apply or, if no, whether any money is eligible to be returned;

   (v) A yes or no indication of whether there is an option to lower benefits to reduce premium;

   (vi) If applicable, a narrative description of fees other than premium;
(vii) If applicable, a narrative explanation of the cost of insurance fee, how the cost of insurance fee changes with age, a narrative explanation of the net amount of risk to which the fee will apply, and the maximum allowable cost of insurance fee allowed under the policy.

(e) “Policy Information” which shall include the following information, as applicable:

(i) Product Policy type (Including single or joint policy);

(ii) Product Policy name;

(iii) State of issue;

(iv) An indication of whether the policy is term or permanent life insurance, and if it is term insurance, the length of the initial term, including whether and how the term may be extended;

(v) If the Policy Overview is provided prior to underwriting, a general description of what the policyholder needs to do to obtain the policy

(vi) If the Policy Overview is provided prior to underwriting, the following statement: “In the course of considering an insured’s application, an insurer may request or collect health information about the insured in variety of ways.” The statement shall indicate whether a physical examination or questionnaire will be required.

(vii) Death benefit or the death benefit as applied for;

(viii) A yes or no indication of whether the death benefit can change, and if yes, a brief summary of the reasons and timing for a change in the death benefit;

(v) State of issue;

(vi) Policy loan options and applicable charges, if applicable;

(f) “Additional Policy Benefits” which shall include the following information, as applicable:

(i) A yes or no indication of whether a waiver of premium or deductions option is available, and if yes, a description summary of the options available;

(ii) A yes or no indication of whether policy conversion options exist and, if yes, a brief summary of conversion options available;

(iii) If the policy has a term, a yes or no indication of whether there are options to extend the term of the coverage;

(iv) A yes or no indication of the availability of optional riders and, if yes, a brief description summary of how the insured may obtain additional information regarding the availability and costs of optional riders;

(vi) A yes or no indication of any living benefit option(s), and if yes, a description summary of the option(s);

(vii) A yes or no indication of whether the policy can accumulate cash value, and if yes, a description summary of the benefit;
(viii) A yes or no indication of whether there are guaranteed interest rates on fixed accounts and, if yes, the amount of the guaranteed interest rate, if applicable;

(ix) A yes or no indication of whether there are indexed account options and if yes, a brief description summary of how the insured may obtain additional information regarding indexed account options, if applicable.

(2)(3) The insurer shall provide a policy summary Guaranteed Premium and Benefits Patterns Summary to prospective purchasers where the insurer identified the policy form as one that will not be marketed with an illustration. Delivery of the Guaranteed Premium and Benefits Patterns Summary shall be consistent with the time for delivery of the Buyer’s Guide as specified in Paragraph (1). The policy summary Guaranteed Premium and Benefits Pattern Summary shall show guarantees only. It shall consist of a separate document with and include all required information set out in a manner that does not minimize or render any portion of the summary obscure. Any amounts that remain level for two (2) or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in Section 4F(5) shall be listed in total, not on a per thousand or per unit basis. If more than one insured is covered under one policy or rider, death benefits shall be displayed separately for each insured or for each class of insureds if death benefits do not differ within the class. Zero amounts shall be displayed as a blank space. Delivery of the policy summary shall be consistent with the time for delivery of the Buyer’s Guide as specified in Paragraph (1). The following amounts, where applicable, for the first five (5) policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns; including at least one age from sixty (60) through sixty-five (65) and policy maturity:

(a) The annual premium for the basic policy;

(b) The annual premium for each optional rider;

(c) The amount payable upon death at the beginning of the policy year regardless of the cause of death, other than suicide or other specifically enumerated exclusions, that is provided by the basic policy and each optional rider; with benefits provided under the basic policy and each rider shown separately;

(d) The total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider;

(e) Any endowment amounts payable under the policy that are not included under cash surrender values above;

(f) The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. If the policy loan interest rate is adjustable, the Guaranteed Premium and Benefits Patterns Summary shall also indicate that the annual percentage rate will be determined by the company in accordance with the provisions of the policy and the applicable law.

B. Requirements Applicable to Existing Policies.

(1) Upon request by the policyowner, the insurer shall furnish either policy data or an in force illustration as follows:

(a) For policies issued prior to the effective date of [insert state equivalent to Life Insurance Illustrations Model Regulation], the insurer shall furnish policy data, or, at its option, an in force illustration meeting the requirements of [insert state equivalent to Life Insurance Illustrations Model Regulation].
(b) For policies issued after the effective date of the illustration regulation that were declared not to be used with an illustration, the insurer shall furnish policy data, limited to guaranteed values, if it has chosen not to furnish an in force illustration meeting the requirements of the regulation.

(c) If the policy was issued after the effective date of the illustration regulation and declared to be used with an illustration, an in force illustration shall be provided.

(d) Unless otherwise requested, the policy data shall be provided for twenty (20) consecutive years beginning with the previous policy anniversary. The statement of policy data shall include nonguaranteed elements according to the current scale, the amount of outstanding policy loans, and the current policy loan interest rate. Policy values shown shall be based on the current application of nonguaranteed elements in effect at the time of the request. The insurer may charge a reasonable fee, not to exceed $[insert amount], for the preparation of the statement.

(2) If a life insurance company changes its method of determining scales of nonguaranteed elements on existing policies; it shall, no later than when the first payment is made on the new basis, advise each affected policy owner residing in this state of this change and of its implication on affected policies. This requirement shall not apply to policies for which the amount payable upon death under the basic policy as of the date when advice would otherwise be required does not exceed $5,000.

(3) If the insurer makes a material revision in the terms and conditions under which it will limit its right to change any nonguaranteed factor; it shall, no later than the first policy anniversary following the revision, advise each affected policy owner residing in this state.

Section 6. Preneed Funeral Contracts or Prearrangements

The following information shall be adequately disclosed at the time an application is made, prior to accepting the applicant’s initial premium or deposit; for a preneed funeral contract or prearrangement that is funded or to be funded by a life insurance policy:

A. The fact that a life insurance policy is involved or being used to fund a prearrangement;

B. The nature of the relationship among the soliciting agent or agents, the provider of the funeral or cemetery merchandise or services, the administrator and any other person;

C. The relationship of the life insurance policy to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement;

D. The impact on the prearrangement:

(1) Of any changes in the life insurance policy including but not limited to, changes in the assignment, beneficiary designation or use of the proceeds;

(2) Of any penalties to be incurred by the policyholder as a result of failure to make premium payments;

(3) Of any penalties to be incurred or monies to be received as a result of cancellation or surrender of the life insurance policy;

E. A list of the merchandise and services which are applied or contracted for in the prearrangement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need;
F. All relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the proceeds of the life insurance policy and the amount actually needed to fund the prearrangement;

G. Any penalties or restrictions, including but not limited to geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or the prearrangement guarantee; and

Drafting Note: States should consider whether the insurance regulator has the authority to enforce the provisions of Subsections E, F and G.

H. If so, the fact that a sales commission or other form of compensation is being paid and the identity of the individuals or entities to whom it is paid.
Section 7. General Rules

A. Each insurer shall maintain, at its home office or principal office, a complete file containing one copy of each document authorized and used by the insurer pursuant to this regulation. The file shall contain one copy of each authorized form for a period of three (3) years following the date of its last authorized use unless otherwise provided by this regulation.

B. An agent shall inform the prospective purchaser, prior to commencing a life insurance sales presentation, that he or she is acting as a life insurance agent and inform the prospective purchaser of the full name of the insurance company which the agent is representing to the buyer. In sales situations in which an agent is not involved, the insurer shall identify its full name.

C. An insurance producer shall not use terms such as “financial planner,” “investment advisor,” “financial consultant,” or “financial counseling” in such a way as to imply that he or she is primarily engaged in an advisory business in which compensation is unrelated to sales unless that is actually the case. This provision is not intended to preclude persons who hold some form of formal recognized financial planning or consultant designation from using this designation even when they are only selling insurance. This provision also is not intended to preclude persons who are members of a recognized trade or professional association having such terms as part of its name from citing membership, providing that a person citing membership, if authorized only to sell insurance products, shall disclose that fact. This provision does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies.

D. Any reference to nonguaranteed elements shall include a statement that the item is not guaranteed and is based on the company’s current scale of nonguaranteed elements (use appropriate special term such as “current dividend” or “current rate” scale.) If a nonguaranteed element would be reduced by the existence of a policy loan, a statement to that effect shall be included in any reference to nonguaranteed elements. A presentation or depiction of a policy issued after the effective date of the [insert citation to state equivalent to Life Insurance Illustrations Model Regulation] that includes nonguaranteed elements over a period of years shall be governed by that regulation.

Section 8. Failure to Comply

Failure of an insurer to provide or deliver a Buyer’s Guide, an in force illustration, a policy summary or policy data as provided in Section 5 shall constitute an omission that misrepresents the benefits, advantages, conditions or terms of an insurance policy.

Section 9. Separability

If any provisions of this rule be held invalid, the remainder shall not be affected.

Section 10. Effective Date

This rule shall become effective [insert a date at least 6 months following adoption by the regulatory authority].
LIFE INSURANCE DISCLOSURE MODEL REGULATION

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Section 1. Authority

This rule is adopted and promulgated by the commissioner of insurance pursuant to [insert state equivalent to Section 4A(1) of the Unfair Trade Practices Act] of the Insurance Code.

Drafting Note: Insert title of chief insurance regulatory official wherever the term "commissioner" appears.

Section 2. Purpose

A. The purpose of this regulation is to require insurers to deliver to purchasers of life insurance information that will improve the buyer’s ability to select the most appropriate plan of life insurance for the buyer’s needs and improve the buyer’s understanding of the basic features of the policy that has been purchased or is under consideration.

B. This regulation does not prohibit the use of additional material that is not a violation of this regulation or any other [state] statute or regulation.

Section 3. Scope

A. Except for the exemptions specified in Section 3B, this regulation shall apply to any solicitation, negotiation or procurement of life insurance occurring within this state. Section 5B shall apply only to an existing nonexempt policy held by a policyowner residing in this state. This regulation shall apply to any issuer of life insurance contracts including fraternal benefit societies.

B. This regulation shall not apply to:

1. Individual and group annuity contracts;
2. Credit life insurance;
3. Group life insurance (except for disclosures relating to preneed funeral contracts or prearrangements; these disclosure requirements shall extend to the issuance or delivery of certificates as well as to the master policy);
4. Life insurance policies issued in connection with pension and welfare plans as defined by and which are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. Section 1001 et seq. as amended; or
Variable life insurance under which the amount or duration of the life insurance varies according to the investment experience of a separate account.

Section 4. Definitions

For the purposes of this regulation, the following definitions shall apply:

A. “Buyer’s Guide” means the current Life Insurance Buyer’s Guide adopted by the National Association of Insurance Commissioners (NAIC) or language approved by the commissioner.

B. “Current scale of nonguaranteed elements” means a formula or other mechanism that produces values for an illustration as if there is no change in the basis of those values after the time of illustration.

C. “Generic name” means a short title that is descriptive of the premium and benefit patterns of a policy or a rider.

C. “Illustration” means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years that is subject to [insert state equivalent to Life Insurance Illustrations Model Regulation (#582)].

D. “Nonguaranteed elements” means the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these, that are subject to company discretion and are not guaranteed at issue. An element is considered non-guaranteed if any of the underlying non-guaranteed elements are used in its calculation.

E. “Policy data” means a display or schedule of numerical values, both guaranteed and nonguaranteed for each policy year or a series of designated policy years of the following information: illustrated annual, other periodic, and terminal dividends; premiums; death benefits; cash surrender values and endowment benefits.

F. “Policy summary Overview” means a written statement describing the elements of the policy, including, but not limited to a brief summary of the policy prepared in accordance with this regulation and an example may be found in Appendix A.

G. “Guaranteed Premium and Benefit Patterns Summary” is a separate document that accompanies the Policy Overview where the insurer has identified the policy as one that will not be marketed with an illustration.

G. “Preneed funeral contract or prearrangement” means an agreement by or for an individual before that individual’s death relating to the purchase or provision of specific funeral or cemetery merchandise or services.

Section 5. Duties of Insurers

A. Requirements Applicable Generally

(1) The insurer shall provide a Buyer’s Guide to all prospective purchasers, prior to accepting the applicant’s initial premium or premium deposit. However, if the policy for which application is made contains an unconditional refund provision of at least ten (10) days, the Buyer’s Guide may be delivered with the policy or prior to delivery of the policy.

(2) The insurer shall provide a Policy Overview to all prospective purchasers. Where the application for a life insurance policy is taken at a face-to-face meeting, the applicant at or before the time of application shall be given the Policy Overview. Where the application for a life insurance policy is taken by means other than in a face-to-face meeting, the applicant shall be sent the Policy Overview not later than five business days after the receipt of the application. The Policy Overview is a summary of the high level features and terms of the policy. Insurers should endeavor to limit the
length of the Policy Overview to the minimum length necessary to reasonably inform consumers of the information required to be included in the Policy Overview. The Policy Overview is not required to be in a specific format beyond the requirements of this Section. The Policy Overview must be prepared in language and in a format that would be understood by a typical person within the segment of the public to which the policy is directed. A sample Policy Overview that meets the requirements of this Section is provided in Appendix A. A Policy Overview shall include the following topics with appropriate headings:

(a) An introductory section containing the following language: “This document lists this product insurance policy’s key features and benefits. You can get a similar summary of key product policy features from other insurance companies to help you compare similar product policies. If you have questions about life insurance generally or other types of policies, the National Association of Insurance Commissioners has useful information at [insert reference to website]. If you have questions about this particular life insurance policy, ask the agent, broker, advisor, or a company representative offering this product for clarification. If you have questions about life insurance products generally or about company or agent licensing, contact [insert reference to state department of insurance].”

(b) “Company [and Agent] Information” which shall contain the name, address, email address and phone contact information of the insurance company and insurance agent, if an agent is involved, and the name of the insured for whom the Policy Overview was prepared and the email and phone contact information of the insurer and insurance agent.

(c) “Information We Use to Determine Your Premium” which shall include the following information about the policy owner and insured, as applicable:

(i) A brief description of the data elements that the insurer collects from the applicant and other sources that are used to determine an applicant’s premium;

(ii) A brief description of the policy features that will affect the amount of premium such as the amount of the death benefit and optional riders;

(iii) Estimated risk class used is assessed to generate the quote, if applicable;

(d) “Cost Information” which shall include the following information, as applicable:

(i) An explanation of how much the life insurance policy costs to cost at the time of application, including the estimated premium and an explanation of the differences in cost based on premium mode selected, if applicable;

(ii) A brief description summary of the available options for funding the policy and the minimum funding needed to maintain the policy in force;

(iii) An yes or no indication of whether the premium can vary and, if so, a brief explanation as to how the premium will be determined;

(iv) An yes or no indication of whether there are any costs associated with cancelling the policy (i.e. surrender charges) and, if yes, the period of time the charges apply or, if no, whether any money is eligible to be returned;
(iv) A yes or no indication of whether there is an option to lower benefits to reduce premium;

(iv) If applicable, a narrative description of fees other than premium;

(vi) If applicable, a narrative explanation of the cost of insurance fee, how the cost of insurance fee changes with age, a narrative explanation of the net amount of risk to which the fee will apply, and the maximum allowable cost of insurance fee allowed under the policy

(d) “Policy Information” which shall include the following information, as applicable:

(i) Product Policy type (Including single or joint policy);

(ii) Product Policy name;

(iii) State of issue;

(iiiy) An indication of whether the policy is term or permanent life insurance, and if it is term insurance, the length of the initial term, including whether and how the term may be extended;

(v) A general description of what the policyholder needs to do to obtain the policy

(vi) The following statement: “In the course of considering an insured’s application, an insurer may request or collect health information about the insured in variety of ways.” The statement shall indicate whether a physical examination or questionnaire will be required;

(vii) Death benefit that is available or the death benefit as applied for;

(vi) A yes or no indication of whether the death benefit can change, and if yes, a brief summary of the reasons and timing for a changes in the death benefit;

(vii) State of issue;

(viii) Policy loan options and applicable charges, if applicable;

(f) “Additional Policy Benefits” which shall include the following information, as applicable:

(i) A yes or no indication of whether a waiver of premium or deductions option is available, and if yes, a summary of the options available;

(ii) A yes or no indication of whether policy conversion options exist and, if yes, a summary of conversion options available;

(iii) If the policy has a term, options to extend the term of the coverage;

(iviii) A yes or no indication of the availability of optional riders and, if yes, a brief description summary of how the insured may obtain additional information regarding the availability and costs of optional riders;

(xiv) A yes or no indication of any living benefit option(s), and if yes, a summary of the option(s);
(vii) A yes or no indication of whether the policy can accumulate cash value, and if yes, a summary of the benefit;

(viii) A yes or no indication of whether there are guaranteed interest rates on fixed accounts and, if yes, the amount of the guaranteed interest rate;

(ixvii) A yes or no indication of whether there are indexed account options and if yes, a brief description summary of how the insured may obtain additional information regarding indexed account options.

(2)(3) The insurer shall provide a policy summary Guaranteed Premium and Benefits Patterns Summary to prospective purchasers where the insurer identified the policy form as one that will not be marketed with an illustration. Delivery of the Guaranteed Premium and Benefits Patterns Summary shall be consistent with the time for delivery of the Buyer’s Guide as specified in Paragraph (1). The policy summary Guaranteed Premium and Benefits Pattern Summary shall show guarantees only. It shall consist of a separate document with and include all required information set out in a manner that does not minimize or render any portion of the summary obscure. Any amounts that remain level for two (2) or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in Section 4F(5) shall be listed in total, not on a per thousand or per unit basis. If more than one insured is covered under one policy or rider, death benefits shall be displayed separately for each insured or for each class of insureds if death benefits do not differ within the class. Zero amounts shall be displayed as a blank space. Delivery of the policy summary shall be consistent with the time for delivery of the Buyer’s Guide as specified in Paragraph (1). The following amounts, where applicable, for the first five (5) policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns; including at least one age from sixty (60) through sixty-five (65) and policy maturity:

(a) The annual premium for the basic policy;

(b) The annual premium for each optional rider;

(c) The amount payable upon death at the beginning of the policy year regardless of the cause of death, other than suicide or other specifically enumerated exclusions, that is provided by the basic policy and each optional rider; with benefits provided under the basic policy and each rider shown separately;

(d) The total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider;

(e) Any endowment amounts payable under the policy that are not included under cash surrender values above;

(f) The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. If the policy loan interest rate is adjustable, the Guaranteed Premium and Benefits Patterns Summary shall also indicate that the annual percentage rate will be determined by the company in accordance with the provisions of the policy and the applicable law.

B. Requirements Applicable to Existing Policies.

(1) Upon request by the policyowner, the insurer shall furnish either policy data or an in force illustration as follows:
(a) For policies issued prior to the effective date of [insert state equivalent to Life Insurance Illustrations Model Regulation], the insurer shall furnish policy data, or, at its option, an in force illustration meeting the requirements of [insert state equivalent to Life Insurance Illustrations Model Regulation].

(b) For policies issued after the effective date of the illustration regulation that were declared not to be used with an illustration, the insurer shall furnish policy data, limited to guaranteed values, if it has chosen not to furnish an in force illustration meeting the requirements of the regulation.

(c) If the policy was issued after the effective date of the illustration regulation and declared to be used with an illustration, an in force illustration shall be provided.

(d) Unless otherwise requested, the policy data shall be provided for twenty (20) consecutive years beginning with the previous policy anniversary. The statement of policy data shall include nonguaranteed elements according to the current scale, the amount of outstanding policy loans, and the current policy loan interest rate. Policy values shown shall be based on the current application of nonguaranteed elements in effect at the time of the request. The insurer may charge a reasonable fee, not to exceed $[insert amount], for the preparation of the statement.

(2) If a life insurance company changes its method of determining scales of nonguaranteed elements on existing policies; it shall, no later than when the first payment is made on the new basis, advise each affected policy owner residing in this state of this change and of its implication on affected policies. This requirement shall not apply to policies for which the amount payable upon death under the basic policy as of the date when advice would otherwise be required does not exceed $5,000.

(3) If the insurer makes a material revision in the terms and conditions under which it will limit its right to change any nonguaranteed factor; it shall, no later than the first policy anniversary following the revision, advise each affected policy owner residing in this state.

Section 6. Preneed Funeral Contracts or Prearrangements

The following information shall be adequately disclosed at the time an application is made, prior to accepting the applicant’s initial premium or deposit; for a preneed funeral contract or prearrangement that is funded or to be funded by a life insurance policy:

A. The fact that a life insurance policy is involved or being used to fund a prearrangement;

B. The nature of the relationship among the soliciting agent or agents, the provider of the funeral or cemetery merchandise or services, the administrator and any other person;

C. The relationship of the life insurance policy to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement;

D. The impact on the prearrangement:

   (1) Of any changes in the life insurance policy including but not limited to, changes in the assignment, beneficiary designation or use of the proceeds;

   (2) Of any penalties to be incurred by the policyholder as a result of failure to make premium payments;

   (3) Of any penalties to be incurred or monies to be received as a result of cancellation or surrender of the life insurance policy;
E. A list of the merchandise and services which are applied or contracted for in the prearrangement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need;

F. All relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the proceeds of the life insurance policy and the amount actually needed to fund the prearrangement;

G. Any penalties or restrictions, including but not limited to geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or the prearrangement guarantee; and

Drafting Note: States should consider whether the insurance regulator has the authority to enforce the provisions of Subsections E, F and G.

H. If so, the fact that a sales commission or other form of compensation is being paid and the identity of the individuals or entities to whom it is paid.

Section 7. General Rules

A. Each insurer shall maintain, at its home office or principal office, a complete file containing one copy of each document authorized and used by the insurer pursuant to this regulation. The file shall contain one copy of each authorized form for a period of three (3) years following the date of its last authorized use unless otherwise provided by this regulation.

B. An agent shall inform the prospective purchaser, prior to commencing a life insurance sales presentation, that he or she is acting as a life insurance agent and inform the prospective purchaser of the full name of the insurance company which the agent is representing to the buyer. In sales situations in which an agent is not involved, the insurer shall identify its full name.

C. An insurance producer shall not use terms such as “financial planner,” “investment advisor,” “financial consultant,” or “financial counseling” in such a way as to imply that he or she is primarily engaged in an advisory business in which compensation is unrelated to sales unless that is actually the case. This provision is not intended to preclude persons who hold some form of formal recognized financial planning or consultant designation from using this designation even when they are only selling insurance. This provision also is not intended to preclude persons who are members of a recognized trade or professional association having such terms as part of its name from citing membership, providing that a person citing membership, if authorized only to sell insurance products, shall disclose that fact. This provision does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies.

D. Any reference to nonguaranteed elements shall include a statement that the item is not guaranteed and is based on the company’s current scale of nonguaranteed elements (use appropriate special term such as “current dividend” or “current rate” scale.) If a nonguaranteed element would be reduced by the existence of a policy loan, a statement to that effect shall be included in any reference to nonguaranteed elements. A presentation or depiction of a policy issued after the effective date of the [insert citation to state equivalent to Life Insurance Illustrations Model Regulation] that includes nonguaranteed elements over a period of years shall be governed by that regulation.

Section 8. Failure to Comply

Failure of an insurer to provide or deliver a Buyer’s Guide, an in force illustration, a policy summary or policy data as provided in Section 5 shall constitute an omission that misrepresents the benefits, advantages, conditions or terms of an insurance policy.

Section 9. Separability

If any provisions of this rule be held invalid, the remainder shall not be affected.
Section 10. Effective Date

This rule shall become effective [insert a date at least 6 months following adoption by the regulatory authority].

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Term Life Sample (post UW)

**ABC Insurance Co. Guaranteed Level Term**

This document lists this insurance policy’s key features and benefits. You can get a similar summary of key policy features from other insurance companies to help you compare similar policies. If you have questions about life insurance generally or other types of policies, the National Association of Insurance Commissioners has useful information at https://content.naic.org/consumer/life-insurance.htm/. If you have questions about this particular life insurance policy, ask the agent, broker, advisor, or a company representative. If you have questions about company or agent licensing, contact [insert reference to state department of insurance].

**Company and Agent Information**

ABC Insurance Company, 111 Half Street, Washington, DC
email@email.com
202-111-222

Prepared by Agent Joe Smith, 111 Main St., Kansas City, MO
email@email.com
816-111-222

**Information We Use to Determine Your Premium**

**Policy Owner and Insured**
This overview is prepared for John Smith for insurance on the life of John Smith.

**Information We Obtain From You**

Age
Sex
Family History
Tobacco Use
Occupation
Hobbies

**Information We Obtain From Other Sources**

Credit Reports
Motor Vehicle Registration
Auto, Home and other Insurance Claims
Driving Records
Medical Prescriptions
Criminal History

**Policy Features that will Affect the Premium**

Amount of the Death Benefit
Optional Riders

**How We Assess Your Risk**
We have X rate levels for (smokers/non smokers). John Smith’s premium will be based on the Y best of the X levels.
**Cost Information**

**What Does this Life Insurance Policy Cost?**

The premium is $AAA annually or $BBB quarterly or $CCC monthly. You may pay the premium monthly, quarterly or semi-annually or annually. If you pay premiums monthly, quarterly or semi-annually the total premium you pay will be more than if you pay annually.

**Will my premium ever change?**

The premium will stay the same for the initial term of the policy. After that term ends, the premium will increase each year if you chose to renew the policy.

**Are there any costs if I decide to cancel the policy? Do I get any money back if I cancel the policy?**

No, there are no costs to cancel this policy. However, if you do cancel this policy, you won’t get any money back.

**Policy Information**

**What is the name of this policy?**

This is a policy to be issued in Wisconsin called Guaranteed Level Term.

**Does the policy ever end? If so, what is the term of the policy**

Yes. The policy ends when the term you choose (20 years) ends but you can choose to renew this policy each year until you are age 95. The premium will increase each year you renew the policy.

**What is the death benefit?**

The death benefit is $500,000.

**Can the death benefit change?**

No, the death benefit will stay the same unless you ask, and the company agrees to increase it.

**Can I take a loan from my policy?**

No. You can’t borrow money from this policy.

**Additional Policy Benefits**

**Does the policy have a waiver of premium option?**

Yes, you can buy a waiver of premium rider for an extra cost. A waiver of premium rider for this policy means you won’t have to pay premiums after you’ve been totally disabled for at least 4 months.

**Can I convert this policy to another type of life insurance?**

Yes, you can convert this policy to a whole life insurance policy before the policy term ends, as long as you’re younger than age 70.

**Are there other policy enhancements or optional riders available for this policy?**

Yes, there are other policy enhancements – known as riders. Ask the agent, broker, advisor, or a company representative offering this product about them.
**Is there a policy option that allows me to access my death benefit while I’m alive?**

Yes, for additional premium, you can get part of your death benefit before you die if you are terminally ill.

**Does this policy accumulate cash value?**

No. This policy provides no cash benefits other than the death benefit.
Term Life Sample (at application)

**ABC Insurance Co. Guaranteed Level Term**

This document lists this insurance policy’s key features and benefits. You can get a similar summary of key policy features from other insurance companies to help you compare similar policies. If you have questions about life insurance generally or other types of policies, the National Association of Insurance Commissioners has useful information at https://content.naic.org/consumer/life-insurance.htm/. If you have questions about this particular life insurance policy, ask the agent, broker, advisor, or a company representative. If you have questions about company or agent licensing, contact [insert reference to state department of insurance].

**Company and Agent Information**

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**Information We Use to Determine Your Premium**

**Policy Owner and Insured**

This overview is prepared for John Smith for insurance on the life of John Smith.

**Information We Obtain From You**

Age  
Sex  
Family History  
Tobacco Use  
Occupation  
Hobbies

**Information We Obtain From Other Sources**

Credit Reports  
Motor Vehicle Registration  
Auto, Home and other Insurance Claims  
Driving Records  
Medical Prescriptions  
Criminal History

**Policy Features that will Affect the Premium**

Amount of the Death Benefit  
Optional Riders

**How We Assess Your Risk**

We have X rate levels for (smokers/non smokers). John Smith’s premium will be based on the Y best of the X levels.
**Cost Information**

**What Does this Life Insurance Policy Cost?**

The premium is $AAA annually or $BBB quarterly or $CCC monthly. You may pay the premium monthly, quarterly or semi-annually or annually. If you pay premiums monthly, quarterly or semi-annually the total premium you pay will be more than if you pay annually.

**Will my premium ever change?**

The premium will stay the same for the initial term of the policy. After that term ends, the premium will increase each year if you chose to renew the policy.

**Are there any costs if I decide to cancel the policy? Do I get any money back if I cancel the policy?**

No, there are no costs to cancel this policy. However, if you do cancel this policy, you won’t get any money back.

**Policy Information**

**What is the name of this policy?**

This is a policy to be issued in Wisconsin called Guaranteed Level Term.

**Does the policy ever end? If so, what is the term of the policy?**

Yes. The policy ends when the term you choose (20 years) ends, but you can choose to renew this policy each year until you are age 95.

**Can I extend the term of coverage?**

Yes. After the initial term ends, you can renew this policy until you are age 95. The premium will increase each year you renew the policy.

**What is the death benefit?**

You have selected a death benefit of $500,000 to generate this quote. You may select a death benefit between $250,000 and $2 million subject to underwriting approval.

**Can I take a loan from my policy?**

No. You can’t borrow money from this policy.

**What do I need to do to buy this policy?**

You’ll need to fill out an application. You also must go through an underwriting process. Underwriters review your application and decide if you’re eligible to buy this policy, and, if you are, what your premium would be and how much coverage you could buy.

In the course of considering your application, an insurer may request or collect health information about you in a variety of ways. You might be approved to buy a policy without any information about your health. If you aren’t, you may still be eligible for this policy, but you’ll be required to fill out a health questionnaire and undergo a physical examination.
Additional Policy Benefits

Does the policy have a waiver of premium option?
Yes, you can buy a waiver of premium rider for an extra cost. A waiver of premium rider for this policy means that you won’t have to pay premiums after you’ve been totally disabled for at least 4 months.

Can I convert this policy to another type of life insurance?
Yes, you can convert this policy to a whole life insurance policy before the policy term ends, as long as you’re younger than age 70.

Are there other policy enhancements or optional riders available for this policy?
Yes, there are other policy enhancements – known as riders. agent, broker, advisor or a company representative offering this product about them.

Is there a policy option that allows me to access my death benefit while I’m alive?
Yes, for additional premium, you can get part of your death benefit before you die if you are terminally ill.

Does this policy accumulate cash value?
No. This policy provides no cash benefits other than the death benefit.
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The Life Actuarial (A) Task Force met Aug. 12, 2021. The following Task Force members participated: Doug Slape, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Judith L. French, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Perry Kupferman, Thomas Reedy, and Ted Chang (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Amy L. Beard represented by Steven Chamblee (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Linda A. Lacewell represented by Bill Carnello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Jonathan T. Pike represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. **Adopted its July 1, June 24, June 17, June 10, May 27, May 20, May 13, May 6, April 29, and April 22 Minutes**

The Task Force met July 1, June 24, June 17, June 10, May 27, May 20, May 13, May 6, April 29, and April 22. During these meetings, the Task Force took the following action: 1) adopted its April 8 minutes (see NAIC Proceedings – Spring 2021, Life Actuarial (A) Task Force); 2) adopted amendment proposal 2019-33, which clarifies the definition of individually underwritten life insurance and the applicability of principle-based reserving (PBR) requirements for group contracts with individual risk selection issued under insurance certificates; 3) adopted amendment proposal 2020-10, which allows the use of a prudent level of mortality improvement beyond the valuation date; 4) adopted amendment proposal 2021-03, which updates the reference to required minimum distribution age; 5) adopted amendment proposal 2021-05, which changes the term in VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation, from “model investment strategy” to “modeled company investment strategy” and clarifies the comparison to the alternative investment strategy; 6) adopted amendment proposal 2021-06, which allows for third-party submission of experience data; 7) adopted amendment proposal 2021-07, which clarifies the universal life with secondary guarantees (ULSG) net premium reserve (NPR) calculation requirements; and 8) adopted amendment proposal 2021-09, which updates the materiality language in Section 3.E.1 of VM-31 to be consistent with VM-21, Requirements for Principle-Based Reserves for Variable Annuities.

Mr. Yanacheak made a motion, seconded by Mr. Schallhorn, to adopt the Task Force’s July 1 (Attachment One), June 24 (Attachment Two), June 17 (Attachment Three), June 10 (Attachment Four), May 27 (Attachment Five), May 20 (Attachment Six), May 13 (Attachment Seven), May 6 (Attachment Eight), April 29 (Attachment Nine), and April 22 (Attachment Ten) minutes. The motion passed unanimously.

2. **Adopted the Report of the Index-Linked Variable Annuity (A) Subgroup**

Mr. Weber made a motion, seconded by Ms. Ahrens, to adopt the report of the Index-Linked Variable Annuity (A) Subgroup (Attachment Eleven), including its July 15 minutes (Attachment Twelve). The motion passed unanimously.

3. **Adopted the Report of the Longevity Risk (E/A) Subgroup**

Mr. Weber made a motion, seconded by Ms. Ahrens, to adopt the report of the Longevity Risk (E/A) Subgroup (Attachment Thirteen). The motion passed unanimously.

4. **Adopted the Report of the GI Life Valuation (A) Subgroup**

Mr. Weber made a motion, seconded by Ms. Ahrens, to adopt the report of the Guaranteed Issue (GI) Life Valuation (A) Subgroup (Attachment Fourteen). The motion passed unanimously.

5. **Adopted the Report of the Experience Reporting (A) Subgroup**

Mr. Weber made a motion, seconded by Ms. Ahrens, to adopt the report of the Experience Reporting (A) Subgroup (Attachment Fifteen). The motion passed unanimously.
6. **Adopted the Report of the IUL Illustration (A) Subgroup**

Mr. Weber made a motion, seconded by Ms. Ahrens, to adopt the report of the Indexed Universal Life (IUL) Illustration (A) Subgroup (Attachment Sixteen). The motion passed unanimously.

7. **Adopted the Report of the VM-22 (A) Subgroup**

Mr. Sartain said the Valuation Manual (VM)-22 (A) Subgroup completed discussions of the American Academy of Actuaries’ (Academy’s) Annuity Reserves and Capital Work Group (ARCWG) preliminary framework. He said the most important discussions were focused on aggregation. He said liability elements, hedging issues, and field test plans were also discussed. He noted that field testing is scheduled for the first half of 2022. He noted that the ARCWG framework is exposed for a 90-day public comment period ending Oct. 19.

Mr. Sartain said the Subgroup initially settled on two reserve categories for aggregation; i.e., one for payout annuities and another for deferred annuities. The Subgroup later decided against using the payout and deferred annuity categories. They revised the categories to refer to a principled-based approach and a prescriptive approach. The Subgroup asked for feedback on the principle-based and prescriptive approaches as part of the framework exposure.

Mr. Sartain said the Subgroup has separate drafting groups focused on developing a standard projection amount (SPA) and studying mortality underlying pension risk transfer (PRT) business. He said the SPA drafting group has not met recently. He said the PRT drafting group meets regularly and is reviewing information solicited from a small group of companies with PRT business. He said the Subgroup hopes to use the formula based or asset adequacy information from those companies in the development of the principle-based aggregation approach.

Mr. Sartain made a motion, seconded by Mr. Yanacheak, to adopt the report of the VM-22 (A) Subgroup, including its July 21 (Attachment Seventeen), July 7 (Attachment Eighteen), June 30 (Attachment Nineteen), June 16 (Attachment Twenty), May 26 (Attachment Twenty-One), May 12 (Attachment Twenty-Two), May 5 (Attachment Twenty-Three), April 28 (Attachment Twenty-Four), and April 21 (Attachment Twenty-Five) minutes. The motion passed unanimously.

8. **Heard an Update on Future Mortality Improvement**

Marianne Purushotham (Academy Mortality Improvements Life Working Group [MILWG] and Society of Actuaries [SOA] Preferred Mortality Project Oversight Group [Joint Committee]) presented a recommendation (Attachment Twenty-Six) for the methodology for developing mortality improvement rates applicable to the VM-20, Requirements for Principle-Based Reserves for Life Products, reserve valuation. The rates will be reviewed annually in a manner similar to the process used for the valuation basic table (VBT) scales. Ms. Purushotham noted that the scale will be subject to a threshold of materiality. A best estimate scale and a loaded scale will be developed. The scales will vary by gender and attained age, and they will be applicable for a 20-year period.

Ms. Purushotham said the scale will be initially based on the best estimate of recent historical mortality improvement. The rates will linearly grade to the long-term mortality improvement rates (LTMIRs), defined as the average of projection years 10–15 from the U.S. Social Security Administration (SSA) intermediate projection, over the first 10 years. The mortality improvement rates will then remain level for five years and linearly grade to no improvement at year 20. She noted that the mortality improvement will not be zero at year 20, it will remain at the level of accumulated mortality improvement for the 20-year period. The mortality improvement factors are expected to be available for 2022 valuations and will factor in COVID-19 impacts.

Scott O’Neal (NAIC) discussed model office results showing the impact on ULSG reserves from the application of the mortality improvement rates, including two levels of margin. He noted that instead of the reserve calculation using historical mortality improvement up to the valuation date and future mortality improvement rates beyond the valuation date, the future mortality improvement rates were used for both historical and future rates as a means of simplification. Historical mortality improvement is not applied prior to 2021. Mr. O’Neal said the model office demonstrates that the use of mortality improvement rates beyond the valuation date results in reductions of 14%, 10%, and 8% for the best estimate, best estimate with 25% margin, and best estimate with 35% margin, respectively. He said the NPR floor is not considered in the analysis but could be reflected at the request of state insurance regulators. He noted that Section 3.D.11.c of VM-31 provides an opportunity for companies to identify and quantify the impact of any perceived implicit margins present in the VM-20 methodology in their PBR Actuarial Reports. Several companies have highlighted VM-20’s prohibition of future mortality improvement as a source of implicit margin in VM-20 and provided a quantification of the impact. He said a review of 2020 PBR Actuarial Reports for a sample...
of large life insurance companies revealed that companies reported between a 9% and 80% reduction to their deterministic reserves for ULSG products with the inclusion of a future mortality improvement assumption.

Ms. Purushotham said the recommendation is to use the best estimate with a 25% margin. She pointed out the 25% reduction is a material cushion to the reserve impact. She noted that the mortality improvement rates are not locked in. The scale is subject to change on an annual basis to reflect any new trends. She said there are several issues that will be considered when setting the rates, including the short-term and long-term impacts of COVID-19, the impact of opioid addiction, the threshold for materiality and the socioeconomic-based mortality differences between the general and insured populations. Mr. Carmello asked if the impacts of COVID-19 will be carved out. Ms. Purushotham said that is being considered, but a final decision is yet to be made. Mr. Carmello suggested delaying implementation of the future mortality improvement for a few years. He asked if the margin will be applied if the mortality improvement is negative. Ms. Purushotham responded that the margin will be applied as a further reduction to the negative mortality improvement. She said a zero mortality rate will receive a flat 25 basis point margin. Mr. Carmello suggested that if the mortality improvement rates are between +1 and -1, they should have a flat margin.

Mr. Yanacheak voiced concern that the SOA determination of materiality threshold would take some decision making out of the hands of the Task Force. Ms. Purushotham said the intent is to fully provide the data to the Task Force. If the SOA recommendation is to forgo changes to the mortality improvement rates, the final decision will reside with the Task Force.

9. **Heard an Update on the ESG**

Mr. O’Neal presented a slide deck (Attachment Twenty-Seven) on the status of the economic scenario generator (ESG). He said the ESG Drafting Group comprises selected Task Force members, NAIC staff, Conning Inc. staff, and industry subject matter experts (SMEs). He said the drafting group is focused on developing a set of recommendations for the GEMS Treasury model and a set of associated scenarios for consideration by the Task Force and the Life Risk-Based Capital (E) Working Group. He listed the key calibration goals. Once the key calibration goals are met and scenarios are created, a field test will be conducted. Mr. O’Neal stressed that the process of meeting the goals and setting the scenarios is iterative. He noted that technical discussions and questions are posted on SharePoint. Dan Finn (Conning Inc.) discussed the calibration targets and the tradeoffs that may be encountered when attempting to meet the calibration targets.

10. **Exposed the 2022 GRET**

Tony Phipps (SOA) discussed the 2022 Generally Recognized Expense Table (GRET) presentation (Attachment Twenty-Eight). He noted that the SOA has also supplied a letter (Attachment Twenty-Nine), which provides a deeper view of the methodology. He said there are no material changes in the process as compared to past years. He said the methodology limits percentage changes to in expense factors to 10% to minimize large jumps from one year to the next. He noted that the number of companies in the study increased from 292 to 375. He attributed the increase to fewer companies falling outside the exclusion criteria.

Mr. Chou made a motion, seconded by Mr. Leung, to expose the 2022 GRET for a 21-day public comment period ending Sept. 7. The motion passed unanimously.

11. **Heard an Update on the LIBOR Transition**

Pat Allison (NAIC) presented an update (Attachment Thirty) on the transition away from the London Interbank Offered Rate (LIBOR). She said the currently recommended replacement for LIBOR is the Secured Overnight Financing Rate (SOFR). On July 29, the Alternative Reference Rates Committee (ARRC) recommended the Chicago Mercantile Exchange’s (CME Group’s) forward-looking SOFR term rates, which are now published daily for one-month, three-month, and six-month tenors. As of July 2023, LIBOR tenors will no longer be published. The NAIC has identified the actions companies must take prior to that date.

Ms. Allison discussed the *Valuation Manual* language related to setting the asset spreads used in cashflow modeling. She said the language makes it clear that the three-month and six-month market observable values referenced are based on LIBOR, which requires that they be replaced. She pointed to the language that supports the move from LIBOR to its replacement. She noted that it does not name a specific replacement, such as the SOFR. She said several competing alternatives, other than the SOFR, have surfaced. She said NAIC staff are conducting research to determine if long-term benchmark spreads might also need to be replaced as part of the LIBOR transition.
Brian Bayerle (American Council of Life Insurers—ACLI) said an industry working group has been set up to assist in the transition effort. He said the working group is monitoring the alternatives, but he believes efforts should be focused on the SOFR as the LIBOR replacement. He noted that it is important for companies to fully understand how they are currently using LIBOR to determine where a replacement may be necessary.

12. Discussed the Mortality Data Collection Project

Ms. Allison gave a presentation (Attachment Thirty-One) on the mortality experience data collection. She said NAIC staff provided training webinars through May 27. She said data for observation years 2018 and 2019 will be collected from 115 companies. The data must be submitted through the NAIC Regulatory Data Collection (RDC) by the end of September. Ms. Allison said the company will receive feedback from the RDC when the data is initially submitted. After the company data meets the RDC critical criteria, the data will undergo further analysis from NAIC staff. NAIC staff will provide feedback within 30 days of receiving the submission. The company must correct any errors discovered by NAIC staff before resubmitting the file. There is no limit on the number of resubmissions a company can make, but the final corrected data file must be submitted on or before Dec. 31. The NAIC has committed to provide the aggregate experience data to the SOA by May 31, 2022. To date, four companies have submitted mortality experience data; only three of the four submissions are complete. Submissions must include data for the 2018 and 2019 observation years; VM-51, Experience Reporting Formats, questionnaires; control totals; and a reconciliation to be considered complete. Five companies have loaded data into the RDC but have not yet submitted the data. The presentation included a list of resources available to participating companies.

13. Heard an Update on SOA Research and Education

Dale Hall (SOA) gave a presentation (Attachment Thirty-Two) on group and individual life COVID-19 mortality experience for various demographic categories and geographic regions by quarter from April 2020 through March 2021. He noted that after seeing general population mortality continue to decline in 2019, the 2020 results were 16% higher than the 2019 mortality rates. He noted that excluding deaths from COVID-19, the 2020 mortality rates were 4.4% higher than the 2019 results. He said the highest actual to expected ratios occurred in the age range from 35 to 54.

14. Heard an Update on the Recent Activities of the Academy LPC

Laura Hanson (Academy Life Practice Council—LPC) gave a presentation (Attachment Thirty-Three) on the LPC’s recent activities. She highlighted that the Academy is providing input to the ESG Drafting Group. She also noted the ARCWG work on VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities, and discussed the Academy webinars and boot camps planned for the remainder of 2021. She listed a few of the Academy efforts supporting its promotion of diversity and inclusion within the actuarial profession and in the broader insurance industry.

Having no further business, the Life Actuarial (A) Task Force adjourned.
The Life Actuarial (A) Task Force met July 1, 2021. The following Task Force members participated: Doug Slape, Chair, represented by Mike Boerner, Rachel Hemphill, and Karen Jiang (TX); Judith L. French, Vice Chair, represented by Jason Wade (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li and Steve Ostlund (AL); Ricardo Lara represented by Thomas Reedy and Ben Bock (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Amy L. Beard represented by Stephen Chamblee (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Rhonda Ahrens (NE); Marlene Caride represented by Kevin Clarkson (NJ); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Jonathan T. Pike represented by Tomasz Serbinowski (UT); Scott A. White represented by Craig Chupp (VA); and James A. Dodrill represented by Joylynn Fix (WV).

1. **Adopted Amendment Proposal 2019-33**

Ms. Hemphill noted that the term “and certificates” was added to the Life Principle-Based Reserving (PBR) Exemption section of amendment proposal 2019-33. She identified several other places in that section where the terms “and certificates” or “or certificates” should be added. NAIC staff agreed to edit the amendment proposal to incorporate those terms.

Mr. Leung made a motion, seconded by Mr. Robinson, to adopt amendment proposal 2019-33 (Attachment One-A), including the edits by NAIC staff. The motion passed unanimously.

2. **Adopted Amendment Proposal 2021-09**

Ms. Hemphill said the first question on the American Council of Life Insurers (ACLI) comment letter (Attachment One-B) asks why VM-21, Requirements for Principle-Based Reserves for Variable Annuities, Section 1.E refers to both the reserve and the Total Asset Requirement (TAR), while VM-21, Section 3.H references only the TAR. She said the two sections are related, but they are not the same. She said Section 3.H follows the precedent in VM-21 that allows simplifications if they have no significant impact or bias on TAR.

Ms. Hemphill said the second and fourth questions on the ACLI comment letter discuss the alternative method and the existing hedging requirements. She said neither are considered simplifications, approximations, or modeling efficiency techniques relative to the benchmark VM-21 requirements; therefore, no adjustment to the amendment proposal is necessary. She said the third question asks whether both the criteria in VM-21 Section 3.F.2.e—the first criteria being that simplifications and approximations cannot materially understate TAR and the second criteria being that simplifications and approximations cannot have a downward bias on TAR—are necessary. She responded that both criteria are necessary to capture both the accuracy and precision of the simplification or approximation. Brian Bayerle (ACLI) said the ACLI concerns were adequately addressed by Ms. Hemphill’s responses.

Ms. Ahrens made a motion, seconded by Mr. Weber, to adopt amendment proposal 2021-09 (Attachment Once-C). The motion passed unanimously.

3. **Discussed Amendment Proposal 2020-12**

Ms. Hemphill said while there is some comfort with the ideas presented in amendment proposal 2020-12 (Attachment One-D), there are enough industry member questions on the scope of the amendment to warrant establishing a state insurance regulator drafting group to initiate a series of one-on-one discussions with companies to better understand the underlying issues. Mr. Clarkson, Mr. Reedy, and Mr. Chou volunteered to join the drafting group.
4. **Re-Exposed Amendment Proposal 2019-34**

Leonard Mangini (American Academy of Actuaries—Academy) said the Academy comment letter (Attachment One-E) asserts that the amendment proposal duplicates the regulatory authority provided by the *Valuation Manual* and is therefore unnecessary. Mr. Bayerle said the ACLI comment letter (Attachment One-F) notes that the requirements created by the amendment proposal are onerous and may produce unreliable results. He said the letter also identifies existing sources of guidance that address the issues the amendment proposal purports to correct. He said the ACLI is willing to present examples to inform state insurance regulators of some of the challenges that could surface if the amendment proposal is adopted. Mr. Chupp said his comment letter (Attachment One-G) aligns with the Academy and ACLI comments, and he advises that the amendment proposal is unnecessary.

Mr. Robinson said one of the goals of the amendment proposal is to provide a national standard for circumstances where an actuary determines the reserves for a block of business, but it does not complete asset adequacy testing on the business. He said the proposal is applicable to all business, but how it will be practically applied to modified coinsurance and coinsurance funds withheld business is still in question.

Mr. Robinson made a motion, seconded by Mr. Leung, to re-expose amendment proposal 2019-34 (Attachment One-H) for a public comment period ending July 20. The motion passed, with Mr. Unger, Mr. Sartain, Mr. Clarkson, Mr. Carmello, and Mr. Serbinowski dissenting.

Having no further business, the Life Actuarial (A) Task Force adjourned.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

American Academy of Actuaries, Life Reserves Work Group

Addition of language to clarify the definition of individually underwritten life insurance and the applicability of Principle-Based Reserve (PBR) requirements for group insurance contracts with individual risk selection issued under insurance certificates.

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

January 1, 2021, version of the Valuation Manual with the revisions to APF 2020-11 (adopted by LATF on 2/11/21) shown in blue text.

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

See Appendix

All proposed changes specific to this amendment proposal are shown in red text.

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

Individual insurance certificates issued under a group contract which utilize an individual risk selection process, pricing, premium rate structures and product features are similar to individual life insurance policies. They are currently excluded from VM-20 because they are filed under a group contract, but they should be subject to VM-20 due to this similarity. See Appendix.

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

NAIC Staff Comments:

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Notes: APF 2019-33
Appendix

Issue

Certain contracts issued under a master group contract require individual risk selection in order to qualify for issuance of the group insurance certificate; the certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing, and risk classification; and they are managed in a similar manner as individual ordinary life insurance contracts. These individual certificates should follow the same reserve requirements as other individual life contracts of the same product type. Therefore, a change is needed within the *Valuation Manual* to bring these individual certificates into scope of VM-20.

Six changes are recommended:

1) Within the Reserve Requirements section (Section II), change the minimum reserve requirements to also apply to group life contracts which, other than the difference between issuing a policy and issuing a group certificate, have the same or mostly similar contract provisions, risk selection process, and underwriting as individual ordinary life contracts (Section II, subsection 1.D);

2) Within the Reserve Requirements section (Section II), add a transition period for individual group certificates issued on or before 1/1/2024 (Section II, subsections 1.F.1 and 1.F.2);

3) Within the Reserve Requirements section (Section II), add language and guidance note to subsection 1.G and the corresponding footnote to include premiums from group life contracts which have individual certificates that were issued using individual risk selection processes (Section II, subsection 1.G.1, footnote, and guidance note) and to clarify the Calculation for Exemption (Section II, subsection 1.G.2). Comment notes need to refer to NAIC Blanks (E) Working Group to update the PBR Supplement;

4) Add new paragraph, VM-20 Section 1.B (and reformat to make current paragraph Section 1.A) to clarify group life certificates issued using individual risk selection processes, including a definition and requirements to be met, are subject to the requirements of VM-20;

5) Add guidance note after first sentence in VM-20 Section 2.A.1 that group life certificates that meet the definition for individual risk selection process use the same VM-20 Reserving Categories as defined in Section 2;

6) Draft referral to the NAIC Blanks (E) Working Group to revise the VM-20 Reserves Supplement, Part 2 to report premiums for total Group Life and Group Life with certificates subjected to an individual risk selection process and which meet all of the conditions as defined in VM-20 Section 1.B separately.
VM Changes 1, 2 and 3 – II. Reserve Requirements

II. Reserve Requirements

This section provides the minimum reserve requirements by type of product, as set forth in the seven subsections below, as follows:

1. Life Insurance Products
2. Annuity Products
3. Deposit-Type Contracts
4. Health Insurance Products
5. Credit Life and Disability Products
6. Riders and Supplemental Benefits
7. Claim Reserves

All reserve requirements provided by this section relate to business issued on or after the operative date of the Valuation Manual. All reserves must be developed in a manner consistent with the requirements and concepts stated in the Overview of Reserve Concepts in Section I of the Valuation Manual.

Guidance Note: The terms “policies” and “contracts” are used interchangeably.

Subsection 1: Life Insurance Products

A. This subsection establishes reserve requirements for all contracts issued on and after the operative date of the Valuation Manual that are classified as life contracts as defined in SSAP No. 50 in the AP&P Manual, with the exception of annuity contracts and credit life contracts. Minimum reserve requirements for annuity contracts and credit life contracts are provided below in subsection 2 and subsection 5, respectively.

B. Minimum reserve requirements for variable and nonvariable individual life contracts—excluding guaranteed issue life contracts, preneed life contracts, industrial life contracts, and policies of companies exempt pursuant to the life PBR exemption in paragraph D below—subsection 1.G are provided by VM-20, Requirements for Principle-Based Reserves for Life Products, except for election of the transition period in paragraph C below subsection 1.F.2 below. For this purpose, joint life policies are considered individual life.

C. Minimum reserve requirements of VM-20 are considered principle-based valuation requirements for purposes of the Valuation Manual.

D. Minimum reserve requirements for individual certificates under group life contracts (regardless of the issue date of the master group life contract) which meet all the requirements in VM-20 Section 1.B are provided by VM-20, except for election of the transition period in subsection 1.F.1 below.

E. Minimum reserve requirements for life contracts not subject to VM-20 are those pursuant to applicable requirements in VM-A and VM-C. For guaranteed issue life contracts issued after Dec. 31, 2018, mortality tables are defined in VM Appendix M, Mortality Tables (VM-M), and the same table shall be used for reserve requirements as is used for minimum nonforfeiture requirements as defined in VM-02, Minimum Nonforfeiture Mortality and Interest.
F. A company may elect to establish minimum reserves pursuant to applicable requirements in VM-A and VM-C for:

1. Business described in subsection 1.D above and issued on or after the operative date of the Valuation Manual and prior to 1/1/2024.

2. Business not described in subsection 1.D otherwise subject to VM-20 requirements and issued during the first three years following the operative date of the Valuation Manual.

A company electing to establish reserves using the requirements of VM-A and VM-C may elect to use the 2017 Commissioners’ Standard Ordinary (CSO) Tables as the mortality standard following the conditions outlined in VM-20 Section 3. If a company during the three years elects to apply VM-20 to a block of such business, then a company must continue to apply the requirements of VM-20 for future issues of this business.

G. Life PBR Exemption

1. A company meeting the at least one of the conditions in D. subsection 1.G.2 below may file a statement of exemption for individual ordinary life insurance policies or certificates, except for policies or certificates in subsection 1.G.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. If a company has no business issued directly or assumed during the current calendar year that would otherwise be subject to VM-20, a statement of exemption is not required. For a filed statement of exemption, the statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that at least one of the two conditions in D. subsection 1.G.2 was met and the statement of exemption must also be included with the NAIC filing for the second quarter of that year.

The domiciliary commissioner may reject such statement prior to September 1 and require the company to follow the requirements of VM-20 for the ordinary life policies or certificates covered by the statement.

If a filed statement of exemption is not rejected by the domiciliary commissioner, the filing of subsequent statements of exemption is not required as long as the company continues to qualify for the exemption; rather, ongoing statements of exemption for each new calendar year will be deemed to not be rejected, unless: 1) the company does not meet either condition in D. subsection 1.G.2 below, 2) the policies or certificates contain those in D. subsection 1.G.3 below, or 3) the domiciliary commissioner contacts the company prior to Sept. 1 and notifies them that the statement of exemption is rejected. If any of these three events occur, then the statement of exemption for the current calendar year is rejected and not not rejected in order for the company to exempt additional policies or certificates. In the case of an ongoing statement of exemption, rather than include a statement of exemption with the NAIC filing for the second quarter of that year, the company should enter “SEE EXPLANATION” in response to the Life PBR Exemption supplemental interrogatory and provide as an explanation that the company is utilizing an ongoing statement of exemption.

2. Condition for Exemption:

a. The company has less than $300 million of ordinary life exemption premiums, and if the company is a member of an NAIC group which includes other life insurance companies, the group has combined ordinary life exemption premiums of less than $600 million or

The only new policies or certificates that would otherwise be subject to VM-20 being issued or assumed by the company are due to election of policy benefits or features from existing policies or certificates valued under VM-A and VM-C and the company was exempted from, or otherwise not subject to, the requirements of VM-20 in the prior year.

Exemption premium is determined as follows:
a. The amount reported in the prior calendar year life/health annual statement, Exhibit 1, Part 1, Column 3 (“Ordinary Life Insurance”), line 20.1; plus

b. The portion of the amount in the prior calendar year life/health annual statement, Exhibit 1, Part 1, Column 3 (“Ordinary Life Insurance”), line 20.2 assumed from unaffiliated companies; minus

c. Amounts included in either (a) or (b) that are associated with guaranteed issue insurance policies and/or preneed life insurance policies; minus

d. Amounts included in either (a) or (b) that represent transfers of reserves in force as of the effective date of a reinsurance assumed transaction; plus

e. Amounts of premium for individual life certificates issued under a group life certificate which meet the conditions defined in VM-20, Section 1.B, and that are not included in either (a) or (b).

Guidance Note:
(i) Definitions of preneed and guaranteed issue insurance policy are in VM-01.
(ii) For statements of exemption filed for calendar year 2022 and beyond, the amount in subsection 2.e was reported in the prior calendar year life/health annual statement, VM-20 Reserve Supplement, Part 2, if applicable.

3. Policies and Certificates Excluded from the Life PBR Exemption:

a. Universal life with secondary guarantee (ULSG) policies or certificates, or policies or certificates – other than ULSG – that contain a rider with a secondary guarantee, in which the secondary guarantee does not meet the VM-01 definition of a “non-material secondary guarantee.”

4. Each exemption, or lack of an exemption, outlined in D. subsection 1.G.1 – D. subsection 1.G.3 above applies only to policies or certificates issued or assumed in the current year, and it applies to all future valuation dates for those policies or certificates. However, if policies or certificates did not qualify for the Life PBR Exemption during the year of issue but would have qualified for the Life PBR Exemption if the current Valuation Manual requirements had been in effect during the year of issue, then the domiciliary commissioner may allow an exemption for such policies or certificates. The minimum reserve requirements for the ordinary life policies, including individual certificates under group life contracts which meet all the requirements in VM-20 Section 1.B, subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.

VM Change 4 – VM-20: Requirements for Principle-Based Reserves for Life Products

VM-20: Requirements for Principles-Based Reserves for Life Products

Section 1: Purpose

A. These requirements establish the minimum reserve valuation standard for individual life insurance policies issued on or after the operative date of the Valuation Manual and subject to a principle-based valuation with an NPR floor under Model #820. These requirements constitute the Commissioners Reserve Valuation Method (CRVM) for policies of individual life insurance.
B. Individual life certificates under a group life contract shall be subject to the requirements of VM-20 if all of the following are met. These requirements constitute the Commissioners Reserve Valuation Method (CRVM) for such certificates.

1. An individual risk selection process, defined as follows, is used to obtain group life insurance coverage;

An individual risk selection process is one that is based on characteristics of the insured(s) beyond sex, gender, age, tobacco usage, and membership in a particular group. This may include, but is not limited to, completion of an application (beyond acknowledgement of membership to the group, sex, gender and age), questionnaire(s), online health history or tele-interview to obtain non-medical and medical or health history information, prescription history information, avocations, usage of tobacco, family history, or submission of fluids such as blood, Home Office Specimens (HOS), or oral fluid. The resulting risk classification is determined based on the characteristics of the individual insured(s) rather than the group, if any, of which it is a member (e.g., employer, affinity, etc.). The individual certificate holder is charged a premium rate based solely on the individual risk selection process and not on membership in a specific group.

**Guidance Note:** The use of evidence of insurability does not by itself constitute an individual risk selection process. Use of information obtained from a census or question(s) regarding gender, occupation, age, income and/or tobacco usage solely for purposes of determining a rate classification does not by itself qualify a group as having used an individual risk selection process. Group insurance where the underwriting based on the characteristics of the group and census data but where some individuals are subjected to individual risk selection as a result of compensation level, age, an existing medical condition or impairment, late entry into the group, failure of the group to meet minimum participation requirements or voluntary buy-up of increased coverage does not meet the definition of an individual risk selection process.

2. The individual certificates utilize premiums or cost of insurance schedules and charges based on the individual applicant’s issue age, duration from underwriting, coverage amount and risk classification and there is a stated or implied schedule of maximum gross premiums or net cash surrender value required in order to continue coverage in force for a period in excess of one year;

**Guidance Note:** Coverage amount does not imply a requirement for banding of premiums or charges but rather rates or charges that are multiplied by number of units of coverage of face amount (or net amount at risk) per $1,000 to obtain the actual premium or charge.

3. The group master contract is designed, priced, solicited, and managed similar to individual ordinary life insurance policies rather than specific to the group as a whole;

4. The individual certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing, and risk classification to individual ordinary life insurance contracts.

5. The individual certificates are issued on or after the operative date of the Valuation Manual except election of the transition period in Section 2, subsection 1.F.1.
Section 2: Minimum Reserve

A. All policies subject to these requirements shall be included in one of the VM-20 Reserving Categories, as specified in Section 2.A.1, Section 2.A.2 and Section 2.A.3 below.

Guidance Note: Since group insurance subject to an individual risk selection process and meeting all the requirements in Section 1.B is subject to VM-20 requirements, Section 2.A shall apply—meaning that any such contracts will be included in one of the VM-20 Reserving Categories defined by Section 2.A.1, Section 2.A.2, and 2.A.3. All requirements in VM-31 which apply to a VM-20 Reserving Category shall apply to any group insurance subject to individual risk selection that has been included in that VM-20 Reserving Category.

The company may elect to exclude one or more groups of policies from the stochastic reserve calculation and/or the deterministic reserve calculation. When excluding a group of policies from a reserve calculation, the company must document that the applicable exclusion test defined in Section 6 is passed for that group of policies. The minimum reserve for each VM-20 Reserving Category is defined by Section 2.A.1, Section 2.A.2 and Section 2.A.3, and the total minimum reserve equals the sum of the Section 2.A.1, Section 2.A.2 and Section 2.A.3 results below, defined as:
VM Change 6 – VM-20 Reserves Supplement, Part 2: Life PBR Exemption

Refer to NAIC Blanks (E) Working Group, request for modification to the supplemental report for the Life PBR Exemption, to show the premiums for group life that utilized an individual risk selection process and meets all of the requirements in VM-20 Section 1.B. as these premiums are currently grouped together with other group insurance in Exhibit 1. As there are other instances where the ordinary life premiums are not included in the determination of the Life PBR Exemption (e.g., for guaranteed issue policies), it may be useful to request addition of the breakdown of premiums used to determine the exemption.

Possible insertion between questions 1 and 2 for disclosure of premiums used in the determination of eligibility for the Life PBR exemption, split by ordinary life and group subject to an individual risk selection process and meeting all of the requirements in VM-20 Section 1.B.

<table>
<thead>
<tr>
<th>Life PBR Exemption as defined in the NAIC adopted Valuation Manual (VM)</th>
<th>Yes</th>
<th>No</th>
<th>[]</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did the company file and keep formal Life PBR Exemption forms the carrier uses to meet requirements of VM-20 and the Valuation Manual by their risk of business?</td>
<td>Yes</td>
<td>No</td>
<td>[]</td>
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<tr>
<td>2. If the answer in Question 1 is “Yes”, then check the boxes in the formal “Life PBR Exemption” templates (Check all 1, 2, 12 or 13)</td>
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<td>2.1 NAIC Adopted VM</td>
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<td>2.2 State Form (ST)</td>
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<td>2.3 State Regulation</td>
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<td>3.3 State Regulation</td>
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Brian Bayerle  
Senior Actuary  

June 16, 2021  

Mr. Mike Boerner  
Chair, NAIC Life Actuarial (A) Task Force (LATF)  

Re: ACLI Comments on APF 2021-09  

Dear Mr. Boerner:  

The American Council of Life Insurers (ACLI) appreciates the opportunity to provide comments on APF 2021-09.  

We have the following technical comments regarding the APF:  

1) Consistency of Reserve vs TAR  

There appears to be an inconsistency between where the APF mentions reserve versus TAR in the threshold to ensure there is no understatement; it was unclear if this was done intentionally or due to porting language from VM-20:  

- In the added VM-21 Section 1.E, it states that the materiality standard should be established “containing the criteria for determining whether an assumption, risk factor or other element… has a material impact on the size of the reserve or TAR”  
- In the added VM-21 Section 3.H, it states that a company can use simplifications, approximations, and modeling efficiency techniques if “the use of such techniques does not understate TAR by a material amount.” Only TAR is used throughout Section 3.H. This language is also used in VM-31 Section 3.F.2.e of the APF.

2) Application to Alternative Method  

It was unclear if the APF intended to apply these requirements regarding approximations, simplifications, etc. to the Alternative Method calculations. The APF specifically mentions the stochastic reserves and the additionally projection amount but did not mention the Alternative Method amount. VM-20, applies requirements regarding simplifications to the NPR, so we request clarification in the text or a guidance note.  

3) Multiple criteria in Section 3.F.2.e  

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Section 3.F.2.e provides for two criteria related to the TAR:
1) the use of each approximation, simplification, or modeling efficiency technique does not understate TAR by a material amount; and
2) the expected value of TAR is not less than the expected value of TAR calculated without using the approximation, simplification, or modeling efficiency technique.

As both approaches would result in a higher TAR, it is not clear how these conditions are significantly different. We would request an example of how these criteria might apply in different cases.

4) Additional allowable demonstrations in Guidance Note

The guidance note discusses various ways to provide the required demonstrations. ACLJ would suggest adding an additional bullet that states that backtesting and E-factor documentation are acceptable demonstrations for hedging modeling simplifications covered by those requirements.

We look forward to a discussion of this amendment on a future call. We appreciate the consideration of our comments.

Sincerely,

cc: Reggie Mazyck, NAIC
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

Identification:
PBR Staff of Texas Department of Insurance

Title of the Issue:
1. Address determination of materiality. VM-21 often refers to materiality but is missing a discussion on how materiality is determined.
2. Address use of approximations and simplifications in VM-21.

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

VM-21 Section 1.E (new), VM-21 Section 3.H (new), VM-31 Section 3.E.1, VM-31 Section 3.F.2.e

January 1, 2021 NAIC Valuation Manual

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

See attached.

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

1. VM-21 often refers to materiality but is missing a discussion on how materiality is determined (a materiality standard), as VM-20 has in VM-20 Section 2.H. Moreover, the current language of Materiality in the VA Summary in VM-31 Section 3.E.1 (2021 edition) is based on the Life PBR Summary in VM-31 (2019 edition). The language of Materiality in the VA Summary in Section 3.E.1 of VM-31 should be updated, consistent with adding a new section to VM-21 to address materiality.

For reference, here are the relevant VM-20 passages:

VM-20 Section 2.H
The company shall establish, for the DR and SR, a standard containing the criteria for determining whether an assumption, risk factor or other element of the principle-based valuation has a material impact on the size of the reserve. This standard shall be applied when identifying material risks. Such a standard shall also apply to the NPR with respect to VM-20 Section 2.G.
VM-31 Section 3.C.1

Life Summary – The PBR Actuarial Report shall contain a Life Summary of the critical elements of all sub-reports of the Life Report as detailed in Section 3.D. In particular, this Life Summary shall include:

1. VM-20 Materiality – The standard established by the company pursuant to VM-20 Section 2.H.

2. While it is common for companies to use a significant number of approximations, simplifications, and modeling efficiency techniques for their VM-21 valuation, VM-21 is missing an explicit allowance of approximations, simplifications, or modeling efficiency techniques. To understand the impact of the large number of approximations, simplifications, and modeling efficiency techniques, they should be covered in one location in the PBR reporting for VA, in contrast to the current reporting where they are scattered throughout the PBR Report. VM-20 Section 2.G does not allow simplifications to bias the reserve downward. This addresses the concern that a large number of immaterial simplifications could add up to a material understatement. VM-21 needs an assurance that simplifications do not compound one another to become material even more than VM-20, due to the very larger number of simplifications commonly used.

VM-21 Section 1.E (new)

Materiality

The company shall establish a standard containing the criteria for determining whether an assumption, risk factor or other element of the principle-based valuation has a material impact on the size of the reserve or TAR. This standard shall be applied when identifying material risks.

VM-21 Section 3.H (new)

H. A company may use simplifications, approximations and modeling efficiency techniques to calculate the stochastic reserve and/or the additional standard projection amount required by this section if the company can demonstrate that the use of such techniques does not understate TAR by a material amount, and the expected value of TAR calculated using simplifications, approximations and modeling efficiency techniques is not less than the expected value of TAR calculated that does not use them.

Guidance Note:

Examples of modeling efficiency techniques include, but are not limited to:

1. Choosing a reduced set of scenarios from a larger set consistent with prescribed models and parameters.
2. Generating a smaller liability or asset model to represent the full seriatim model using grouping compression techniques or other similar simplifications.

There are multiple ways of providing the demonstration required by Section 3.H. The complexity of the demonstration depends upon the simplifications, approximations or modeling efficiency techniques used. Examples include, but are not limited to:

1. Rounding at a transactional level in a direction that is clearly and consistently conservative or is clearly and consistently unbiased with an obviously immaterial impact on the result (e.g., rounding to the nearest dollar) would satisfy 3.H without needing a demonstration. However,
rounding to too few significant digits relative to the quantity being rounded, even in an unbiased way, may be material and in that event, the company may need to provide a demonstration that the rounding would not produce a material understatement of TAR.

2. A brute force demonstration involves calculating the minimum reserve both with and without the simplification, approximation or modeling efficiency technique, and making a direct comparison between the resulting TAR. Regardless of the specific simplification, approximation or modeling efficiency technique used, brute force demonstrations always satisfy the requirements of Section 3.H.

3. Choosing a reduced set of scenarios from a larger set consistent with prescribed models and parameters and providing a detailed demonstration of why it did not understate TAR by a material amount and the expected value of TAR would not be less than the expected value of TAR that would otherwise be calculated. This demonstration may be a theoretical, statistical or mathematical argument establishing, to the satisfaction of the insurance commissioner, general bounds on the potential deviation in the TAR estimate rather than a brute force demonstration.

4. Justify the use of randomly sampling withdrawal ages for each contract instead of following the exact prescribed WDCM method by demonstrating that the random sampling method is materially equivalent to the exact prescribed approach, and the simplification does not materially reduce the Additional Standard Projection Amount and the final reported TAR. In particular, the company should demonstrate that the statistical variability of the results based on the random sampling approach is immaterial by testing different random sets, e.g., if randomly selecting a withdrawal age for each contract, the probability distribution of the withdrawal age should be stable and not vary significantly when using different random number sets.

VM-31 Section 3.F.1

VA Summary – The PBR Actuarial Report shall contain a VA Summary of the critical elements of all sub-reports of the VA Report as detailed in Section 3.F. In particular, this VA Summary shall include:

1. Materiality – The Standard established by the company pursuant to VM-21 Section 1.E.

VM-31 Section 3.F.2.e

e. Approximations, Simplifications, and Modeling Efficiency Techniques – A description of each approximation, simplification or modeling efficiency technique used in reserve or TAR calculations, and a statement that the required VM-21 Section 3.H demonstration is available upon request and shows that: 1) the use of each approximation, simplification, or modeling efficiency technique does not understate TAR by a material amount; and 2) the expected value of TAR is not less than the expected value of TAR calculated without using the approximation, simplification, or modeling efficiency technique. 

Deleted: A description of the rationale for determining whether a decision, information, assumption, risk or other element of a principle-based valuation under VM-21 has a material impact on the modeled reserve. Such rationale could include criteria such as a percentage of reserves, a percentage of surplus, and/or a specific monetary value, as appropriate.

Deleted: Approximations and Simplifications – Description of any approximations and simplifications used in cash flow projection calculations and not described in a different section of this report, including documentation that these did not materially reduce the resulting reserve.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

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

Identification:
Rachel Hemphill and Karen Jiang, Texas Department of Insurance

Title of the Issue:
Create consistency between CDHS determination in VM-20 and VM-21. Revise hedge modeling to only require CDHS if modeling future hedging reduces the reserves under VM-20 or TAR under VM-21.

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


January 1, 2021 NAIC Valuation Manual

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

See attached.

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

6/17/2021 Notes:
We have made notes (highlighted in yellow) in the below summary of the 4/2/2021 and 5/17/2021 updates to emphasize the treatment of macro hedging (excluded from the scope of this APF), hedging strategies that are still in the formative stages (excluded from the scope of this APF), and conservative simplifications (allowed, as always, with documentation). We also addressed the concern that SHS could be perceived as one-sided. See below for full context/intent.

Summary of 5/17/2021 Editorial Changes and Clarifications:

1. Editorial changes were made in response to the comment by John Robinson of MN:
   a. Replace “hedge” with “hedging” when used as an adjective.
   b. Clarify that the Principles apply to the modeling of a CDHS or SHS.
   c. Add references to “one or more” CDHS or SHS, to reflect that a company may have multiple CDHS or SHS.
d. Add reference to a CDHS that the company is following.

2. Clarifying edits were made in response to the comment ACLI:
   a. Clarify that PBR reflecting a company’s investment policy and risk management strategies supporting the policies or contracts does not target, deem illegitimate, or otherwise reflect a negative view on the company’s investment policy and risk management strategies supporting the policies or contracts. In fact, the opposite is true. Note that this is consistent with VM-20 Section 7.K.1’s treatment of non-hedging derivative use.
   b. Clarify even further that the CDHS requirements are documentation requirements (i.e., documentation clearly defining the hedging strategy) and may always be satisfied at the company’s option. (6/17/2021 Added Emphasis: There has been the suggestion that SHS is one-sided. But we can see that that is not true, when we see that the consideration of SHS and CDHS are each necessary and complementary pieces of a complete PBR treatment of hedging, the result of the two pieces together being “model your hedging, but only reflect a benefit from hedging if you have provided adequate documentation of your hedging program so that regulators can rely on its projected performance.”)
   c. Clarify that SHS “are normally modeled as part of any of the company’s risk assessment and evaluation processes” (emphasis added).

3. Materiality was explicitly addressed. (6/17/2021 Added Emphasis: A company may continue doing conservative simplifications, such as not modeling hedging that would have been a benefit for them to model. In these cases, the intent is for there to be transparency, documentation, and support of the simplification in the PBR Report. As with all simplifications, the support can range from a robust analysis to a qualitative analysis, depending on the individual company situation.)

Summary of 4/2/2021 Updates:

1. Revisions were made to VM-20 Section 7.K.4 (add “supporting the policies”) and VM-21 Section 9.A.6 (add “supporting the contracts”) in response to Nationwide’s comments. (6/17/2021 Added Emphasis: These edits were to clarify that macro hedging was not in scope.)
2. We added a definition for “hedging transactions,” taken from the APPM but modified slightly to be consistent with Valuation Manual terminology in response to Will Wilton’s comments.
3. We have updated the list of CDHS criteria in response to Will Wilton’s comments where we agreed:
   a. Added “significant” before risks in item (c) of the CDHS definition.
   b. Combined items (f) – (h) in the CDHS definition.
   c. Change “person or persons” to “group or area, including whether internal or external,” in item (i) of the CDHS definition.
   d. We did not remove items (k) or (l) as suggested by Will Wilton, as we find this information useful to regulators. Given that these are retained, and because we were uncertain what else would be included in the new “primary risks” item suggested by Will Wilton, we have not added it. If we can be provided additional information on the risks to be reflected under this new item, an edit could be made.
4. We modified the definition of a SHS to clarify “normally modelled” in response to the ACLI comment and clarify what may be a SHS in response to Will Wilton’s comment (e.g., a single bond would not be a SHS). (6/17/2021 Added Emphasis: We would not consider a hedging strategy that is in the formative stages to be “normally modelled” just because of some sensitivity testing or other analysis as the hedging approach is formed. However, the determination of “normally modelled” appropriately requires judgment and is intended to encourage robust discussions with domestic regulators.)
We propose having consistent requirements for a CDHS in VM-20 and VM-21, as well as any future work on VM-22, and consolidating these requirements in the VM-01 definition of a CDHS. This involves adding two criteria to VM-21’s definition of CDHS that currently exist for VM-20:

- Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
- The circumstances under which hedging strategy will not be effective in hedging the risks.

These criteria are both reasonable and apply in principle to VM-21, and to any future work on VM-22, as well as VM-20.

Further, we propose revising the requirement for hedging to be a CDHS in order for future hedging to be modeled under VM-20, VM-21, and LR027’s C-3 RBC Amount calculation to only apply when modeling such hedging reduces the life reserve level or variable annuity Total Asset Requirement (TAR) level.

The current regulatory requirements for hedging to be a CDHS in order for future hedging to be modeled under VM-20, modeled under VM-21, modeled for the C-3 RBC Amount calculation for variable annuities, and to be eligible for SSAP 108 treatment are all logical requirements when one considers whether hedging should be allowed to reduce the life reserve level or variable annuity TAR level, or whether any mismatch between movements in hedge assets and movements in the corresponding reserve levels should be allowed to be amortized over time.

However, this same requirement has led to a situation of there being unintended optionality in whether a hedging strategy that is like a CDHS is modeled or is not modeled, since a company may choose to satisfy or not satisfy certain of the criteria. This has been especially relevant for cases where modeling a company’s hedging strategy would increase reserves or variable annuity TAR.

As noted in the current guidance note in VM-20 Section 7.K.1 in the 2021 Valuation Manual:

“The prohibition in these modeled reserve requirements against projecting future hedging transactions other than those associated with a clearly defined hedging strategy is intended to address initial concerns expressed by various parties that reserves could be unduly reduced by reflection of programs whose future execution and performance may have greater uncertainty. The prohibition appears, however, to be in conflict with Principle 2 listed in VM-21. Companies may actually execute and reflect in their risk assessment and evaluation processes hedging strategies similar in many ways to clearly defined hedging strategies but lack sufficient clarity in one or more of the qualification criteria. By excluding the associated derivative instruments, the investment strategy that is modeled may also not reflect the investment strategy the company actually uses. Further, because the future hedging transactions may be a net cost to the company in some scenarios and a net benefit in other scenarios, the exclusion of such transactions can result in a modeled reserve that is either lower or higher than it would have been if the transactions were not excluded. The direction of such impact on the reserves could also change from period to period as the actual and projected paths of economic conditions change. A more graded approach to recognition of non-qualifying hedging strategies may be more theoretically consistent with Principle 2. It is recommended that as greater experience is gained by actuaries and state insurance regulators with the principle-based approach and as industry hedging programs mature, the various requirements of this section be reviewed.”

We propose to continue addressing the regulatory concern that reserves could be unduly reduced by reflection of programs whose future execution and performance may have greater uncertainty, by continuing to only allowing hedging strategies that qualify as a CDHS to reduce life reserves and variable annuity TAR. However, we propose that the treatment of CDHS be made more principles-based and less subject to manipulation. To accomplish this, the proposal requires that any hedging strategy that is a part
of the investment strategy supporting the policies and is normally modeled as part of the company’s risk assessment and evaluation processes be modeled as if it were a CDHS if doing so results in an increase in life reserves or variable annuity TAR.

That is, CDHS becomes a requirement solely for hedging strategies that reduce life reserves or variable annuity TAR, and so becomes a more clear regulatory guardrail requiring that hedging strategies that reduce life reserves or variable annuity TAR must be clearly defined.

We continue to need the concept of a CDHS. A CDHS simply formally documents items that a company should be able to document for a robust, well-defined hedging strategy. It requires that the following be identified:

- The specific risks being hedged (e.g., cash flow, policy interest credits, delta, rho, vega, etc.).
- The hedge objectives.
- The risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).
- The financial instruments used to hedge the risks.
- The hedge trading rules, including the permitted tolerances from hedging objectives.
- The metrics for measuring hedging effectiveness.
- The frequency of measuring hedging effectiveness.
- The conditions under which hedging will not take place.
- The person or persons responsible for implementing the hedging strategy.
- Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
- The circumstances under which hedging strategy will not be effective in hedging the risks.

While the last two criteria have historically applied for life but not variable annuities, these are all reasonable documentation items that for a robust, well-defined hedging strategy regardless of whether the product is life or variable annuity.

The concept of a CDHS is used for accounting in SSAP 108. SSAP 108 allows companies to set up a deferred asset or liability to amortize the mismatch between changes in the value of the liability and changes in the value of the hedging instruments attributable to the hedged risk underlying a highly effective CDHS modeled for VM-21. Allowing this treatment encourages companies to reduce risk through robust, well-defined and highly effective hedging. Without having the hedging strategy be well-defined, regulators could not rely on past effectiveness being indicative of future effectiveness, and so could not offer companies the benefit of SSAP 108 treatment. Once we recognize the need for a concept of a well-defined hedging strategy, the only question is what criteria would need to be met to be considered well-defined—that is, what criteria should be required to be considered a CDHS. This is a distinct question from whether the concept of a CDHS is needed. We have not heard critiques of individual criteria in the CDHS definition, but consideration of the criteria is appropriate as we go forward to make the definitions in VM-20 and VM-21 consistent. Similarly, in reserve and capital calculations, we rely on the concept of historical effectiveness to determine an error factor. If modeling hedging reduces the reserve or capital amount, the error factor determines the magnitude to which this is reflected. However, this use of the historical effectiveness relies on the hedging strategy being well-documented and comparable between historical hedging and planned future hedging. So, again, a need for hedging strategies to be well-defined presents itself—a CDHS concept is needed.

Finally, edits to VM-31 are needed to reflect these updates and bring VM-20 and VM-21 reporting requirements more in line with one another where appropriate.
**Note on Coordination with RBC and APPM:** We have reviewed, and with these edits there are no corresponding edits necessary for LR027 for RBC but corresponding edits are necessary for SSAP 108. A referral to SAPWG is to be concurrently considered with this APF.

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

**NAIC Staff Comments:**
The term “clearly defined hedging strategy” (CDHS) means a strategy undertaken by a company to manage risks through the future purchase or sale of hedging instruments and the opening and closing of hedging positions. A CDHS must identify:

- The specific risks being hedged (e.g., cash flow, policy interest credits, delta, rho, vega, etc.).
- The hedging objectives.
- The significant risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).
- The financial instruments used to hedge the risks.
- The metrics, criteria, and frequency for measuring hedging effectiveness.
- The conditions under which hedging will not take place.
- The group or area, including whether internal or external, responsible for implementing the hedging strategy.
- Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
- The circumstances under which hedging strategy will not be effective in hedging the risks.

The hedging strategy may be dynamic, static or a combination thereof. A strategy involving the offsetting of the risks associated with products falling under the scope of different requirements within the Valuation Manual (e.g., VM-20, VM-21, or VM-22) does not qualify as CDHS.

Guidance Note: All of the principles outlined in VM-21 Section 1.B (particularly Principle 5) apply to the modeling of a CDHS.

The term “hedging transaction” means a derivative(s) transaction which is entered into and maintained to reduce:

- The risk of a change in the fair value or cash flow of assets and liabilities which the company has acquired or incurred or has a firm commitment to acquire or incur or for which the company has a forecasted acquisition or incurrence; or
- The currency exchange rate risk or the degree of foreign currency exposure in assets and liabilities which the company has acquired or incurred or has a firm commitment to acquire or incur or for which the company has forecasted acquisition or incurrence.

The term “Seasoned Hedging Strategy” (SHS) means a hedging strategy that is part of the company’s investment strategy and for which future hedging transactions are normally modeled as part of any of the company’s risk assessment and evaluation processes. A SHS may or may not be a CDHS.

The hedging strategy may be dynamic, static, or a combination thereof. A strategy involving the offsetting of the risks associated with products falling under the scope of different requirements within the Valuation Manual (e.g., VM-20, VM-21, or VM-22) does not qualify as SHS.

Guidance Note: All of the principles outlined in VM-21 Section 1.B (particularly Principle 5) apply to the modeling of a SHS.
VM-20 Section 6.A.1.b

A company may not exclude a group of policies for which there is one or more CDHS or one or more SHS required to be modeled pursuant to Section 7.K.4 from stochastic reserve requirements, except in the case where all CDHS and all SHS required to be modeled pursuant to Section 7.K.4 are solely associated with product features that are determined to not be material under Section 7.B.1 due to low utilization.

VM-20 Section 7.E.1.g

Notwithstanding the above requirements, the modeled reserve shall be the higher of that produced by the model investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the model investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of a CDHS (in compliance with the definition of CDHS in VM-01) or a SHS that is required to be modeled pursuant to Section 7.K.4 are not affected by this requirement.

VM-20 Section 7.K

K. Modeling of Derivative Programs

1. When determining the deterministic reserve and the stochastic reserve, the company shall include in the projections the appropriate costs and benefits of derivative instruments that are currently held by the company in support of the policies subject to these requirements. The company shall also include the appropriate costs and benefits of anticipated future derivative instrument transactions associated with the execution of a CDHS or a SHS that is required to be modeled pursuant to Section 7.K.4, as well as the appropriate costs and benefits of anticipated future derivative instrument transactions associated with non-hedging derivative programs (e.g., replication, income generation) undertaken as part of the investment strategy supporting the policies, provided they are normally modeled as part of the company’s risk assessment and evaluation processes.

2. For each derivative program that is modeled, the company shall reflect the company’s established investment policy and procedures for that program; project expected program performance along each scenario; and recognize all benefits, residual risks and associated frictional costs. The residual risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, etc.). Frictional costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. For CDHS or SHS required to be modeled pursuant to Section 7.K.4, the company may not assume that residual risks and frictional costs have a value of zero, unless the company demonstrates in the PBR Actuarial Report that “zero” is an appropriate expectation.

1. In circumstances where one or more material risk factors related to a derivative program are not fully captured within the cash-flow model used to calculate CTE 70, the company shall reflect such risk factors by increasing the stochastic reserve as described in Section 8.E.
4. If a SHS supporting the policies is not a CDHS but modeling it would result in a material increase to the company’s minimum reserve, then the company shall model the SHS as if it were a CDHS when calculating reserves under VM-20. In addition, if modeling the SHS as if it were a CDHS would result in a decrease in the company’s minimum reserve, the company may provide the documentation required for the SHS to be a CDHS as defined in VM-01 and then model the SHS as a CDHS.

**Guidance Note:** The intent of reflecting SHS is not to penalize any hedging strategies, but rather to reflect the company’s investment strategy and risk management strategies, including all material established hedging strategies supporting the policies, while requiring CDHS documentation for any such hedging strategies that reduce the minimum reserve.

**VM-20 Section 7.L (Remove entire Section 7.L)**

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<tr>
<td>L. Clearly Defined Hedging Strategy</td>
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<td>A clearly defined hedging strategy must identify:</td>
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<tr>
<td>The specific risks being hedged (e.g., cash flow, policy interest credits, delta, rho, vega, etc.).</td>
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<tr>
<td>The hedge objectives.</td>
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<tr>
<td>The risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).</td>
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<tr>
<td>The financial instruments used to hedge the risks.</td>
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<td>The hedge trading rules, including the permitted tolerances from hedging objectives.</td>
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<td>The metrics for measuring hedging effectiveness.</td>
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<td>The criteria used to measure hedging effectiveness.</td>
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<td>The frequency of measuring hedging effectiveness.</td>
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<td>The person or persons responsible for implementing the hedging strategy.</td>
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<td>Areas where basis, gap or assumption risk related to the hedging strategy have been identified.</td>
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<tr>
<td>The circumstances under which hedging strategy will not be effective in hedging the risks.</td>
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<tr>
<td>Hedging strategies involving the offsetting of the risks associated with other products outside of the scope of these requirements is not a clearly defined hedging strategy.</td>
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</table>

**Guidance Note:** For purposes of the above criteria, “effectiveness” need not be measured in a manner as defined in SSAP No. 86—Derivatives in the AP&P Manual.
VM-21 Section 1.D.2 (Delete entire definition and renumber subsequent sections VM-21 Section 1.D.3 and VM-21 Section 1.D.4)

VM-21 Section 4.A.4

Modeling of Hedges

a. For a company that does not have a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6:
   i. The company shall not consider the cash flows from any future hedge purchases or any rebalancing of existing hedge assets in its modeling.
   ii. Existing hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the starting assets. The hedge assets may then be considered in one of two ways:
      a) Include the asset cash flows from any contractual payments and maturity values in the projection model; or
      b) No hedge positions – in which case the hedge positions held on the valuation date are replaced with cash and/or other general account assets in an amount equal to the aggregate market value of these hedge positions.

Guidance Note: If the hedge positions held on the valuation date are replaced with cash, then as with any other cash, such amounts may then be invested following the company’s investment strategy.

A company may switch from method a) to method b) at any time, but it may only change from b) to a) with the approval of the domiciliary commissioner.

b. For a company following one or more CDHS or one or more SHS that are required to be modeled pursuant to Section 9.A.6, the detailed requirements for the modeling of hedges are defined in Section 9. The following paragraphs are a high-level summary and do not supersede the detailed requirements.
   i. The appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the projections used in the determination of the stochastic reserve.
   ii. The projections shall take into account the appropriate costs and benefits of hedge positions expected to be held in the future through the execution of a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6. Because models do not always accurately portray the results of hedge programs, the company shall, through back-testing and other means, assess the accuracy of the hedge modeling. The company shall determine a stochastic reserve as the weighted average of two CTE values; first, a CTE70 (“best efforts”) representing the company’s projection of all of the hedge cash flows, including future hedge purchases, and a second CTE70 (“adjusted”) which shall use only hedge assets held by the company on the valuation date and no future hedge purchases. These are discussed in greater detail in Section 9. The stochastic reserve shall be the weighted average of the two CTE70 values, where the weights reflect the error factor (E) determined following the guidance of Section 9.C.4.
iii. The company is responsible for verifying compliance with CDHS requirements, or SHS requirements if required to be modeled pursuant to Section 9.A.6, and any other requirements in Section 9 for all hedging instruments included in the projections.

iv. The use of products not falling under the scope of these requirements (e.g., equity-indexed annuities) as a hedge shall not be recognized in the determination of accumulated deficiencies.

VM-21 Section 4.D.4.b

Notwithstanding the above requirements, the model investment strategy and any non-prescribed asset spreads shall be adjusted as necessary so that the aggregate reserve is not less than that which would be obtained by substituting an alternative investment strategy in which all fixed income reinvestment assets are public non-callable corporate bonds with gross asset spreads, asset default costs, and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of a CDHS (in compliance with the definition of CDHS in VM-01) or a SHS that is required to be modeled pursuant to Section 9.A.6 are not affected by this requirement.

VM-21 Section 6.B.3.a.ii – Footnote (Footnote at Bottom of Page 21-22)

Throughout this Section 6, references to CTE70 (adjusted) shall also mean the Stochastic Reserve for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6 as discussed in Section 4.A.4.a.

VM-21 Section 6.B.3.b.ii

Calculate the Prescribed Projections Amount as the CTE70 (adjusted) using the same method as that outlined in Section 9.C (which is the same as the stochastic reserves following Section 4.A.4.a for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6) but substituting the assumptions prescribed by Section 6.C. The calculation of this Prescribed Projections Amount also requires that the scenario reserve for any given scenario be equal to or in excess of the cash surrender value in aggregate on the valuation date for the group of contracts modeled in the projection.

VM-21 Section 6.B.5

Cash flows associated with hedging shall be projected in the same manner as that used in the calculation of the CTE70 (adjusted) as discussed in Section 9.C or Section 4.A.4.a for a company without a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6.

VM-21 Section 9

Section 9: Modeling of Hedges under a CDHS
A. Initial Considerations

1. Subject to Section 9.C.2, the appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the calculation of the stochastic reserve, determined in accordance with Section 3.D and Section 4.D.

2. If the company is following one or more CDHS, in accordance with an investment policy adopted by the board of directors, or a committee of board members, the company shall take into account the costs and benefits of hedge positions expected to be held by the company in the future along each scenario based on the execution of the hedging strategy, and it is eligible to reduce the amount of the stochastic reserve using projections otherwise calculated. The investment policy must clearly articulate the company’s hedging objectives, including the metrics that drive rebalancing/trading. This specification could include maximum tolerable values for investment losses, earnings, volatility, exposure, etc. in either absolute or relative terms over one or more investment horizons vis-à-vis the chance of occurrence. Company management is responsible for developing, documenting, executing and evaluating the investment strategy, including the hedging strategy, used to implement the investment policy.

3. For this purpose, the investment assets refer to all the assets, including derivatives supporting covered products and guarantees. This also is referred to as the investment portfolio. The investment strategy is the set of all asset holdings at all points in time in all scenarios. The hedging portfolio, which also is referred to as the hedging assets, is a subset of the investment assets. The hedging strategy is the hedging asset holdings at all points in time in all scenarios. There is no attempt to distinguish what is the hedging portfolio and what is the investment portfolio in this section. Nor is the distinction between investment strategy and hedging strategy formally made here. Where necessary to give effect to the intent of this section, the requirements applicable to the hedging portfolio or the hedging strategy are to apply to the overall investment portfolio and investment strategy.

4. This particularly applies to restrictions on the reasonableness or acceptability of the models that make up the stochastic cash-flow model used to perform the projections, since these restrictions are inherently restrictions on the joint modeling of the hedging and non-hedging portfolio. To give effect to these requirements, they must apply to the overall investment strategy and investment portfolio.

5. Before either a new or revised hedging strategy can be used to reduce the amount of the stochastic reserve otherwise calculated, the hedging strategy should be in place (i.e., effectively implemented by the company) for at least three months. The company may meet the time requirement by having evaluated the effective implementation of the hedging strategy for at least three months without actually having executed the trades indicated by the hedging strategy (e.g., mock testing or by having effectively implemented the strategy with similar annuity products for at least three months).

6. If a SHS supporting the contracts is not a CDHS but modeling it as if it were a CDHS would result in a material increase in the company’s TAR, then the company shall model the SHS as a CDHS when calculating reserves under AG43 and/or VM-21 and when calculating the C-3 RBC Amount under LR027. In addition, if modeling the SHS as if it were a CDHS would result in a decrease in the company’s TAR, the company may provide the documentation required for the SHS to be a CDHS as defined in VM-01 and then model the SHS as a CDHS when calculating reserves under AG43 and/or VM-21 and when calculating the C-3 RBC Amount under LR027. The company shall not treat a SHS as a CDHS for purposes of SSAP 108 without providing the documentation required for the SHS to be a CDHS as defined in VM-01.

Guidance Note: The intent of reflecting SHS is not to penalize any hedging strategies, but rather to reflect the company’s investment strategy and risk management strategies, including all material established...
B. Modeling Approaches

1. The analysis of the impact of the hedging strategy on cash flows is typically performed using either one of two types of methods as described below. Although a hedging strategy normally would be expected to reduce risk provisions, the nature of the hedging strategy and the costs to implement the strategy may result in an increase in the amount of the stochastic reserve otherwise calculated.

2. The fundamental characteristic of the first type of method, referred to as the “explicit method,” is that hedging positions and their resulting cash flows are included in the stochastic cash-flow model used to determine the scenario reserve, as discussed in Section 3.D, for each scenario.

3. The fundamental characteristic of the second type of method, referred to as the “implicit method,” is that the effectiveness of the current hedging strategy on future cash flows is evaluated, in part or in whole, outside of the stochastic cash-flow model. There are multiple ways that this type of modeling can be implemented. In this case, the reduction to the stochastic reserve otherwise calculated should be commensurate with the degree of effectiveness of the hedging strategy in reducing accumulated deficiencies otherwise calculated.

4. Regardless of the methodology used by the company, the ultimate effect of the current hedging strategy (including currently held hedge positions) on the stochastic reserve needs to recognize all risks, associated costs, imperfections in the hedges and hedging mismatch tolerances associated with the hedging strategy. The risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, annuitization, etc.). Costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. In addition, the reduction to the stochastic reserve attributable to the hedging strategy may need to be limited due to the uncertainty associated with the company’s ability to implement the hedging strategy in a timely and effective manner. The level of operational uncertainty varies indirectly with the amount of time that the new or revised strategy has been in effect or mock tested.

Guidance Note: No hedging strategy is perfect. A given hedging strategy may eliminate or reduce some but not all risks, transform some risks into others, introduce new risks, or have other imperfections. For example, a delta-only hedging strategy does not adequately hedge the risks measured by the “Greeks” other than delta. Another example is that financial indices underlying typical hedging instruments typically do not perform exactly like the separate account funds, and hence the use of hedging instruments has the potential for introducing basis risk.

5. A safe harbor approach is permitted for CDHS reflection for those companies whose modeled hedge assets comprise only linear instruments not sensitive to implied volatility. For companies with option-based hedge strategies, electing this approach would require representing the option-based portion of the strategy as a delta-rho two-Greek hedge program. The normally modeled option portfolio would be replaced with a set of linear instruments that have the same first-order Greeks as the original option portfolio.

C. Calculation of Stochastic Reserve (Reported)

1. The company shall calculate CTE70 (best efforts)—the results obtained when the CTE70 is based on incorporating the CDHS (including both currently held and future hedge positions) into the stochastic cash-flow model on a best efforts basis, including all of the factors and assumptions needed to execute the CDHS...
(e.g., stochastic implied volatility). The determination of CTE70 (best efforts) may utilize either explicit or implicit modeling techniques.

2. The company shall calculate a CTE70 (adjusted) by recalculating the CTE70 assuming the company has no CDHS, therefore following the requirements of Section 4.A.4.a.

3. Because most models will include at least some approximations or idealistic assumptions, CTE70 (best efforts) may overstate the impact of the hedging strategy. To compensate for potential overstatement of the impact of the hedging strategy, the value for the stochastic reserve is given by:

\[ \text{Stochastic reserve} = \text{CTE70 (best efforts)} + E \times \max[0, \text{CTE70 (adjusted)} - \text{CTE70 (best efforts)}] \]

4. The company shall specify a value for \( E \) (the “error factor”) in the range from 5% to 100% to reflect the company’s view of the potential error resulting from the level of sophistication of the stochastic cash-flow model and its ability to properly reflect the parameters of the hedging strategy (i.e., the Greeks being covered by the strategy), as well as the associated costs, risks and benefits. The greater the ability of the stochastic model to capture all risks and uncertainties, the lower the value of \( E \). The value of \( E \) may be as low as 5% only if the model used to determine the CTE70 (best efforts) effectively reflects all of the parameters used in the hedging strategy. If certain economic risks are not hedged, yet the model does not generate scenarios that sufficiently capture those risks, \( E \) must be in the higher end of the range, reflecting the greater likelihood of error. Likewise, simplistic hedge cash-flow models shall assume a higher likelihood of error.

5. The company shall conduct a formal back-test, based on an analysis of at least the most recent 12 months, to assess how well the model is able to replicate the hedging strategy in a way that supports the determination of the value used for \( E \).

6. Such a back-test shall involve one of the following analyses:

a. For companies that model hedge cash flows directly (“explicit method”), replace the stochastic scenarios used in calculating the CTE70 (best efforts) with a single scenario that represents the market path that actually manifested over the selected back-testing period and compare the projected hedge asset gains and losses against the actual hedge asset gains and losses – both realized and unrealized – observed over the same time period. For this calculation, the model assumptions may be replaced with parameters that reflect actual experience during the back-testing period. In order to isolate the comparison between the modeled hedge strategy and actual hedge results for this calculation, the projected liabilities should accurately reflect the actual liabilities throughout the back-testing period; therefore, adjustments that facilitate this accuracy (e.g. reflecting actual experience instead of model assumptions, including new business, etc.) are permissible.

To support the choice of a low value of \( E \), the company should ascertain that the projected hedge asset gains and losses are within close range of 100% (e.g., 80–125%) of the actual hedge asset gains and losses. The company may also support the choice of a low value of \( E \) by achieving a high R-squared (e.g., 0.80 or higher) when using a regression analysis technique.

b. For companies that model hedge cash flows implicitly by quantifying the cost and benefit of hedging using the fair value of the hedged item (an “implicit method” or “cost of reinsurance method”), calculate the delta, rho and vega coverage ratios in each month over the selected back-testing period in the following manner:

i. Determine the hedge asset gains and losses—both realized and unrealized—incurred over the month attributable to equity, interest rate, and implied volatility movements.
ii. Determine the change in the fair value of the hedged item over the month attributable to equity, interest rate, and implied volatility movements. The hedged item should be defined in a manner that reflects the proportion of risks hedged (e.g., if a company elects to hedge 50% of a contract’s market risks, it should quantify the fair value of the hedged item as 50% of the fair value of the contract).

iii. Calculate the delta coverage ratio as the ratio between (i) and (ii) attributable to equity movements.

iv. Calculate the rho coverage ratio as the ratio between (i) and (ii) attributable to interest rate movements.

v. Calculate the vega coverage ratio as the ratio between (i) and (ii) attributable to implied volatility movements.

vi. To support the company’s choice of a low value of E, the company should be able to demonstrate that the delta and rho coverage ratios are both within close range of 100% (e.g., 80–125%) consistently across the back-testing period.

vii. In addition, the company should be able to demonstrate that the vega coverage ratio is within close range of 100% in order to use the prevailing implied volatility levels as of the valuation date in quantifying the fair value of the hedged item for the purpose of calculating CTE70 (best efforts). Otherwise, the company shall quantify the fair value of the hedged item for the purpose of calculating CTE70 (best efforts) in a manner consistent with the realized volatility of the scenarios captured in the CTE (best efforts).

c. Companies that do not model hedge cash flows explicitly, but that also do not use the implicit method as outlined in Section 9.C.6.b above, shall conduct the formal back-test in a manner that allows the company to clearly illustrate the appropriateness of the selected method for reflecting the cost and benefit of hedging, as well as the value used for E.

7. A company that does not have 12 months of experience to date shall set E to a value that reflects the amount of experience available, and the degree and nature of any change to the hedge program. For a material change in strategy, with no history, E should be at least 0.50. However, E may be lower than 0.50 if some reliable experience is available and/or if the change in strategy is a refinement rather than a substantial change in strategy.

Guidance Note: The following examples are provided as guidance for determining the E factor when there has been a change to the hedge program:

- The error factor should be temporarily large (e.g., ≥ 50%) for substantial changes in hedge methodology (e.g., moving from a fair-value based strategy to a stop-loss strategy) where the company has not been able to provide a meaningful simulation of hedge performance based on the new strategy.
- A temporary moderate increase (e.g., 15–30%) in error factor should be used for substantial modifications to hedge programs or CDHS modeling where meaningful simulation has not been created (e.g., adding second-order hedging, such as gamma or rate convexity).
- No increase in the error factor may be used for incremental modifications to the hedge strategy (e.g., adding death benefits to a program that previously covered only living benefits, or moving from swaps to Treasury Department futures).

D. Additional Considerations for CTE70 (best efforts)

If the company is following a CDHS, the fair value of the portfolio of contracts falling within the scope of these requirements shall be computed and compared to the CTE70 (best efforts) and CTE70 (adjusted). If the CTE70 (best efforts) is below both the fair value and CTE70 (adjusted), the company should be prepared to explain why that result is reasonable.
For the purposes of this analysis, the stochastic reserve and fair value calculations shall be done without requiring the scenario reserve for any given scenario to be equal to or in excess of the cash surrender value in aggregate for the group of contracts modeled in the projection.

E. Specific Considerations and Requirements

1. As part of the process of choosing a methodology and assumptions for estimating the future effectiveness of the current hedging strategy (including currently held hedge positions) for purposes of reducing the stochastic reserve, the company should review actual historical hedging effectiveness. The company shall evaluate the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, the mix of business and other items that are likely to result in materially adverse results. This includes an analysis of model assumptions that, when combined with the reliance on the hedging strategy, are likely to result in adverse results relative to those modeled. The parameters and assumptions shall be adjusted (based on testing contingent on the strategy used and other assumptions) to levels that fully reflect the risk based on historical ranges and foreseeable future ranges of the assumptions and parameters. If this is not possible by parameter adjustment, the model shall be modified to reflect them at either anticipated experience or adverse estimates of the parameters.

2. A discontinuous hedging strategy is a hedging strategy where the relationships between the sensitivities to equity markets and interest rates (commonly referred to as the Greeks) associated with the guaranteed contract holder options embedded in the variable annuities and other in-scope products and these same sensitivities associated with the hedging assets are subject to material discontinuities. This includes, but is not limited to, a hedging strategy where material hedging assets will be obtained when the variable annuity account balances reach a predetermined level in relationship to the guarantees. Any hedging strategy, including a delta hedging strategy, can be a discontinuous hedging strategy if implementation of the strategy permits material discontinuities between the sensitivities to equity markets and interest rates associated with the guaranteed contract holder options embedded in the variable annuities and other in-scope products and these same sensitivities associated with the hedging assets. There may be scenarios that are particularly costly to discontinuous hedging strategies, especially where those result in large discontinuous changes in sensitivities (Greeks) associated with the hedging assets. Where discontinuous hedging strategies contribute materially to a reduction in the stochastic reserve, the company must evaluate the interaction of future trigger definitions and the discontinuous hedging strategy, in addition to the items mentioned in the previous paragraph. This includes an analysis of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.

3. A strategy that has a strong dependence on acquiring hedging assets at specific times that depend on specific values of an index or other market indicators may not be implemented as precisely as planned.

4. The combination of elements of the stochastic cash-flow model—including the initial actual market asset prices, prices for trading at future dates, transaction costs and other assumptions—should be analyzed by the company as to whether the stochastic cash-flow model permits hedging strategies that make money in some scenarios without losing a reasonable amount in some other scenarios. This includes, but is not limited to:
   a. Hedging strategies with no initial investment that never lose money in any scenario and in some scenarios make money.
   b. Hedging strategies that, with a given amount of initial money, never make less than accumulation at the one-period risk-free rates in any scenario but make more than this in one or more scenarios.

5. If the stochastic cash-flow model allows for such situations, the company should be satisfied that the results do not materially rely directly or indirectly on the use of such strategies. If the results do materially rely directly or indirectly on the use of such strategies, the strategies may not be used to reduce the stochastic reserve otherwise calculated.
6. In addition to the above, the method used to determine prices of financial instruments for trading in scenarios should be compared to actual initial market prices. In addition to comparisons to initial market prices, there should be testing of the pricing models that are used to determine subsequent prices when scenarios involve trading financial instruments. This testing should consider historical relationships. For example, if a method is used where recent volatility in the scenario is one of the determinants of prices for trading in that scenario, then that model should approximate actual historic prices in similar circumstances in history.

VM-31 Section 3.C.5

**Assets and Risk Management** – A brief description of the asset portfolio, and the approach used to model risk management strategies, such as hedging, and other derivative programs, including a description of any CDHS and any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4.

VM-31 Section 3.D.6.f

**Risk Management** – Detailed description of model risk management strategies, such as hedging and other derivative programs specific to the groups of policies covered in this sub-report and not discussed in the Life Summary Section 3.C.5. This should include documentation for any hedging strategy that meets the requirements to be a CDHS. It should also include, for any SHS that is not a CDHS, documentation of any CDHS criteria met, listing of CDHS criteria not met, and documentation of the impact on minimum reserves of the SHS being modeled as if it were a CDHS. In particular, such documentation should address the directional impact on minimum reserves and whether the impact is material.


a. **Investment Officer on Investments** – A certification from a duly authorized investment officer that the modeled company investment strategy, including any CDHS and any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4, is representative of and consistent with the company’s investment policy.

b. **Qualified Actuary on Investments** – A certification by a qualified actuary, not necessarily the same qualified actuary that has been assigned responsibility for the PBR Actuarial Report or this sub-report, that the modeling of any CDHS and any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4 was performed in accordance with VM-20 and in compliance with all applicable ASOPs, and the alternative investment strategy as defined in VM-20 Section 7.E.1.g reflects the prescribed mix of assets with the same WAL as the reinvestment assets in the company investment strategy.

VM-31 Section 3.E.5

**Assets and Risk Management** – A brief description of the general account asset portfolio, and the approach used to model risk management strategies, such as hedging and other derivative programs, including a description of any CDHS or any SHS that is required to be modeled pursuant to VM-21 Section 9.A.5, and any material changes to the hedging strategy from the prior year.
VM-31 Section 3.F.8

Hedging and Risk Management – The following information regarding the hedging and risk management assumptions used by the company in performing a principle-based valuation under VM-21:

a. Strategies – Detailed description of risk management strategies, such as hedging and other derivative programs, including any CDHS or any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, specific to the groups of contracts covered in this sub-report.
   i. Descriptions of basis risk, gap risk, price risk and assumption risk.
   ii. Methods and criteria for estimating the a priori effectiveness of the strategy.
   iii. Results of any reviews of actual historical hedging effectiveness.

b. CDHS – Documentation for any hedging strategy that meets the requirements to be a CDHS.

c. Other Modeled Hedging Strategies – Documentation for any SHS that is not a CDHS, including documentation of any CDHS criteria met, listing of CDHS criteria not met, and documentation of the impact on TAR of the SHS being modeled as if it were a CDHS. In particular, such documentation should address the directional impact on TAR and whether the impact is material.

d. Strategy Changes – Discussion of any changes to the hedging strategy during the past 12 months, including identification of the change, reasons for the change, and the implementation date of the change.

e. Hedge Modeling – Description of how the hedge strategy was incorporated into modeling, including:
   i. Differences in timing between model and actual strategy implementation.
   ii. For a company that does not have a CDHS or a SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, disclosure of the method used to consider hedge assets included in the starting assets, either (1) including the asset cash flows in the projection model; or (2) replacing the hedge positions with cash and/or other general account assets in an amount equal to the market value of the hedge positions, as discussed in VM-21 Section 4.A.4.a.
   iii. Evaluations of the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, and other items that are likely to result in materially adverse results.
   iv. If residual risks and frictional costs are assumed to have a value of zero, a demonstration that a value of zero is an appropriate expectation.
   v. Any discontinuous hedging strategies modeled, and where such discontinuous hedging strategies contribute materially to a reduction in the stochastic reserve, any evaluations of the interaction of future trigger definitions and the discontinuous hedging strategy, including any analyses of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.
   vi. Disclosure of any situations where the modeled hedging strategies make money in some scenarios without losing a reasonable amount in some other scenarios, and an explanation of why the situations are not material for determining the CTE 70 (best efforts).
   vii. Results of any testing of the method used to determine prices of financial instruments for trading in scenarios against actual initial market prices, including how the testing considered historical relationships. If there are substantial discrepancies, disclosure of the substantial discrepancies and documentation as to why the model-based prices are appropriate for determining the stochastic reserve.
   viii. Any model adjustments made when calculating CTE 70 (adjusted), in particular, any liquidation or substitution of assets for currently held hedges.

e. Error Factor (E) and Back-Testing – Description of E, the error factor, and formal back-tests performed, including:
i. The value of \( E \), and the approach and rationale for the value of \( E \) used in the reserve calculation.

ii. For companies that model hedge cash flows using the explicit method, as described in VM-21 Section 9.C.6.a, and have 12 months of experience, an analysis of at least the most recent 12 months of experience and the results of a back-test showing that the model is able to replicate the hedging results experienced in a way that justifies the value used for \( E \). Include at least a ratio of the actual change in market value of the hedges to the modeled change in market value of the hedges at least quarterly.

iii. For companies that model hedge cash flows using the implicit method, and have 12 months of experience, as described in VM-21 Section 9.C.6.b, the results of a back-test in which (a) actual hedge asset gains and losses are compared against (b) proportional fair value movements in hedged liability, including:
   a) Delta, rho and vega coverage ratios in each month over the back-testing period, which may be presented in a chart or graph.
   b) The implied volatility level used to quantify the fair value of the hedged item, as well as the methodology undertaken to determine the appropriate level used.

iv. For companies that do not model hedge cash flows using either the explicit method or the implicit method, as described in VM-21 Section 9.C.6.c, and have 12 months of experience, the results of the formal back-test conducted to validate the appropriateness of the selected method and value used for \( E \).

v. For companies that do not have 12 months of experience, the basis for the value of \( E \) is chosen based on the guidance provided in VM-21 Section 9.C.7, considering the actual history available and the degree and nature of any changes made to the hedge strategy.

f. Safe Harbor for CDHS – If electing the safe harbor approach for CDHS, as discussed in VM-21 Section 9.C.8, a description of the linear instruments used to model the option portfolio.

g. Hedge Model Results – Disclosure of whether the calculated CTE 70 (best efforts) is below both the fair value and CTE 70 (adjusted), and if so, justification for why that result is reasonable, as discussed in VM-21 Section 9.D.

VM-31 Section 3.F.12.c

CTEPA – If using the CTEPA method, a summary including:

i. Disclosure (in tabular form) of the scenario reserves using the same method and assumptions as those used by the company to calculate CTE 70 (adjusted) as outlined in VM-21 Section 9.C (or the stochastic reserves following VM-21 Section 4.A.4.a for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to VM-21 Section 9.A.6), as well as the corresponding scenarios reserves substituting the assumptions prescribed by VM-21 Section 6.C.

ii. Summary of results from a cumulative decrement projection along the scenario whose reserve value is closest to the CTE 70 (adjusted), as outlined in VM-21 Section 9.C (or the stochastic reserves following VM-21 Section 4.A.4.a for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to VM-21 Section 9.A.6), under the assumptions outlined in VM-21 Section 6.C. Such a cumulative decrement projection shall include, at the end of each projection year, the projected proportion (expressed as a percent of the total projected account value) of persisting contracts as well as the allocation of projected decrements across death, full surrender, account value depletion, elective annuitization, and other benefit election.
iii. Summary of results from a cumulative decrement projection, identical to (ii) above, but replacing all assumptions outlined in VM-21 Section 6.C with the corresponding assumptions used in calculating the stochastic reserve.

VM-31 Section 3.F.16.a and Section 3.F.16.b

a. Investment Officer on Investments – A certification from a duly authorized investment officer that the modeled asset investment strategy, including any CDHS and any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, is consistent with the company’s current investment strategy except where the modeled reinvestment strategy may have been substituted with the alternative investment strategy, and also any CDHS meets the requirements of a CDHS.

b. Qualified Actuary on Investments – A certification by a qualified actuary, not necessarily the same qualified actuary, that has been assigned responsibility for the PBR Actuarial Report or this sub-report, that the modeling of any CDHS and any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6 was performed in accordance with VM-21 and in compliance with all applicable ASOPs.
June 14, 2021

Mr. Mike Boerner
Chair, Life Actuarial (A) Task Force
National Association of Insurance Commissioners

Re: APF 2019-34

Dear Mr. Boerner,

The Life Reserves Work Group (LRWG) of the American Academy of Actuaries\(^1\) is pleased to have the opportunity to submit the following comments regarding exposed amendment proposal form (APF) 2019-34. This APF, as written, would require that the Appointed Actuary for a ceding insurer subject to the Standard Valuation Law (SVL) either perform Asset Adequacy Analysis Testing (AAT) on amounts ceded under reinsurance or provide results of AAT performed by the company’s reinsurer for the subject reinsured business.

APF 2019-34 explicitly notes that it is not sufficient to merely rely on an actuarial opinion of the reinsurer’s actuary that ceded reserves are adequate. It implicitly addresses situations where the regulatory jurisdiction of the reinsurer is one where AAT may not be required. The APF also states that a zero net reported reserve by the ceding company is not sufficient to “foreclose the need” for AAT on such reinsured business.

The LRWG agrees that it is appropriate for the actuary to consider the amounts ceded under reinsurance when forming an opinion on the adequacy of the net reserves being reported. However, we are concerned with LATF adopting the APF because we have the following concerns that have technical, regulatory, and practical implications:

1. We believe the Valuation Manual already provides the regulator with the authority under VM-30 Section 1.A.3 to require support for the reserve adequacy opinion.

“The AOM requirements shall be applied in a manner that allows the appointed actuary to use his or her professional judgment in performing the actuarial analysis and developing the actuarial opinion and supporting actuarial memoranda, conforming to relevant ASOPs. However, a state commissioner has the authority to specify methods of analysis and assumptions when, in the commissioner’s judgment, these specifications are necessary for the actuary to render an acceptable opinion relative to the adequacy of reserves and related actuarial items.”

\(^{1}\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
2. If ceding company actuaries provide results of AAT performed by one or more of the company’s reinsurer(s) for the reinsured business, we question whether this additional documentation would provide the regulator with comfort that the ceded reserves are adequate. There could be diversity in local regulations, accounting regimes, and applicable actuarial standards of practice (ASOPs), between a US domiciled cedant and a non-US domiciled reinsurer. Regardless of jurisdiction, there is likely to be diversity in the mix of business on the counterparties’ respective balance sheets potentially resulting in different AAT conclusions. There could also be potential diversity in actuarial assumptions. For example, the challenge in establishing similar assumptions among different actuaries on a block of reinsured business has already been recognized, which led to the yearly renewable term (YRT) field test.

3. It may be possible for ceding company actuaries to perform AAT “gross of reinsurance” without speculative assumption setting for some modified coinsurance and funds withheld coinsurance business, because the reinsurance agreement could specify the assumptions used for valuing the business. Otherwise, performing AAT “gross of reinsurance” might involve speculative assumption setting for “hypothetical assets,” policyholder behavior, or other assumptions assuming a hypothetical recapture of reinsurance.

4. ASOPs Nos. 7, 22, 28, and 41; the current version of ASOP No. 11; the revised ASOP No. 11 (effective December 1, 2022) and others require the actuary to consider and document how these elements were considered.

5. Finally, the proposed APF appears to require AAT regardless of the materiality of the impact of the ceded reserves on the cedent.

In summary, the LRWG believes that there would be technical challenges associated with the implementation of the APF. In addition, the ASOPs already require the actuary to consider and document elements that could impact the adequacy of the net reserves reported, and VM-30 already provides the regulators with the authority to require additional information to gain comfort with the adequacy of the net reserves being reported. Therefore, the LRWG has concern with the adoption of this APF.

Thank you for your consideration. Please contact Academy life policy analyst Khloe Greenwood (greenwood@actuary.org) with any questions.

Leonard Mangini, MAAA, FSA
Chairperson, Life Reserves Work Group
American Academy of Actuaries
Brian Bayerle  
Senior Actuary  

June 14, 2021  

Mr. Mike Boerner  
Chair, NAIC Life Actuarial (A) Task Force (LATF)  

Re: ACLI Comments on APF 2019-34  

Dear Mr. Boerner:  

The American Council of Life Insurers (ACLI) appreciates the opportunity to provide comments on APF 2019-34.  

Our understanding is that the APF is intended to address situations in which the appointed actuary does not appear to consider all material aspects of their reinsured business (both ceded and assumed) when providing their Statement of Actuarial Opinion (SAO). While we support clarification on the role of the appointed actuary in these circumstances, we do not support this APF because it seemingly creates onerous requirements for appointed actuaries and will produce unreliable results for regulators.  

While actuaries are currently subject to existing requirements and guidance in the performance of asset adequacy analysis and the preparation of the SAO, industry supports enhancements which enable the appointed actuary and regulator to reliably analyze and mitigate risks. Thus, ACLI supports a further discussion of the specific risks that regulators are seeking to mitigate, and how the APF could be worded to address these risks, increase transparency, and affirm appropriate risk mitigation actions.  

Principles around SAO responsibilities  

The Standard Valuation Law imposes certain responsibilities on the appointed actuaries of both the assuming and ceding ends of a reinsurance arrangement. In either case, the appointed actuary needs to consider its reinsurance arrangements when preparing the SAO. Such consideration may vary in its complexity and should be appropriate for the types of risks the reinsured business presents to the company and the materiality of those risks.  

The following sources provide additional guidance:  

- Valuation Manual (VM-30)
The Opinion must consider the “contractual obligations” of the company. This includes reinsurance contracts/treaties.

The Actuarial Memorandum requires disclosure of “the method of treating reinsurance in the asset adequacy analysis”.

The Regulatory Asset Adequacy Issues Summary includes a section on “The methods used by the actuary to recognize the impact of reinsurance on the company’s cash flows, including both assets and liabilities, under each of the scenarios tested.”

- Actuarial Standards of Practice (ASOPs)
  - ASOP No. 7, Analysis of Life, Health, or Property/Casualty Insurer Cash Flows, contains the following guidance on reinsurance:
    
    **3.8 REINSURANCE**
    The actuary should consider whether reinsurance receivables will be collectible when due, and any terms, conditions, or other aspects that may be reasonably expected to have a material impact on the cash flow analysis.
    
    **4.3 DOCUMENTATION**
    g.8. the characteristics of any reinsurance agreements, and how these were reflected in the analysis;

  - ASOP No. 11, Treatment of Reinsurance or Similar Risk Transfer Programs Involving Life Insurance, Annuities, or Health Benefit Plans in Financial Reports (Effective December 1, 2022), provides a wealth of guidance on the treatment of reinsurance in financial reports (which includes asset adequacy analysis reports), including:
    
    **3.1 REINSURANCE PROGRAM FEATURES**
    When preparing financial reports, the actuary should take into account aspects of relevant reinsurance program(s), including [...] the risks transferred in the reinsurance agreement [and] the structure of the reinsurance agreement.
    
    **3.6 ASSESSING AND ANALYZING THE RISKS BEING TRANSFERRED IN A REINSURANCE PROGRAM**
    When preparing a financial report to assess and analyze the risks being transferred in a reinsurance program, the actuary should take into account the terms and conditions of the reinsurance program.
    
    **3.9 ADDITIONAL LIABILITIES, RESERVES, OR ALLOCATION OF CAPITAL**
    The actuary should consider establishing additional liabilities, reserves, or allocation of capital based upon the terms and conditions of the reinsurance program. When considering this issue, the actuary should use assumptions consistent with the purpose of the financial report.

  - The second exposure draft of ASOP No. 22, Statements of Actuarial Opinion Based on Asset Adequacy Analysis for Life Insurance, Annuity, or Health Insurance Reserves and Other Liabilities, contains the following guidance on reinsurance:
    
    **3.1.3 REINSURANCE CEDED**
    The actuary should consider reflecting reinsurance ceded cash flows in the asset adequacy analysis regardless of whether the analysis is performed for a direct writing company or a reinsurer. In deciding whether and how to reflect the reinsurance ceded cash flows, the actuary should solicit information from
management regarding the extent of reinsurance, the associated cash flows, their collectability, any disputes with reinsurers, and practices regarding provisions for reinsurance ceded. The actuary’s consideration of reinsurance ceded does not imply an opinion on the financial condition of any reinsurer.

4.1 REQUIRED DISCLOSURES IN AN ACTUARIAL REPORT

h. whether and how reinsurance ceded cash flows were reflected in the asset adequacy analysis (see section 3.1.3).

- 2017 Practice Note on Asset Adequacy Analysis
  - Q31 discusses treatment of modified coinsurance in asset adequacy analyses.

We believe this guidance addresses many of the concerns identified in the APF without being overly prescriptive.

Additional Comments

Regarding the specific text of the APF, we have the following comments by section:

Section 4.1:
The existing SAO requirements, as noted above, already necessitate consideration of all contracts, both obligations to policyholders and requirements under reinsurance arrangements. Therefore, we suggest removing this section.

Section 4.2:
Current requirements recognize that asset adequacy analysis may not always be appropriate or required. Accordingly, these requirements allow the appointed actuary to apply judgement in selecting a method of analysis to support the SAO. Sections 1 and 2 lead us to believe this APF would impose an asset adequacy analysis requirement for each reinsured block on a standalone basis, because results need to be reportable back to the ceding company. This requirement eliminates any ability for the appointed actuary to apply professional judgement which is permitted in the current requirements. In addition, an asset adequacy analysis requirement would potentially:

- Introduce requirements for the appointed actuary to test business which it has divested by ceding the risk to a qualified and credit worthy counterparty. In such cases, the ceding company may not have retained the assumption setting, modeling capabilities, or expertise to support asset adequacy analysis.
- Introduce requirements for the appointed actuary to perform asset adequacy analysis for business where there is limited or no information related to assets supporting the ceded liabilities.
- Impose a significant new requirement and operational burden for companies that would need to perform asset adequacy analysis on different reinsured blocks if such analysis is to be performed separately. Such a standalone requirement would deviate from the current guidance that requires additional asset adequacy reserves, if any, to be determined in the aggregate. Further, as many blocks are managed collectively, the result of this standalone testing would produce results that may not appropriately reflect the true economics had the ceding company retained the block.

Section 4.3:
We agree that materiality should be a consideration in the assessment. We note that ASOP 22 allows certain blocks to not be tested due to immateriality. Further, this section does not actually tie back to reinsurance. We suggest removing this section.

Section 4.4/Guidance Note: We believe the requirements of Section 4.4 are generally already covered by the existing requirements, and thus are redundant. We suggest removing this section.

We look forward to a discussion of this amendment on a future call. We appreciate the consideration of our comments.

Sincerely,

[Signature]

cc: Reggie Mazyck, NAIC
Date: May 17, 2021

Virginia is submitting comments regarding the following exposure:

**APF 2019-34 (Clarify Responsibilities for Reinsurance)**

**Comments:**

1. There have been reports of companies neglecting to perform proper asset adequacy analysis of reported reserves for various reinsurance treaties, however, I believe the current requirements of Model 820, ASOP #22, and VM-30 are sufficient and adequate to handle these situations and APF 2019-34 should not be necessary. However, if it is really felt that additional guidance in VM-30 is necessary, then please consider the following comments 2-5 below.

2. The numbering is not consistent with VM-30. The subsections should not be numbered 1-4, but rather should be numbered A-D. Also, the subsections under Section 4.4 should be re-numbered 1. and 2., rather than (a) and (b). The paragraphs in the Guidance Note should follow a different numbering scheme as used in Section 4.4, so as to avoid confusion.

3. In Section 4 heading, I would suggest removing the words “treaties of” and just have “Section 4: Asset Adequacy Analysis for Reinsurance”

4. In Section 4.1, the phrase “currently in force” should be replaced with “in force as of the annual statement date” to be more consistent with the rest of VM-30. It is possible that appointed actuary may be performing analysis as of a date other than annual statement date (e.g., as of September 30), so in order to capture new treaties which may have been entered into during the 4th quarter, it is necessary to make this change. Note there are two places in Section 4.1 where this change needs to be made.

5. In the Guidance Note at the bottom of Section 4.4, the last sentence conflicts with Section 3.A.6 of VM-30, as well as Section 4.4 of ASOP #22. The last sentence reads as follows: “In relying on the work of another appointed actuary, an appointed actuary may not rely solely on the other actuary’s statement of actuarial opinion.” There are a couple of issues with this sentence. First, the appointed actuary does not have to rely on the work of another *appointed actuary*. The appointed actuary may rely on the work of an actuary who is not the appointed actuary or even a non-actuary. The sentence appears to imply that the appointed actuary is relying on the work of the appointed actuary of the reinsurance counterparty. The preceding sentence gives this as an example, that the appointed actuary may be relying on the appointed actuary of the
reinsurance counterparty, but this may not be true in all instances. Therefore, I believe it is better that the first occurrence of the word “appointed” be removed. Second, by use of the word “solely” the wording implies that the appointed actuary may rely on the opinion of another actuary when establishing his own opinion. The implication is that the appointed actuary may rely in part on the other actuary’s statement of actuarial opinion, but not in whole. Section 3.A.6 of VM-30 is clear that in forming his opinion, the appointed actuary may rely on “other experts for data, assumptions, projections or analysis”, but there is no provision for the appointed actuary to rely on other actuaries’ opinions, in whole or in part. This is made clear in Section 4.4 of ASOP #22. In situations where more than one actuary contributes to forming an opinion, the following statement is made: “The actuary should then form an overall opinion without claiming reliance on the opinions of other actuaries.” The opinion of the appointed actuary must be solely his own opinion. Therefore, the last sentence should be removed or re-worded. If re-worded, one suggested wording would be as follows:

“When the other actuary has provided an opinion, the appointed actuary may consider the opinion of the other actuary in forming their own opinion, however, the appointed actuary shall not rely on the other actuary’s statement of actuarial opinion when forming their own overall opinion.”

Thank you for your consideration of these comments.

Craig Chupp, FSA, MAAA
Life and Health Insurance Actuary
Virginia Bureau of Insurance
craig.chupp@scc.virginia.gov
Phone: (804) 371-9131
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

John Robinson, Director, PBR – Valuation Actuary, MN

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


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

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

The purposes of this APF are to
(a) Clarify the responsibilities of the appointed actuaries of both the ceding and assuming companies for all forms of reinsurance, relative to both the SAO and asset adequacy analysis.
(b) Make a minor modification to the table headings in VM-30, Section 3.A.5.

Discussion of Rationale:

1. Every appointed actuary should be held accountable for ensuring that all the reserves covered by the actuary’s SAO are subjected to asset adequacy analysis. Usually, this requires the appointed actuary to perform the analysis; however, circumstances may exist where the appointed actuary can rely on work performed by the counterparty’s appointed actuary. In any event, whether relying on another actuary or not, this APF will require the appointed actuary to provide the results of the asset adequacy analysis, as evidence that the analysis was performed.

2. VM-30 Section 3.A.7.e includes the following required statement as part of the SAO:
“The reserves and related actuarial items, when considered in light of the assets held by the company with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on the assets, and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision, according to presently accepted ASOPs, for the anticipated cash flows required by the contractual obligations and related expenses of the company.”

In a situation where part or all of the risk is reinsured, the assets held by the company may only be in respect of the portion of the risk supported by the reserves held; however, the appointed actuary’s actuarial opinion must address all the contractual obligations. It follows that, while asset adequacy analysis can only be performed on the reserves and assets held (i.e. net of reinsurance), the appointed actuary’s responsibility may extend beyond the reserves and assets held.
3. In a recent Academy survey of appointed actuaries (“A Survey of Life Appointed Actuaries, December 4, 2020”, Question 66), most of them (50.38%) indicated that for the YE2019 AAT, “no special consideration for reinsurance recoverability will be added”.

This APF will provide guidance that should produce more clarity and uniformity on this issue.

4. The following excerpt is from ASOP 7, “Analysis of Life, Health, or Property/Casualty Insurer Cash Flows”:

3.8 Reinsurance—The actuary should consider whether reinsurance receivables will be collectible when due, and any terms, conditions, or other aspects that may be reasonably expected to have a material impact on the cash flow analysis.”

This APF will propose that similar guidance apply to the appointed actuary in meeting his/her responsibility beyond the reserves and assets held.

5. ASOP 11, Section 3.3, “Treatment of Reinsurance Ceded” states as follows: “Because the ceding entity and the assuming entity each establish and test statement liabilities and assets independently, it is possible for the value of the net statement liabilities held by the ceding entity, plus those held by the reinsurer on a reinsured contract, to be more or less than the amount that would have been held if the ceding entity had not reinsured the contract. For example, the two entities may have different investment strategies, resulting in the use of different interest rate assumptions.”

It is clear that both the ceding and assuming companies are expected to both establish and test their respective liabilities.

The proposed text is in the Appendix below.

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

**NAIC Staff Comments:**

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<th>Dates: Received</th>
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<th>Distributed</th>
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</table>

**Notes:** VM Maintenance Agenda 2019-34
APPENDIX

1. It is proposed to add the following text as VM-30, Section 4:

Section 4: Asset Adequacy Analysis For Treaties Of Reinsurance

A. Each counterparty to a reinsurance treaty has established a reserve in respect of its obligations relative to the underlying policies. Furthermore, the appointed actuary’s statement of actuarial opinion covers the reserves established for all of the company’s reinsurance treaties as of the annual statement date. Consequently, a company’s appointed actuary is required to perform asset adequacy analysis on the reserves, net of reinsurance when a reinsurance reserve credit is applicable, which the company has entered into with the company which has entered into a reinsurance treaty as of the annual statement date.

B. The results of the asset adequacy analysis shall be reported in the appointed actuary’s actuarial memorandum, as required in Section 3.B.12.b.

C. Materiality considerations may influence the decision whether to perform the asset adequacy analysis. However, the size of the reserve must not be the sole materiality criterion.

D. The appointed actuary of a direct writer must perform a review of each reinsurance counterparty to assess:
   1. Whether reinsurance receivables will be collectible when due; and
   2. Any terms, conditions, or other aspects that may be reasonably expected to have a material impact on the direct writer’s ability to meet its obligations to policyholders.

Evidence of having performed such reviews shall be provided in the actuarial memorandum.

Guidance Note:
(a) Under certain circumstances, for example, when risk is ceded under a modified coinsurance agreement, a counterparty may report a reserve of 0. This alone does not foreclose on the requirement for the asset adequacy analysis to be performed.

(b) If an appointed actuary relies on the work of another actuary, such as the appointed actuary of the reinsurance counterparty, the guidance in Section 3.A.6 and Section 3.B.2 must be followed. In relying on the work of another appointed actuary, an appointed actuary may not rely solely on the other actuary’s statement of actuarial opinion.

(c) When performing a review of a counterparty per Section 4.D., and providing evidence thereof, the appointed actuary is reminded to refer to ASOP 11 for guidance.

[Underlying principles:
1. The SAO itself
2. Each counterparty has its own perspective
3. Regulatory accountability]

Questions for commenters:
2. In 4., should there be more specificity as to what evidence should be provided? If so, what should be required?

(b) It is widely believed that the counterparty that bears the risk should perform the testing. This perspective has been used by appointed actuaries as the rationale for not performing asset adequacy analysis. Please provide a reference to formal guidance that supports this point of view.

2. Revision to Section 3.A.5, Table Headings:

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<th>Formula Reserves (1)</th>
<th>Principle-Based Reserves (2)</th>
<th>Additional Reserves (3)</th>
<th>Analysis Method (4)</th>
<th>Other Amount Not Tested (5)</th>
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<td></td>
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<td></td>
<td>Total Amount = (1)+(2)+(3)+(4)+(5)</td>
</tr>
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</table>

Response to Commenters:

1. Commenters have pointed out that there is guidance in place that covers this topic. I note that the VM states that a goal of developing the VM is “to promote uniformity among states’ valuation requirements”. In that spirit, the purpose of this APF is to establish a national standard of regulatory accountability which is currently lacking, as evidenced by the fact that actuaries are referring to the Practice Note for guidance. It is grounded in the current guidance. In particular, the intent of this guidance is not to address any particular risks.

2. This national standard pertains universally to the reserves set, and associated assets held, by the company, plus a requirement for direct writers. In particular, I hesitate to set a national standard for performing AAT on the gross reserve because I consider the value of an analysis based on hypothetical assets to be limited.

3. This guidance is meant to apply to all forms of reinsurance. However, CFW presents some interesting questions. Note that this guidance is applicable to whatever is covered by the SAO. So, the question is whether the FW liability is subject to the SAO. Currently, the conventional wisdom is that Exhs 5, 6, 7 and 8.1 are covered; however, guidance is lacking as to what must be covered.

4. Commenters have indicated that presenting the counterparty’s results may not be sufficient evidence of reserve adequacy. My response is that relying on the counterparty’s work is not required; therefore, it is up to the AA that is relying on the results to justify the use of said results. VM-30 is explicit as to the terms of reliance. The purpose of requiring that results be provided is to provide the regulator assurance that the work was performed.
5. Implementation of this APF will lead to some stand-alone analysis being required. This is a function of the aggregation restrictions. I note that aggregation is not a requirement; it is an option. However, the fact that it is stand-alone should not be a reason to not perform the analysis.
The Life Actuarial (A) Task Force met June 24, 2021. The following Task Force members participated: Doug Slape, Chair, represented by Mike Boerner, Rachel Hemphill, and Karen Jiang (TX); Judith L. French, Vice Chair, represented by Jason Wade (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li and Steve Oslund (AL); Ricardo Lara represented by Thomas Reedy and Ben Bock (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Amy L. Beard represented by Stephen Chamblee (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and John Robinson (MN); Chlorinda Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Rhonda Ahrens (NE); Marlene Caride represented by David Wolf (NJ); Linda A. Lacey represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Jonathan T. Pike represented by Tomasz Serbinowski (UT); Scott A. White represented by Craig Chupp (VA); and James A. Dodrill represented by Joylynn Fix (WV).

1. **Adopted Amendment Proposal 2021-10**

Mr. Leung made a motion, seconded by Mr. Weber, to adopt amendment proposal 2021-10 (Attachment Two-A). The motion passed unanimously.

2. **Tabled Amendment Proposal 2021-08**

Mr. Boerner said amendment proposal 2021-08 recommends reducing the experience reporting data collection lag from two years to one year and collecting experience data for the 2020 and 2021 exposure periods in 2022. He said Mary Bahna-Nolan (Society of Actuaries—SOA) and Larry Bruning (SOA) advocate reducing the lag to allow for additional experience data for the 2015 Valuation Basic Table (VBT) update. He said the American Council of Life Insurers (ACLI) comment letter supports deferring adoption of the amendment proposal until new accelerated underwriting data elements are adopted. He noted that adoption of the accelerated underwriting data elements may be a couple of years away. He said the ACLI is also concerned that the existing deadlines may not allow companies sufficient time to provide the data for the 2021 exposure year. Dan Schelp (NAIC) said the *Valuation Manual* allows the experience reporting agent to modify the reporting requirements as needed, with the approval of the Task Force. He recommended that any action taken to extend the reporting deadline be applied broadly and not on a case-by-case basis. Ms. Ahrens agreed that companies may not have sufficient resources to provide the required data. Brian Bayerle (ACLI) said the ACLI questions whether collecting two years of data in 2022 will stretch NAIC resources. He asked that adoption of the amendment proposal be deferred. Mr. Boerner said the effort to collect two years of data in 2022 is not appreciably different from the current efforts to collect data for 2018 and 2019. Philip Wunderlich (Nationwide) said having only six months between the year of the reporting year and the initial data submission date makes the reporting of deaths challenging. He said it will also affect the quality of the data submitted due to the reduction in the time available for the company’s internal data scrubbing efforts.

Ms. Ahrens made a motion, seconded by Mr. Carmello, to table amendment proposal 2021-08 (Attachment Two-B). The motion passed unanimously.

3. **Re-Exposed Amendment Proposal 2019-33**

Mr. Boerner said a non-substantive change was made to the prior version of amendment proposal 2019-33. The change clarifies that the scope of the individual certificates issued under group contracts is not limited by or dependent upon the date of the group master contract. Mr. Chupp listed some editorial changes to the prior version. Leonard Mangini (American Academy of Actuaries—Academy) said the Academy agrees with the Mr. Chupp’s editorial changes. Mr. Chupp also proposed to change the wording in VM-20, Requirements for Principles-Based Reserves for Life Products, Section 1.B.2 from “premiums or cost of insurance schedules and charges…” to “premiums or cost of insurance schedules or charges…” Ms. Bahna-Nolan said Mr. Chupp is considering banding when looking at the language. She said the term “coverage amount” refers to units per $1,000, and it was not intended to consider banding. She suggested adding a note to clarify “coverage amount” does not imply banding, instead of making the proposed change. Mr. Chupp agreed that adding a note will be sufficient. Mr. Boerner asked if the Academy would like the exposure to address the author’s note in the exposure, which questions whether the term “ordinary life...
policies” should be changed to “individual life insurance policies and certificates.” Ms. Bahna-Nolan said she would address the matter by providing a clarification of the issue raised by the author’s note for inclusion in the exposure.

Mr. Chupp made a motion, seconded by Mr. Leung, to re-expose amendment proposal 2019-33 (Attachment Two-C), including Mr. Chupp’s editorial changes and both the note on coverage amount and the clarification of the author’s note to be provided by Ms. Bahna-Nolan for a public comment period ending June 30. The motion passed unanimously.

4. Adopted Amendment Proposal 2021-07

Mr. Bock said the first four suggestions in his comment letter (Attachment Two-D) are editorial changes. He said his fifth suggestion recommends repositioning certain paragraphs of VM-20 Section 3.B.5 to improve its flow. He noted that the adoption of the fifth suggestion will alleviate the need for the editorial changes proposed in the fourth suggestion. David Neve (Actuarial Resources Corporation of GA—ARCGA) agreed with Mr. Bock’s suggested changes.

Mr. Chupp made a motion, seconded by Mr. Weber, to adopt amendment proposal 2021-07 (Attachment Two-E), including suggestions #1, #2, #3, and #5 from Mr. Bock. The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

Angela McNabb & Pat Allison – NAIC staff support

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

January 1, 2021, version of the Valuation Manual – VM-51 Appendix 4

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

<table>
<thead>
<tr>
<th>ITEM</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
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</table>
| 11   | 1 | Smoker Status (at issue) | Smoker status should be submitted where reliable.  
0 = Unknown  
1 = No tobacco usage  
2 = Nonsmoker  
3 = Cigarette smoker  
4 = Tobacco user |

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

In the event that additional underwriting is done after issue, it is possible that the preferred class would be inconsistent with the smoker status at issue. By removing the “at issue” specification, the smoker status would then be the current smoker status.

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

NAIC Staff Comments:

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Notes: APF 2021-10
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force

Amendment Proposal Form*

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

Society of Actuaries Valuation Basic Table Team – Chair Larry Bruning

Revisions to VM-51 to allow for the data experience reporting observation calendar year to be one year prior to the reporting calendar year.

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


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

Section 2: Statistical Plan for Mortality

D. Process for Submitting Experience Data Under This Statistical Plan

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

Data for this statistical plan for mortality will be compiled using a calendar year method. The reporting calendar year is the calendar year that the company submits the experience data. The observation calendar year is the calendar year of the experience data that is reported. The observation calendar year will be one year prior to the reporting calendar year. For example, if the current calendar year is 2022 and that is the reporting calendar year, the company is to report the experience data that was in-force or issued in calendar year 2021, which is the observation calendar year. For the 2022 reporting calendar year, companies that are required to submit data for this statistical plan for mortality will be required to submit observation calendar years of data, namely observation calendar year 2020 and observation calendar year 2021. For reporting calendar years after 2022, companies that are required to submit data for this statistical plan for mortality will be required to submit one observation calendar year of data.

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

i. Report policies in force during or issued during calendar year 20XX.
ii. Report terminations that were incurred in calendar year 20XX and reported before July 1, 20XX+1. However, exclude rescinded policies (e.g., 10-day free look exercises) from the data submission.

For any reporting calendar year, the data call will occur during July of that reporting calendar year, and data is to be submitted according to the requirements of the Valuation Manual in effect during that calendar year. For the 2022 reporting calendar year, the requirements of the 2022 Valuation Manual will be used for both the 2020 and 2021 observation years. Data submissions must be made by Sept. 30 of the reporting calendar year. Corrections of data submissions must be completed by Dec. 31 of the reporting calendar year.

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

This APF is needed for the following reasons:

1. There is a need to shorten the time period between data observation and data collection to facilitate more timely analysis and reporting of mortality experience.

2. Under a Principle Based Reserving methodology, valuation basic tables should reflect recent and current mortality experience.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

American Academy of Actuaries, Life Reserves Work Group

Addition of language to clarify the definition of individually underwritten life insurance and the applicability of Principle-Based Reserve (PBR) requirements for group insurance contracts with individual risk selection issued under insurance certificates.

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

January 1, 2021, version of the Valuation Manual, with the revisions to APF 2020-11 (adopted by LATF on 2/11/21) shown in blue text.

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

See Appendix

All proposed changes specific to this amendment proposal are shown in red text.

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

Individual insurance certificates issued under a group contract which utilize an individual risk selection process, pricing, premium rate structures and product features are similar to individual life insurance policies. They are currently excluded from VM-20 because they are filed under a group contract, but they should be subject to VM-20 due to this similarity. See Appendix.

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

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Notes: APF 2019-33
Appendix

Issue

Certain contracts issued under a master group contract require individual risk selection in order to qualify for issuance of the group insurance certificate; the certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing, and risk classification; and they are managed in a similar manner as individual ordinary life insurance contracts. These individual certificates should follow the same reserve requirements as other individual life contracts of the same product type. Therefore, a change is needed within the Valuation Manual to bring these individual certificates into scope of VM-20.

Six changes are recommended:

1) Within the Reserve Requirements section (Section II), change the minimum reserve requirements to also apply to group life contracts which, other than the difference between issuing a policy and issuing a group certificate, have the same or mostly similar contract provisions, risk selection process, and underwriting as individual ordinary life contracts (Section II, subsection 1.D);

2) Within the Reserve Requirements section (Section II), add a transition period for individual group certificates issued on or before 1/1/2024 (Section II, subsections 1.F.1 and 1.F.2);

3) Within the Reserve Requirements section (Section II), add language and guidance note to subsection 1.G and the corresponding footnote to include premiums from group life contracts which have individual certificates that were issued using individual risk selection processes (Section II, subsection 1.G.1, footnote, and guidance note) and to clarify the Calculation for Exemption (Section II, subsection 1.G.2). Comment notes need to refer to NAIC Blanks (E) Working Group to update the PBR Supplement;

4) Add new paragraph, VM-20 Section 1.B (and reformat to make current paragraph Section 1.A) to clarify group life certificates issued using individual risk selection processes, including a definition and requirements to be met, are subject to the requirements of VM-20;

5) Add guidance note after first sentence in VM-20 Section 2.A.1 that group life certificates that meet the definition for individual risk selection process use the same VM-20 Reserving Categories as defined in Section 2;

6) Draft referral to the NAIC Blanks (E) Working Group to revise the VM-20 Reserves Supplement, Part 2 to report premiums for total Group Life and Group Life with certificates subjected to an individual risk selection process and which meet all of the conditions as defined in VM-20 Section 1.B separately.
II. Reserve Requirements

This section provides the minimum reserve requirements by type of product, as set forth in the seven subsections below, as follows:

(1) Life Insurance Products
(2) Annuity Products
(3) Deposit-Type Contracts
(4) Health Insurance Products
(5) Credit Life and Disability Products
(6) Riders and Supplemental Benefits
(7) Claim Reserves

All reserve requirements provided by this section relate to business issued on or after the operative date of the Valuation Manual. All reserves must be developed in a manner consistent with the requirements and concepts stated in the Overview of Reserve Concepts in Section I of the Valuation Manual.

Guidance Note: The terms “policies” and “contracts” are used interchangeably.

Subsection 1: Life Insurance Products

A. This subsection establishes reserve requirements for all contracts issued on and after the operative date of the Valuation Manual that are classified as life contracts as defined in SSAP No. 50 in the AP&P Manual, with the exception of annuity contracts and credit life contracts. Minimum reserve requirements for annuity contracts and credit life contracts are provided below in subsection 2 and subsection 5, respectively.

B. Minimum reserve requirements for variable and nonvariable individual life contracts—including guaranteed issue life contracts, preneed life contracts, industrial life contracts, and policies of companies exempt pursuant to the life PBR exemption in paragraph D below—are provided in VM-20, Requirements for Principle-Based Reserves for Life Products, except for election of the transition period in paragraph C below. For this purpose, joint life policies are considered individual life.

C. Minimum reserve requirements of VM-20 are considered principle-based valuation requirements for purposes of the Valuation Manual.

D. Minimum reserve requirements for individual certificates under group life contracts (regardless of the issue date of the master group life contract) which meet all the requirements in VM-20 Section 1.B are provided by VM-20, except for election of the transition period in subsection 1.F.1 below.

E. Minimum reserve requirements for life contracts not subject to VM-20 are those pursuant to applicable requirements in VM-A and VM-C. For guaranteed issue life contracts issued after Dec. 31, 2018, mortality tables are defined in VM Appendix M, Mortality Tables (VM-M), and the same table shall be used for reserve requirements as is used for minimum nonforfeiture requirements as defined in VM-02, Minimum Nonforfeiture Mortality and Interest.
F. A company may elect to establish minimum reserves pursuant to applicable requirements in VM-A and VM-C for:

1. Business described in subsection 1.D above and issued on or after the operative date of the Valuation Manual and prior to 1/1/2024.

2. Business not described subsection 1.D otherwise subject to VM-20 requirements and issued during the first three years following the operative date of the Valuation Manual.

A company electing to establish reserves using the requirements of VM-A and VM-C may elect to use the 2017 Commissioners’ Standard Ordinary (CSO) Tables as the mortality standard following the conditions outlined in VM-20 Section 3. If a company during the three years elects to apply VM-20 to a block of such business, then a company must continue to apply the requirements of VM-20 for future issues of this business.

G. Life PBR Exemption

1. A company meeting the at least one of the conditions in Dsubsection 1.G.2 below may file a statement of exemption for individual ordinary life insurance policies and certificates, except for policies in Dsubsection 1.G.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. If a company has no business issued directly or assumed during the current calendar year that would otherwise be subject to VM-20, a statement of exemption is not required. For a filed statement of exemption, the statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that at least one of the two conditions in Dsubsection 1.G.2 was met and the statement of exemption must also be included with the NAIC filing for the second quarter of that year.

The domiciliary commissioner may reject such statement prior to September 1 and require the company to follow the requirements of VM-20 for the ordinary life policies covered by the statement.

If a filed statement of exemption is not rejected by the domiciliary commissioner, the filing of subsequent statements of exemption is not required as long as the company continues to qualify for the exemption; rather, ongoing statements of exemption for each new calendar year will be deemed to not be rejected unless: 1) the company does not meet either condition in Dsubsection 1.G.2 below, 2) the policies contain those in Dsubsection 1.G.3 below, or 3) the domiciliary commissioner contacts the company prior to Sept. 1 and notifies them that the statement of exemption is rejected. If any of these three events occur, then the statement of exemption for the current calendar year is rejected and a new statement of exemption must be filed and not rejected in order for the company to exempt additional policies. In the case of an ongoing statement of exemption, rather than include a statement of exemption with the NAIC filing for the second quarter of that year, the company should enter “SEE EXPLANATION” in response to the Life PBR Exemption supplemental interrogatory and provide as an explanation that the company is utilizing an ongoing statement of exemption.

2. Condition for Exemption:

- The company has less than $300 million of ordinary life exemption premiums, and if the company is a member of an NAIC group of life insurers, which includes other life insurance companies, the group has combined ordinary life exemption premiums of less than $600 million, or

The only new policies that would otherwise be subject to VM-20 being issued or assumed by the company are due to election of policy benefits or features from existing policies valued under VM-A and VM-C and the company was exempted from, or otherwise not subject to, the requirements of VM-20 in the prior year.

Exemption premium is determined as follows:
a. The amount reported in the prior calendar year life/health annual statement, Exhibit 1, Part 1, Column 3 (“Ordinary Life Insurance”), line 20.1; plus
b. The portion of the amount in the prior calendar year life/health annual statement, Exhibit 1, Part 1, Column 3 (“Ordinary Life Insurance”), line 20.2 assumed from unaffiliated companies; minus
c. Amounts included in either (a) or (b) that are associated with guaranteed issue insurance policies and/or preneed life insurance policies; minus
d. Amounts included in either (a) or (b) that represent transfers of reserves in force as of the effective date of a reinsurance assumed transaction; plus
e. Amounts of premium for individual life certificates issued under a group life certificate which meet the conditions defined in VM-20, Section 1.B, and that are not included in either (a) or (b).

Guidance Note:
(i) Definitions of preneed and guaranteed issue insurance policy are in VM-01.
(ii) For statements of exemption filed for calendar year 2022 and beyond, the amount in subsection 2.e was reported in the prior calendar year life/health annual statement, VM-20 Reserve Supplement, Part 2, if applicable.

3. Policies Excluded from the Life PBR Exemption:
   a. Universal life with secondary guarantee (ULSG) policies, or policies – other than ULSG – that contain a rider with a secondary guarantee, in which the secondary guarantee does not meet the VM-01 definition of a “non-material secondary guarantee.”

4. Each exemption, or lack of an exemption, outlined in D. subsection 1.G.1 – D. subsection 1.G.3 above applies only to policies issued or assumed in the current year, and it applies to all future valuation dates for those policies. However, if policies did not qualify for the Life PBR Exemption during the year of issue but would have qualified for the Life PBR Exemption if the current Valuation Manual requirements had been in effect during the year of issue, then the domiciliary commissioner may allow an exemption for such policies. The minimum reserve requirements for the ordinary life policies, including individual certificates under group life contracts which meet all the requirements in VM-20 Section 1.B, subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.

VM Change 4 – VM-20: Requirements for Principle-Based Reserves for Life Products

VM-20: Requirements for Principles-Based Reserves for Life Products

Section 1: Purpose

A. These requirements establish the minimum reserve valuation standard for individual life insurance policies issued on or after the operative date of the Valuation Manual and subject to a principle-based valuation with an NPR floor under Model #820. These requirements constitute the Commissioners Reserve Valuation Method (CRVM) for policies of individual life insurance.
B. Individual life certificates under a group life contract shall be subject to the requirements of VM-20 if all of the following are met. These requirements constitute the Commissioners Reserve Valuation Method (CRVM) for such certificates.

1. An individual risk selection process, defined as follows, is used to obtain group life insurance coverage;

An individual risk selection process is one that is based on characteristics of the insured(s) beyond sex, gender, age, tobacco usage, and membership in a particular group. This may include, but is not limited to, completion of an application (beyond acknowledgement of membership to the group, sex, gender and age), questionnaire(s), online health history or tele-interview to obtain non-medical and medical or health history information, prescription history information, avocations, usage of tobacco, family history, or submission of fluids such as blood, Home Office Specimens (HOS), or oral fluid. The resulting risk classification is determined based on the characteristics of the individual insured(s) rather than the group, if any, of which it is a member (e.g., employer, affinity, etc.). The individual certificate holder is charged a premium rate based solely on the individual risk selection process and not on membership in a specific group.

2. The individual certificates utilize premiums or cost of insurance schedules and charges based on the individual applicant’s issue age, duration from underwriting, coverage amount and risk classification and there is a stated or implied schedule of maximum gross premiums or net cash surrender value required in order to continue coverage in force for a period in excess of one year;

Guidance Note: Coverage amount does not imply a requirement for banding of premiums or charges but rather rates or charges that are multiplied by number of units of coverage of face amount (or net amount at risk) per $1,000 to obtain the actual premium or charge.

3. The group master contract is designed, priced, solicited, and managed similar to individual ordinary life insurance policies rather than specific to the group as a whole;

4. The individual certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing, and risk classification to individual ordinary life insurance contracts.

5. The individual certificates are issued on or after the operative date of the Valuation Manual except election of the transition period in Section 2, subsection 1.F.1.
VM Change 5 - VM-20: Requirements for Principle-Based Reserves for Life Products

Section 2: Minimum Reserve

A. All policies subject to these requirements shall be included in one of the VM-20 Reserving Categories, as specified in Section 2.A.1, Section 2.A.2 and Section 2.A.3 below.

Guidance Note: Since group insurance subject to an individual risk selection process and meeting all the requirements in Section 1.B is subject to VM-20 requirements, Section 2.A shall apply—meaning that any such contracts will be included in one of the VM-20 Reserving Categories defined by Section 2.A.1, Section 2.A.2, and 2.A.3. All requirements in VM-31 which apply to a VM-20 Reserving Category shall apply to any group insurance subject to individual risk selection that has been included in that VM-20 Reserving Category.

The company may elect to exclude one or more groups of policies from the stochastic reserve calculation and/or the deterministic reserve calculation. When excluding a group of policies from a reserve calculation, the company must document that the applicable exclusion test defined in Section 6 is passed for that group of policies. The minimum reserve for each VM-20 Reserving Category is defined by Section 2.A.1, Section 2.A.2 and Section 2.A.3, and the total minimum reserve equals the sum of the Section 2.A.1, Section 2.A.2 and Section 2.A.3 results below, defined as:
VM Change 6 – VM-20 Reserves Supplement, Part 2: Life PBR Exemption

Refer to NAIC Blanks (E) Working Group, request for modification to the supplemental report for the Life PBR Exemption, to show the premiums for group life that utilized an individual risk selection process and meets all of the requirements in VM-20 Section 1.B. as these premiums are currently grouped together with other group insurance in Exhibit 1. As there are other instances where the ordinary life premiums are not included in the determination of the Life PBR Exemption (e.g., for guaranteed issue policies), it may be useful to request addition of the breakdown of premiums used to determine the exemption.

Possible insertion between questions 1 and 2 for disclosure of premiums used in the determination of eligibility for the Life PBR exemption, split by ordinary life and group subject to an individual risk selection process and meeting all of the requirements in VM-20 Section 1.B.
June 3, 2021

Mr. Mike Boerner  
Chair, Life Actuarial Task Force  
National Association of Insurance Commissioners

Re: APF 2021-07

Dear Mike:

In the event that LATF decides to move forward with APF 2021-07, California wishes to suggest a few minor edits, which we would characterize as friendly amendments. See attached for details.

Sincerely,

[Signature]

Ben Bock, FSA, MAAA  
Senior Life Actuary  
California Department of Insurance

CC: Reggie Mazyck, NAIC
Friendly Amendment Suggestions for APF 2021-07

California has 5 suggestions. The first four relate directly to APF 2021-07 itself and the other is an idea for improving the “flow” of this part of the VM “while we are at it”.

We also agree with Craig Chupp that VM-20 Section 3.B.1.b in the APF should have been labeled 3.B.1.d.

Our wording suggestions below are yellow highlighted.

Suggestion #1 – By combining 3.B.5 and 3.B.6 into one section, that section (new 3.B.5) now has two different valuation net premiums being defined within it. Therefore the reference to the 3.B.5 valuation net premium that occurs in Section 2.A.2.c ought to clarified.

VM-20 Section 2.A.2.c

c. The due and deferred premium asset, if any, shall be based on the valuation net premiums computed in accordance with Section 3.B.5.d, for the base policy, determined without regard to any NPR floor amount from Section 3.D.2.

Suggestion #2 – In the 2021 Valuation Manual, in VM-20, Section 3.B.5 and 3.B.6 use different valuation interest rates. This fact is reflected clearly in the wording of the introductions to VM-20 Sections 3.C.2.a and 3.C.2.b. The APF as proposed diminishes this clarity. Accordingly we suggest:

VM-20 Section 3.C.2.a

a. For NPR amounts calculated according to Section 3.B.5.d:

VM-20 Section 3.C.2.b

b. For NPR amounts calculated according to Section 3.B.4 or Section 3.B.5.c.  

Deleted: 6
Suggestion #3 – Similarly, the current Section 3.B.5 and 3.B.6 use different lapse rates. This fact is reflected clearly in the wording of the introductions to VM-20 Sections 3.C.3.a and 3.C.3.c. of the 2021 Valuation Manual. The distinction is not as clear any more in the APF as currently worded. Accordingly we suggest:

VM-20 Section 3.C.3.a

a. For NPR amounts calculated according to Section 3.B.5.d, the lapse rates used shall be 0% per year during the premium paying period and 0% per year thereafter.

VM-20 Section 3.C.3.c

c. For NPR amounts calculated according to Section 3.B.5.c, the lapse rate, \( L_{x+t} \), for an insured age \( x \) at issue for all durations subsequent to the valuation date shall be determined as follows:

Suggestion #4 – A Section reference was not updated in the logic for computing \( E_{x+t} \) (however, this change would be trumped by Suggestion #5 below if Suggestion #5 is adopted):

VM-20 (new) Section 3.B.5.d.ii

ii. Using the level gross premium from Section 3.B.5.d.i, determine the value of the expense allowance components for the policy at issue as \( x_1 \), \( y_{2-5} \), and \( z_1 \) defined below:

\[
\begin{align*}
  x_1 &= \text{a first-year expense equal to the level gross premium at issue} \\
  y_{2-5} &= \text{an expense equal to 10\% of the level gross premium and applied in each year from the second through fifth policy year} \\
  z_1 &= \text{a first-year expense of $2.50 per $1,000 of insurance issued}
\end{align*}
\]

The expense allowance shall be amortized over the period during which premiums are permitted to be paid. \( E_{x+t} \), the expense allowance balance, as of the end of policy year \( t \), shall be calculated as follows:

\[
E_{x+t} = \begin{cases} 
  VNP&R & \text{for } t < s \\
  0 & \text{for } t \geq s
\end{cases}
\]

Where:

\( t = 1,2,... \) (number of completed years since issue)

\[
VNP&R = \text{Valuation Net Premium Ratio from 3.B.5.e.d.iii}
\]
Suggestion #5 – In computing $Ex+t$, the steps shown involve using the value of VNPR prior to the step in which VNPR is calculated. It would seem more logical to place the calculation of VNPR prior to the $Ex+t$ calculation. This occurs in two different places. Thus we suggest:

VM-20 (new) Section 3.B.5.c.i.

i. As of the policy issue date:

1. Determine the level gross premium at issue, assuming payments are made each year for which premiums are permitted to be paid, such period defined as $v$ years in this subsection, that would keep the policy in force to the end of year $n$, based on policy provisions, including the secondary guarantee provisions, such as mortality, interest and expenses. In no event shall $v$ be greater than $n$ for purposes of the NPR calculated in this subsection.

2. Determine the annual valuation net premiums at issue as that uniform percentage (the valuation net premium ratio) of the respective gross premiums such that at issue the actuarial present value of future valuation net premiums over the $n$-year period shall equal the actuarial present value of future benefits over the $n$-year period. The valuation net premium ratio determined shall not change for the policy.

3. Using the level gross premium from Section 3.B.5.c.i.1 above, determine the value of the expense allowance components for the policy at issue as $x_1$, $y_{2-5}$ and $z_2$ defined below.

\[ x_1 = \text{a first-year expense equal to the level gross premium at issue} \]

\[ y_{2-5} = \text{an expense equal to 10\% of the level gross premium and applied in each year from the second through fifth policy year} \]

\[ z_1 = \text{a first-year expense of $2.50 per $1,000 of insurance issued} \]

The expense allowance shall be amortized over the span of years in the secondary guarantee period during which premiums are permitted to be paid. $Ex+t$, the expense allowance balance as of the end of the policy year $t$, shall be computed as follows:

\[
E_{x+t} = VNPR \cdot \frac{x_1 + y_{2-5} + z_1}{2} + \frac{y_{2-5} \cdot C_{x+t}}{2}
\]

for $t < v$

\[
E_{x+t} = 0
\]

for $t \geq v$

[Deleted: 6]
Where:

\[ j = 1, 2, \ldots \text{ (number of completed years since issue)} \]

\[ VNPR = \text{Valuation Net Premium Ratio from 3.B.5.c.i.3.2 above} \]

\[ C_{x \uparrow t} = 0 \quad \text{when } t = 1 \]

\[ * = \frac{\sum_{w=1}^{t-1} (1/\bar{a}_{x+w-w})}{2 \leq t \leq 5} \]

\[ * = C_{x \uparrow 5} \quad \text{when } t > 5 \]

3. Determine the annual valuation net premiums at issue as that uniform percentage (the valuation net premium ratio) of the respective gross premiums such that at issue the actuarial present value of future valuation net premiums over the n-year period shall equal the actuarial present value of future benefits over the n-year period. The valuation net premium ratio determined shall not change for the policy.

VM-20 (new) Section 3.B.5.d

d. A reserve amount for the policy shall be calculated assuming the secondary guarantee is not in effect. The reserve amount shall be determined by the policy features and guarantees of the policy without considering any secondary guarantee provisions as follows:

i. Determine the level gross premium at issue, assuming payments are made each year for which premiums are permitted to be paid, such period defined as “s” in this subsection, that would keep the policy in force for the entire period coverage is to be provided based on the policy guarantees of mortality, interest and expenses.

ii. Determine the annual valuation net premiums as that uniform percentage (the valuation net premium ratio) of the respective gross premiums, such that at issue the actuarial present value of future valuation net premiums shall equal the actuarial present value of future benefits.

iii. Using the level gross premium from Section 3.B.5.d.i, determine the value of the expense allowance components for the policy at issue as \( x_1, y_{2-5}, \) and \( z_1 \) defined below.

\( x_1 = \) a first-year expense equal to the level gross premium at issue

\( y_{2-5} = \) an expense equal to 10% of the level gross premium and applied in each year from the second through fifth policy year

\( z_1 = \) a first-year expense of $2.50 per $1,000 of insurance issued

[Type here]
The expense allowance shall be amortized over the period during which premiums are permitted to be paid. \( E_{x+t} \), the expense allowance balance, as of the end of policy year \( t \), shall be calculated as follows:

\[
E_{x+t} = VNP_{\cdot} \cdot \bar{a}_{x+t, t-1} \left[ (r_1 + z_1) / \bar{a}_{x, s} + y_{2-s} \cdot C_{x+t} \right]
\]

for \( t < s \)

\[
= 0
\]

for \( t \geq s \)

Where:

\( t = 1, 2, \ldots \) (number of completed years since issue)

\( VNP_{\cdot} = \text{Valuation Net Premium Ratio from 3. B. 5. \textit{ed.ii above}} \)

\[
C_{x+t} = \begin{cases} 
0 & \text{when } t = 1 \\
\sum_{w=1}^{t-1} \left( 1 / \bar{a}_{x+w, t-w} \right) & \text{when } 2 \leq t \leq 5 \\
C_{x+5} & \text{when } t > 5
\end{cases}
\]

iii. Determine the annual valuation net premiums as that uniform percentage (the valuation net premium ratio) of the respective gross premiums, such that at issue the actuarial present value of future valuation net premiums shall equal the actuarial present value of future benefits.
### Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force

**Amendment Proposal Form**

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

**Identification:** David Neve, VP and Consulting Actuary, Actuarial Resources Corporation of GA  
**Title of the Issue:** Clarify ULSG NPR calculation requirements

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

   January 1, 2021 NAIC *Valuation Manual*, but incorporating APF 2020-03  
   Section 2.A.3 
   Section 3.B.1, 2, 5 and 6 
   Section 6.B.5.b 
   Section 3.A 
   Section 3.C.2 and 3

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

   See attached.

   As a general overview, Section 3.B.5 stayed in 3.B.5 but was renumbered, but Section 3.B.6 was moved to 3.B.5.b and c.

   Below is a detailed summary of the items that were moved to a new section (and/or renumbered) but were not redlined. In some cases, the wording was redlined after it was moved (if the wording changed).

<table>
<thead>
<tr>
<th>Prior version</th>
<th>New version</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.B.5 last half of first sentence</td>
<td>3.B.5.a</td>
</tr>
<tr>
<td>3.B.5 2nd and 3rd sentence</td>
<td>3.B.5.d</td>
</tr>
<tr>
<td>3.B.5.a thru g</td>
<td>renumbered as 3.B.5.d.i thru vii</td>
</tr>
<tr>
<td>3.B.6.a</td>
<td>3.B.5.b</td>
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<td>3.B.6.c</td>
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<tr>
<td>3.B.6.c</td>
<td>3.B.5.c.i (with sub-bullets renumbered)</td>
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<tr>
<td>3.B.6.d</td>
<td>3.B.5.c.ii (with sub-bullets renumbered)</td>
</tr>
<tr>
<td>3.B.6.e</td>
<td>3.B.5.c.iii (with sub-bullets renumbered)</td>
</tr>
</tbody>
</table>

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

The NPR calculation requirements for ULSG products are currently contained in Section 3.B.5 and 3.B.6 of the Valuation Manual. The current wording takes the reader back and forth between Section 3.B.5 and 3.B.6 when trying to follow the reserve calculation for ULSG products, which can be confusing. And the current wording also has led some people to incorrectly interpret Section 3.B.5 to be applicable to UL products without a SG.

The APF combines the current 3.B.5 and 3.B.6 sections into a single section labeled 3.B.5 and clarifies how to determine the NPR when the policy duration at the valuation date is either prior to, or after the SG has expired. Importantly, no change has been made to the current requirements, only the formatting of the requirements to make them easier to follow. Note that the new wording has flipped the order of the old 3.B.5 and 3.B.6 when combining them in the new 3.B.5, but this movement is not shown as a tracked change (since no changes were made to the existing reserve calculation requirements in the two sections).

Section 3.A has also been revised to eliminate the confusion that can arise on whether the NPR for products in the All Other VM-20 Reserving Category is still a VM-20 reserve. The NPR requirement for products in the All Other VM-20 Reserving Category has been moved to Section 3.B.6.

Impacted references have been updated.
ATTACHMENT

Section 2: Minimum Reserve

A. All policies subject to these requirements shall be included in one of the VM-20 Reserving Categories, as specified in Section 2.A.1, Section 2.A.2 and Section 2.A.3 below.

1. Term Reserving Category —

2. ULSG Reserving Category —

3. All Other VM-20 Reserving Category — All policies and riders belonging to the All Other VM-20 Reserving Category are to be included in Section 2.A.3 unless the company has elected to exclude a group of them from the stochastic reserve calculation or both the deterministic and stochastic reserve calculations and has applied the applicable exclusion test defined in Section 6, passed the test and documented the results.

Section 3: Net Premium Reserve

A. Applicability

1. The NPR for each policy must be determined on a seriatim basis pursuant to Section 3.

2. When valuing term riders pursuant to Paragraph E in “Riders and Supplemental Benefits Requirements” in Section II, the reserve requirements for term policies are applicable.

B. NPR Calculation

1. For the purposes of Section 3, the following terms apply:

   d. The “level secondary guarantee” at any time is:

      i. For a shadow account secondary guarantee, the shadow account fund value that would have existed at that time assuming payment of the level gross premium determined according to Section 3.B.3.c.i.1.

      ii. For a cumulative premium secondary guarantee, the amount of cumulative level gross premiums determined according to Section 3.B.5.c.i.1, accumulated with any interest or accumulation factors per the contract provisions for the secondary guarantee.

2. Section 3.B.4 and Section 3.B.5 provide the calculation of a terminal NPR under the assumption of an annual mode gross premium. In Section 3.B.4 and Section 3.B.5, the gross premium referenced is the gross premium for the policy assuming an annual premium mode.

4. For all policies and riders within the Term Reserving Category, other than those addressed in Section 3.B.8 below, the NPR on any valuation date shall be equal to the actuarial present value of future benefits less the actuarial present value of future annual valuation net premiums as follows:

5. For all policies and riders within the ULSG Reserving Category, the NPR shall be determined as follows:

   a. If the policy duration on the valuation date is prior to the point when all secondary guarantee periods have expired, the NPR shall be the greater of the reserve amount determined in Section

   Deleted: (Life Insurance Policies Subject to Section 3.A.2)

   Deleted: term policy and for each ULSG

   Deleted: "Except for policies subject to Section 3.A.1, the NPR shall be determined pursuant to applicable methods in VM-A and VM-C for the basic reserve. The mortality tables to be used are those defined in Section 3.C.1 and in VM-M Section 1.H."

   Deleted: i

   Deleted: ii

   Deleted: Section 3.B.4 and Section 3.B.5 provide the calculation of a terminal NPR under the assumption of an annual mode gross premium. In Section 3.B.4 and Section 3.B.5, the gross premium referenced is the gross premium for the policy assuming an annual premium mode.

   Deleted: and Section 3.B.6

   Deleted: and Section 3.B.6

   Commented [MR1]: Section 3.B.5.a was moved from what was previously part of the first sentence of Section 3.B.5

   Deleted: p

   Deleted:

b. If the policy duration on the valuation date is after the expiration of all secondary guarantee periods, the NPR shall be the reserve amount determined according to Section 3.B.5.d only, subject to the floors specified in 3.D.2.

c. The reserve amount for the policy shall be calculated assuming the secondary guarantee is in effect as described below. If the policy has multiple secondary guarantees, the NPR shall be calculated as below for the secondary guarantee that provides the greatest NPR as of the valuation date. For the purposes of this subsection, let n be the longest number of years the policy can remain in force under the provisions of the secondary guarantee. However, if a shorter period produces a materially greater NPR, then n shall be that shorter number of years.

i. As of the policy issue date:
   a) Determine the level gross premium at issue, assuming payments are made each year for which premiums are permitted to be paid, such period defined as v years in this subsection, that would keep the policy in force to the end of year n, based on policy provisions, including the secondary guarantee provisions, such as mortality, interest and expenses. In no event shall v be greater than n for purposes of the NPR calculated in this subsection.
   b) Using the level gross premium from Section 3.B.5.c.i.a above, determine the value of the expense allowance components for the policy at issue as $x_1$, $y_{2.5} - z_5$ and $z_5$ defined below.
      
      - $x_1$ = a first-year expense equal to the level gross premium at issue
      - $y_{2.5} - z_5$ = an expense equal to 10% of the level gross premium and applied in each year from the second through fifth policy year
      - $z_5$ = a first-year expense of $2.50 per $1,000 of insurance issued

      The expense allowance shall be amortized over the span of years in the secondary guarantee period during which premiums are permitted to be paid. $E_{j,t}$, the expense allowance balance as of the end of the policy year t, shall be computed as follows:

      $E_{j,t} = VNPRA \alpha_{j+t+1}^t \left( \frac{x_1}{x_1} + y_{2.5} \cdot C_{j+1} \right)$

      for $t < v$

      0

      for $t \geq v$

      Where:

      $VNPRA = \text{Valuation Net Premium Ratio from 3.B.5.c.i}$

      $C_{j+1} = 0$

      when $t = 1$

      $\alpha_{j+t+1}^t$ = when $2 \leq t \leq 5$

      $- \sum_{s=2}^{5} \left( 1 / \alpha_{j+s+1}^t \right)$

      when $t > 5$

      $j = 1, 2, ...$ (number of completed years since issue)

      c) Determine the annual valuation net premiums at issue as that uniform percentage (the valuation net premium ratio) of the respective gross premiums such that at issue the
actuarial present value of future valuation net premiums over the n-year period shall equal the actuarial present value of future benefits over the n-year period. The valuation net premium ratio determined shall not change for the policy.

ii. After the policy issue date, on each future valuation date, the NPR shall be determined as follows:

a) As of the valuation date for the policy being valued, determine the actual secondary guarantee, denoted ASG_{t,n}, as outlined in Section 3.B.1.c and the fully funded secondary guarantee, denoted FFSG_{t,n}, as outlined in Section 3.B.1.b.

b) Divide ASG_{t,n} by FFSG_{t,n}, with the resulting ratio capped at 1. The ratio is intended to measure the level of prefunding for a secondary guarantee, which is used to establish reserves. Assumptions within the numerator and denominator of the ratio, therefore, must be consistent in order to appropriately reflect the level of prefunding. As used here, “assumptions” include any factor or value, whether assumed or known, which is used to calculate the numerator or denominator of the ratio.

c) Compute the net single premium (NSP_{t,n}) on the valuation date for the coverage provided by the secondary guarantee for the period of time ending at attained age x+n, using the interest, lapse and mortality assumptions prescribed in Section 3.C below. The net single premium (NSP) shall include consideration for death benefits only.

d) The NPR for an insured age x at issue at time t shall be according to the formula below:

\[
\text{NPR}_x = \frac{\text{ASG}_{x+t}}{\text{FFSG}_{x+t}} \times \frac{1}{1} \times \text{NSP}_{x+t} - E_{x+t}
\]

Guidance Note: For a non-integer value of t, E_{x+t} is obtained by taking the present value at duration t of E_{x+n}, where T is the next higher integer; i.e., entails discounting by valuation interest, mortality, and lapse for the fractional year between the valuation date and next anniversary (T – t).

iii. Actuarial present values referenced in this Section 3.B are calculated using the interest, mortality and lapse assumptions prescribed in Section 3.C below.

d. A reserve amount for the policy shall be calculated assuming the secondary guarantee is not in effect. The reserve amount shall be determined by the policy features and guarantees of the policy without considering any secondary guarantee provisions as follows:

i. Determine the level gross premium at issue, assuming payments are made each year for which premiums are permitted to be paid, such period defined as “s” in this subsection, that would keep the policy in force for the entire period coverage is to be provided based on the policy guarantees of mortality, interest, and expenses.

ii. Using the level gross premium from Section 3.B.5.d.i, determine the value of the expense allowance components for the policy at issue as x_1, y_2, and z_2 defined below.

x_1 = a first-year expense equal to the level gross premium at issue

y_2 = an expense equal to 10% of the level gross premium and applied in each year from the second through fifth policy year

z_2 = a first-year expense of $2.50 per $1,000 of insurance issued

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The expense allowance shall be amortized over the period during which premiums are permitted to be paid. $E_{x+t}$, the expense allowance balance, as of the end of policy year $t$, shall be calculated as follows:

$$E_{x+t} = VNPR \times \tilde{a}_{x+t}\text{\|}(x_{1} + x_{2})/\tilde{a}_{x}\text{\|} + y_{2-s-t}C_{x+t}$$

for $t < s$

$= 0$

for $t \geq s$

Where:

$t = 1,2,..$ (number of completed years since issue)

$$VNPR = \frac{\text{Valuation Net Premium Ratio from 3.B.5.i}}{}$$

$$C_{x+t} = 0 \quad \text{when } t = 1$$

$$= \sum_{i=0}^{t-1} \left( \frac{1}{\hat{a}_{x+t+i}} \right) \quad \text{when } 2 \leq t \leq 5$$

$$= C_{x+t+5} \quad \text{when } t > 5$$

iii. Determine the annual valuation net premiums as that uniform percentage (the valuation net premium ratio) of the respective gross premiums, such that at issue the actuarial present value of future valuation net premiums shall equal the actuarial present value of future benefits.

iv. For a policy issued at age $x$, at any duration $t$, the net premium reserve shall equal:

$$m_{x+t} \times r_{x+t} \quad \text{Where:}$$

a) $m_{x+t}$ = the actuarial present value of future benefits less the actuarial present value of future valuation net premiums and less the unamortized expense allowance for the policy, $E_{x+t}$.

Guidance Note: For a non-integer value of $t$, $E_{x+t}$ is obtained by taking the present value at duration $t$ of $E_{x+\lfloor t \rfloor}$, where $\lfloor t \rfloor$ is the next higher integer; i.e., entails discounting by valuation interest and survivorship for the fractional year between the valuation date and the next anniversary ($T - t$).

b) Let:

$$e_{x+t} = \max(\text{the actual policy fund value on the valuation date}, 0)$$

$$f_{x+t} = \text{the policy fund value on the valuation date is that amount which, together with the payment of the future level gross premiums determined in Section 3.B.5.d.i above, keeps the policy in force for the entire period coverage is to be provided, based on the policy guarantees of mortality, interest and expenses.}$$

Then set $r_{x+t}$ equal to:

$$1, \text{ if } f_{x+t} \leq 0$$

$$\min[(e_{x+t}/f_{x+t}), 1], \text{ otherwise}$$

v. The future benefits used in determining the value of $m_{x+t}$ shall be based on the greater of $e_{x+t}$ and $f_{x+t}$ together with the future payment of the level gross premiums determined in Section 3.B.5.d.i above, and assuming the policy guarantees of mortality, interest and expenses.
vi. The values of $\bar{a}$ are determined using the NPR interest, mortality and lapse assumptions applicable on the valuation date.

vii. Actuarial present values referenced in this Section 3.B.5.d are calculated using the interest, mortality and lapse assumptions prescribed in Section 3.C.

6. For all policies and riders within the All Other VM-20 Reserving Category, the NPR shall be determined pursuant to applicable methods in VM-A and VM-C for the basic reserve. The mortality tables to be used are those defined in Section 3.C.1 and in VM-M Section 1.H.

7. The actuarial present value of future benefits equals the present value of future benefits including, but not limited to, death, endowment (including endowments intermediate to the term of coverage) and cash surrender benefits. Future benefits are before reinsurance and before netting the repayment of any policy loans.

8. For life insurance coverage that the company has assumed on a YRT basis, the reinsurer’s net premium reserve shall be one half year’s cost of insurance for the reinsured net amount at risk.

C. Net Premium Reserve Assumptions

2. Interest Rates
   b. For NPR amounts calculated according to Section 3.B.4 or Section 3.B.5.e.

3. Lapse Rates
   c. For NPR amounts calculated according to Section 3.B.5.e the lapse rate, $L_{x+t}$, for an insured age $x$ at issue for all durations subsequent to the valuation date shall be determined as follows:

i. Determine the ratio $R_{x+t}$ where:

$R_{x+t} = [FFSG_{x+t} - ASG_{x+t}] / [FFSG_{x+t} - LSG_{x+t}] \text{ but not } > 1 \text{ and not } < 0$

Where:

$FFSG_{x+t}$ = the fully funded secondary guarantee on the valuation date for the insured age $x$ at issue

$ASG_{x+t}$ = the actual secondary guarantee on the valuation date for the insured age $x$ at issue

$LSG_{x+t}$ = the level secondary guarantee on the valuation date for the insured age $x$ at issue

**Guidance Note:** The $FFSG_{x+t}$, $ASG_{x+t}$, and $LSG_{x+t}$ are based on the secondary guarantee values as of the valuation date and will remain constant throughout the cash flow projection. This will result in a constant lapse assumption, calculated as of the valuation date, that does not vary by duration throughout the cash flow projection for the NPR calculation.

ii. As of the valuation date, which is $t$ years after issue, the annual lapse rate for the policy shall be assumed to be level for all future years and denoted as $L_{x+t}$, which shall be set equal to:

$L_{x+t} = R_{x+t} \times 0.01 + (1 - R_{x+t}) \times 0.005 \times r_{x+t}$

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Where $r_{x+t}$ is the ratio determined in Section 3.B.5.d.

**Guidance Note:** By similar logic, it follows (from ASG $x+t$ being 0 when $t=0$) that the level annual lapse rate to be used in the calculations in Section 3.B.5.c.i.b and 3.B.5.c.i.c is 1%. On the other hand, when performing the calculations in Section 3.B.5.c.ii.c, $L_{x+t}$, though level, is not generally equal to what it was for the same policy on the previous valuation date.

**Section 6: Stochastic and Deterministic Exclusion Tests**

**B. Deterministic Exclusion Test (DET)**

5. For purposes of determining the valuation net premiums used in the demonstration in Section 6.B.2:

   a. If pursuant to Section 2, the NPR for the group of policies is the minimum reserve required under VM-A and VM-C, then the valuation net premiums are determined according to those minimum reserve requirements.

   b. If the NPR is determined according to Section 3.B.4 or Section 3.B.5, then the lapse rates assumed for all durations shall for the purposes of the DET be set to 0%;
The Life Actuarial (A) Task Force met June 17, 2021. The following Task Force members participated: Doug Slape, Chair, represented by Mike Boerner, Rachel Hemphill, and Karen Jiang (TX); Judith L. French, Vice Chair, represented by Jason Wade (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li and Steve Ostlund (AL); Ricardo Lara represented by Thomas Reedy and Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Amy L. Beard represented by Fred Andersen and John Robinson (MN); Clora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Rhonda Ahrens (NE); Marlene Caride represented by David Wolf (NJ); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Glenn Mulready represented by Andrew Schallhorn (OK); Jonathan T. Pike represented by Tomasz Serbinowski (UT); Scott A. White represented by Craig Chupp (VA); and James A. Dodrill represented by Joylynn Fix (WV).

1. **Discussed Amendment Proposal 2021-08**

Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI comment letter (Attachment A) reiterates the ACLI verbal comments from the Task Force’s June 10 meeting. The comments included concerns about amendment proposal 2021-08 (Attachment B) aiming to reduce the data lag given the expected implementation of additional data elements in 2023. Mr. Boerner noted that the accelerated underwriting data elements, which comprise most of the additional elements, will not be added until 2023 or 2024. He suggested that the workload issues of concern to the ACLI can be addressed at that time. Pat Allison (NAIC) said the amount of work related to implementing the additional data elements into the data collection process is substantial. She noted that adding accelerated underwriting data elements may scope in some companies that are not currently subject to the data collection requirements. She said the current stability of the data collection process gives NAIC staff comfort with collecting two years of data in 2022 to facilitate the reduction in the data lag. She said the data collection process workload will be lighter if the data lag reduction occurs prior to the implementation of the additional data elements. Larry Bruning (Society of Actuaries—SOA) said the 2015 Valuation Basic Table (VBT) is based on industry experience from 2002 through 2009, making the data 12–15 years old. He said confidence intervals of actual to expected mortality for the 2015 VBT, updated with data through 2016, showed that the 2015 VBT is out of date when compared to current experience. Mary Bahna-Nolan (SOA) said there is not enough information to properly analyze the underlying reasons for the lower actual to expected confidence intervals. She said the additional data that can be collected by reducing the data lag is essential for developing a new VBT in a timely manner. Mr. Chou agreed that reducing the time lag prior to introducing the accelerated underwriting data elements is preferable. Ms. Ahrens expressed concerns about the impact reducing the data lag will have on company and state insurance regulator workload. Mr. Bayerle asked if accommodations will be made for companies that are unable to meet the required timeline due to the reduced data lag. Ms. Allison said it may be possible to extend the timeline. Dan Schelp (NAIC) agreed to review the *Valuation Manual* to determine the degree of discretion the NAIC may have in moving the target dates. Mr. Boerner said the discussion will continue when additional information from Mr. Schelp is available.

2. **Appoint a Subgroup to Consider Interim Values for ILVAs**

Mr. Weber said additional regulation is required to establish interim values for index-linked variable annuities (ILVAs). He asked the Task Force to appoint a subgroup to address the issue. He proposed a single charge for Task Force consideration. Mr. Serbinowski made a motion, seconded by Ms. Ahrens, to adopt the subgroup charge (Attachment C) and allow the subgroup members to determine whether to retain the name Index-Linked Variable Annuity (A) Subgroup, as identified in the charge. The motion passed unanimously.

3. **Discussed Amendment Proposal 2020-12**

Ms. Hemphill said several changes have been made to amendment proposal 2020-12 (Attachment D) to narrow its scope. She said the intent of the changes is to take a principle-based approach to hedging as opposed to addressing specific hedging strategies. Ken Christy (Allianz) discussed the Allianz comment letter (Attachment E). He said the issues stated in the letter have been addressed by the changes to amendment proposal 2020-12. Discussion of the proposal will resume on June 24.

Having no further business, the Life Actuarial (A) Task Force adjourned.
Brian Bayerle  
Senior Actuary  

June 14, 2021  

Mr. Mike Boerner  
Chair, NAIC Life Actuarial (A) Task Force (LATF)  

Re: ACLI Comments on AFP 2021-08  

Dear Mr. Boerner:  

The American Council of Life Insurers (ACLI) appreciates the opportunity to provide comments on AFP 2021-08.  

ACLI supports the monitoring of experience and development of valuation basic tables reflecting recent experience. With the move to accelerated underwriting, we appreciate the need for additional data for analysis. However, we are concerned about the timing of this change; specifically, with the anticipated increase of data elements to, among other things, collect more data for accelerated underwriting under development, we believe this APF should be deferred until companies have had an opportunity to include additional data in their submissions.  

Companies that are familiar with experience data submission note the possibility of certain data quality issues when validating the data. They have concerns that making a Q2 data extract in time for a Q3 submission does not provide sufficient to thoroughly vet the data before submission. The reduction from 2 years to 1 year might stress the process. One notable area of concerns is terminations, which may not be reviewed until the following year. The compressed timeframe gives little time to appropriately validate the work. The current 2-year lag provides a significant amount of time for the submission, and while a shorter lag with a longer submission period may work, it would not materially improve the availability of data for analysis.  

Additionally, we know additional data elements will be added to the experience reporting format. It will take companies time to incorporate the new fields, and critically, to validate the values before submission. This increase in requirements may pose problems with a shorter turnaround.  

ACLI is committed to working with regulators on timely experience data submissions. While we have concerns at this time, we would encourage further discussion on how to best incorporate emerging experience. As this APF is further contemplated, we would encourage providing additional hardship allowances for both the expansion of the data elements as well as potential reduction of the lag.
We look forward to a discussion of this amendment on a future call. We appreciate the consideration of our comments.

Sincerely,

[Signature]

cc: Reggie Mazyck, NAIC
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force

Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.
   
   Society of Actuaries Valuation Basic Table Team – Chair Larry Bruning

   Revisions to VM-51 to allow for the data experience reporting observation calendar year to be one year prior to the reporting calendar year.

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


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

   Section 2: Statistical Plan for Mortality

   D. Process for Submitting Experience Data Under This Statistical Plan

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

   Data for this statistical plan for mortality will be compiled using a calendar year method. The reporting calendar year is the calendar year that the company submits the experience data. The observation calendar year is the calendar year of the experience data that is reported. The observation calendar year will be one year prior to the reporting calendar year. For example, if the current calendar year is 2022 and that is the reporting calendar year, the company is to report the experience data that was in-force or issued in calendar year 2021, which is the observation calendar year.

   For the 2022 reporting calendar year, companies that are required to submit data for this statistical plan for mortality will be required to submit two observation calendar years of data, namely observation calendar year 2020 and observation calendar year 2021. For reporting calendar years after 2022, companies that are required to submit data for this statistical plan for mortality will be required to submit one observation calendar year of data.

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

   i. Report policies in force during or issued during calendar year 20XX.
ii. Report terminations that were incurred in calendar year 20XX and reported before July 1, 20XX+1. However, exclude rescinded policies (e.g., 10-day free look exercises) from the data submission.

For any reporting calendar year, the data call will occur during July of that reporting calendar year, and data is to be submitted according to the requirements of the Valuation Manual in effect during that calendar year. For the 2022 reporting calendar year, the requirements of the 2022 Valuation Manual will be used for both the 2020 and 2021 observation years. Data submissions must be made by Sept. 30 of the reporting calendar year. Corrections of data submissions must be completed by Dec. 31 of the reporting calendar year.

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

This APF is needed for the following reasons:

1. There is a need to shorten the time period between data observation and data collection to facilitate more timely analysis and reporting of mortality experience.
2. Under a Principle Based Reserving methodology, valuation basic tables should reflect recent and current mortality experience.
June 17, 2021

To: Life Actuarial Task (A) Force Members

From: Pete Weber, Vice Chair
Life Actuarial Task (A) Force

A design of annuity product has emerged over the past several years that does not fall neatly into existing regulations. They are commonly referred to as ILVAs – Index-Linked Variable Annuities or "RILAs" – Registered Index-Linked Annuities. These products are exclusively filed in the states as variable annuities and are funded through non-unitized separate accounts. The Task Force has discussed developing a draft standard for minimum interim values for these products and providing direction for implementing the standard.

This document proposes the establishment of a new Indexed-Linked Variable Annuity (A) Subgroup and provides an accompanying charge to develop the interim value standard. The Task Force is asked to consider approval of the Subgroup and the adoption of its proposed charge.

The Subgroup will be identified as follows:

**Index-Linked Variable Annuity (A) Subgroup**

Pete Weber, Chair

Staff: Reggie Mazyck

2021 Charge:

The **Index-Linked Variable Annuity (A) Subgroup** will:

1. Provide recommendations and changes, as appropriate, to nonforfeiture, or interim value requirements related to Index-Linked Variable Annuities
1. Identify yourself, your affiliation and a very brief description (title) of the issue.

**Identification:**
Rachel Hemphill and Karen Jiang, Texas Department of Insurance

**Title of the Issue:**
Create consistency between CDHS determination in VM-20 and VM-21. Revise hedge modeling to only require CDHS if modeling future hedging reduces the reserves under VM-20 or TAR under VM-21.

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


January 1, 2021 NAIC Valuation Manual

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

See attached.

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

**6/17/2021 Notes:**

We have made notes (highlighted in yellow) in the below summary of the 4/2/2021 and 5/17/2021 updates to emphasize the treatment of macro hedging (excluded from the scope of this APF), hedging strategies that are still in the formative stages (excluded from the scope of this APF), and conservative simplifications (allowed, as always, with documentation). We also addressed the concern that SHS could be perceived as one-sided. See below for full context/intent.

**Summary of 5/17/2021 Editorial Changes and Clarifications:**

1. Editorial changes were made in response to the comment by John Robinson of MN:
   a. Replace “hedge” with “hedging” when used as an adjective.
   b. Clarify that the Principles apply to the modeling of a CDHS or SHS.
   c. Add references to “one or more” CDHS or SHS, to reflect that a company may have multiple CDHS or SHS.
d. Add reference to a CDHS that the company is following.

2. Clarifying edits were made in response to the comment ACLI:
   a. Clarify that PBR reflecting a company’s investment policy and risk management strategies supporting the policies or contracts does not target, deem illegitimate, or otherwise reflect a negative view on the company’s investment policy and risk management strategies supporting the policies or contracts. In fact, the opposite is true. Note that this is consistent with VM-20 Section 7.K.1’s treatment of non-hedging derivative use.
   b. Clarify even further that the CDHS requirements are documentation requirements (i.e., documentation clearly defining the hedging strategy) and may always be satisfied at the company’s option. (6/17/2021 Added Emphasis: There has been the suggestion that SHS is one-sided. But we can see that that is not true, when we see that the consideration of SHS and CDHS are each necessary and complementary pieces of a complete PBR treatment of hedging, the result of the two pieces together being “model your hedging, but only reflect a benefit from hedging if you have provided adequate documentation of your hedging program so that regulators can rely on its projected performance.”)
   c. Clarify that SHS “are normally modeled as part of any of the company’s risk assessment and evaluation processes” (emphasis added).

3. Materiality was explicitly addressed. (6/17/2021 Added Emphasis: A company may continue doing conservative simplifications, such as not modeling hedging that would have been a benefit for them to model. In these cases, the intent is for there to be transparency, documentation, and support of the simplification in the PBR Report. As with all simplifications, the support can range from a robust analysis to a qualitative analysis, depending on the individual company situation.)

Summary of 4/2/2021 Updates:

1. Revisions were made to VM-20 Section 7.K.4 (add “supporting the policies”) and VM-21 Section 9.A.6 (add “supporting the contracts”) in response to Nationwide’s comments. (6/17/2021 Added Emphasis: These edits were to clarify that macro hedging was not in scope.)

2. We added a definition for “hedging transactions,” taken from the APPM but modified slightly to be consistent with Valuation Manual terminology in response to Will Wilton’s comments.

3. We have updated the list of CDHS criteria in response to Will Wilton’s comments where we agreed:
   a. Added “significant” before risks in item (c) of the CDHS definition.
   b. Combined items (f) – (h) in the CDHS definition.
   c. Change “person or persons” to “group or area, including whether internal or external,” in item (j) of the CDHS definition.
   d. We did not remove items (k) or (l) as suggested by Will Wilton, as we find this information useful to regulators. Given that these are retained, and because we were uncertain what else would be included in the new “primary risks” item suggested by Will Wilton, we have not added it. If we can be provided additional information on the risks to be reflected under this new item, an edit could be made.

4. We modified the definition of a SHS to clarify “normally modelled” in response to the ACLI comment and clarify what may be a SHS in response to Will Wilton’s comment (e.g., a single bond would not be a SHS). (6/17/2021 Added Emphasis: We would not consider a hedging strategy that is in the formative stages to be “normally modelled” just because of some sensitivity testing or other analysis as the hedging approach is formed. However, the determination of “normally modelled” appropriately requires judgment and is intended to encourage robust discussions with domestic regulators.)
We propose having consistent requirements for a CDHS in VM-20 and VM-21, as well as any future work on VM-22, and consolidating these requirements in the VM-01 definition of a CDHS. This involves adding two criteria to VM-21’s definition of CDHS that currently exist for VM-20:

- Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
- The circumstances under which hedging strategy will not be effective in hedging the risks.

These criteria are both reasonable and apply in principle to VM-21, and to any future work on VM-22, as well as VM-20.

Further, we propose revising the requirement for hedging to be a CDHS in order for future hedging to be modeled under VM-20, VM-21, and LR027’s C-3 RBC Amount calculation to only apply when modeling such hedging reduces the life reserve level or variable annuity Total Asset Requirement (TAR) level.

The current regulatory requirements for hedging to be a CDHS in order for future hedging to be modeled under VM-20, modeled under VM-21, modeled for the C-3 RBC Amount calculation for variable annuities, and to be eligible for SSAP 108 treatment are all logical requirements when one considers whether hedging should be allowed to reduce the life reserve level or variable annuity TAR level, or whether any mismatch between movements in hedge assets and movements in the corresponding reserve levels should be allowed to be amortized over time.

However, this same requirement has led to a situation of there being unintended optionality in whether a hedging strategy that is like a CDHS is modeled or is not modeled, since a company may choose to satisfy or not satisfy certain of the criteria. This has been especially relevant for cases where modeling a company’s hedging strategy would increase reserves or variable annuity TAR.

As noted in the current guidance note in VM-20 Section 7.K.1 in the 2021 Valuation Manual:

“The prohibition in these modeled reserve requirements against projecting future hedging transactions other than those associated with a clearly defined hedging strategy is intended to address initial concerns expressed by various parties that reserves could be unduly reduced by reflection of programs whose future execution and performance may have greater uncertainty. The prohibition appears, however, to be in conflict with Principle 2 listed in VM-21. Companies may actually execute and reflect in their risk assessment and evaluation processes hedging strategies similar in many ways to clearly defined hedging strategies but lack sufficient clarity in one or more of the qualification criteria. By excluding the associated derivative instruments, the investment strategy that is modeled may also not reflect the investment strategy the company actually uses. Further, because the future hedging transactions may be a net cost to the company in some scenarios and a net benefit in other scenarios, the exclusion of such transactions can result in a modeled reserve that is either lower or higher than it would have been if the transactions were not excluded. The direction of such impact on the reserves could also change from period to period as the actual and projected paths of economic conditions change. A more graded approach to recognition of non-qualifying hedging strategies may be more theoretically consistent with Principle 2. It is recommended that as greater experience is gained by actuaries and state insurance regulators with the principle-based approach and as industry hedging programs mature, the various requirements of this section be reviewed.”

We propose to continue addressing the regulatory concern that reserves could be unduly reduced by reflection of programs whose future execution and performance may have greater uncertainty, by continuing to only allowing hedging strategies that qualify as a CDHS to reduce life reserves and variable annuity TAR. However, we propose that the treatment of CDHS be made more principles-based and less subject to manipulation. To accomplish this, the proposal requires that any hedging strategy that is a part
of the investment strategy supporting the policies and is normally modeled as part of the company’s risk assessment and evaluation processes be modeled as if it were a CDHS if doing so results in an increase in life reserves or variable annuity TAR.

That is, CDHS becomes a requirement solely for hedging strategies that reduce life reserves or variable annuity TAR, and so becomes a more clear regulatory guardrail requiring that hedging strategies that reduce life reserves or variable annuity TAR must be clearly defined.

We continue to need the concept of a CDHS. A CDHS simply formally documents items that a company should be able to document for a robust, well-defined hedging strategy. It requires that the following be identified:

a. The specific risks being hedged (e.g., cash flow, policy interest credits, delta, rho, vega, etc.).
b. The hedge objectives.
c. The risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).
d. The financial instruments used to hedge the risks.
e. The hedge trading rules, including the permitted tolerances from hedging objectives.
f. The metrics for measuring hedging effectiveness.
g. The criteria used to measure hedging effectiveness.
h. The frequency of measuring hedging effectiveness.
i. The conditions under which hedging will not take place.
j. The person or persons responsible for implementing the hedging strategy.
k. Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
l. The circumstances under which hedging strategy will not be effective in hedging the risks.

While the last two criteria have historically applied for life but not variable annuities, these are all reasonable documentation items that for a robust, well-defined hedging strategy regardless of whether the product is life or variable annuity.

The concept of a CDHS is used for accounting in SSAP 108. SSAP 108 allows companies to set up a deferred asset or liability to amortize the mismatch between changes in the value of the liability and changes in the value of the hedging instruments attributable to the hedged risk underlying a highly effective CDHS modeled for VM-21. Allowing this treatment encourages companies to reduce risk through robust, well-defined and highly effective hedging. Without having the hedging strategy be well-defined, regulators could not rely on past effectiveness being indicative of future effectiveness, and so could not offer companies the benefit of SSAP 108 treatment. Once we recognize the need for a concept of a well-defined hedging strategy, the only question is what criteria would need to be met to be considered well-defined – that is, what criteria should be required to be considered a CDHS. This is a distinct question from whether the concept of a CDHS is needed. We have not heard critiques of individual criteria in the CDHS definition, but consideration of the criteria is appropriate as we go forward to make the definitions in VM-20 and VM-21 consistent. Similarly, in reserve and capital calculations, we rely on the concept of historical effectiveness to determine an error factor. If modeling hedging reduces the reserve or capital amount, the error factor determines the magnitude to which this is reflected. However, this use of the historical effectiveness relies on the hedging strategy being well-documented and comparable between historical hedging and planned future hedging. So, again, a need for hedging strategies to be well-defined presents itself – a CDHS concept is needed.

Finally, edits to VM-31 are needed to reflect these updates and bring VM-20 and VM-21 reporting requirements more in line with one another where appropriate.
**Note on Coordination with RBC and APPM**: We have reviewed, and with these edits there are no corresponding edits necessary for LR027 for RBC but corresponding edits are necessary for SSAP 108. A referral to SAPWG is to be concurrently considered with this APF.

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

**NAIC Staff Comments:**
The term “clearly defined hedging strategy” (CDHS) means a strategy undertaken by a company to manage risks through the future purchase or sale of hedging instruments and the opening and closing of hedging positions. A CDHS must identify:

a. The specific risks being hedged (e.g., cash flow, policy interest credits, delta, rho, vega, etc.).
b. The hedging objectives.
c. The significant risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).
d. The financial instruments used to hedge the risks.
e. The hedging strategy’s trading rules, including the permitted tolerances from hedging objectives.
f. The metrics, criteria, and frequency for measuring hedging effectiveness.
g. The conditions under which hedging will not take place.
h. The group or area, including whether internal or external, responsible for implementing the hedging strategy.
i. Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
j. The circumstances under which hedging strategy will not be effective in hedging the risks.

The hedging strategy may be dynamic, static or a combination thereof. A strategy involving the offsetting of the risks associated with products falling under the scope of different requirements within the Valuation Manual (e.g., VM-20, VM-21, or VM-22) does not qualify as CDHS.

Guidance Note: All of the principles outlined in VM-21 Section 1.B (particularly Principle 5) apply to the modeling of a CDHS.

The term “hedging transaction” means a derivative(s) transaction which is entered into and maintained to reduce:

a. The risk of a change in the fair value or cash flow of assets and liabilities which the company has acquired or incurred or has a firm commitment to acquire or incur or for which the company has a forecasted acquisition or incurrence; or
b. The currency exchange rate risk or the degree of foreign currency exposure in assets and liabilities which the company has acquired or incurred or has a firm commitment to acquire or incur or for which the company has forecasted acquisition or incurrence.

The term “Seasoned Hedging Strategy” (SHS) means a hedging strategy that is part of the company’s investment strategy and for which future hedging transactions are normally modeled as part of any of the company’s risk assessment and evaluation processes. A SHS may or may not be a CDHS.

The hedging strategy may be dynamic, static, or a combination thereof. A strategy involving the offsetting of the risks associated with products falling under the scope of different requirements within the Valuation Manual (e.g., VM-20, VM-21, or VM-22) does not qualify as SHS.

Guidance Note: All of the principles outlined in VM-21 Section 1.B (particularly Principle 5) apply to the modeling of a SHS.
VM-20 Section 6.A.1.b

A company may not exclude a group of policies for which there is one or more CDHS or one or more SHS required to be modeled pursuant to Section 7.K.4 from stochastic reserve requirements, except in the case where all CDHS and all SHS required to be modeled pursuant to Section 7.K.4 are solely associated with product features that are determined to not be material under Section 7.B.1 due to low utilization.

VM-20 Section 7.E.1.g

Notwithstanding the above requirements, the modeled reserve shall be the higher of that produced by the model investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the model investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of a CDHS (in compliance with the definition of CDHS in VM-01) or a SHS that is required to be modeled pursuant to Section 7.K.4 are not affected by this requirement.

VM-20 Section 7.K

K. Modeling of Derivative Programs

1. When determining the deterministic reserve and the stochastic reserve, the company shall include in the projections the appropriate costs and benefits of derivative instruments that are currently held by the company in support of the policies subject to these requirements. The company shall also include the appropriate costs and benefits of anticipated future derivative instrument transactions associated with the execution of a CDHS or a SHS that is required to be modeled pursuant to Section 7.K.4, as well as the appropriate costs and benefits of anticipated future derivative instrument transactions associated with non-hedging derivative programs (e.g., replication, income generation) undertaken as part of the investment strategy supporting the policies, provided they are normally modeled as part of the company’s risk assessment and evaluation processes.

2. For each derivative program that is modeled, the company shall reflect the company’s established investment policy and procedures for that program; project expected program performance along each scenario; and recognize all benefits, residual risks and associated frictional costs. The residual risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, etc.). Frictional costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. For CDHS or SHS required to be modeled pursuant to Section 7.K.4, the company may not assume that residual risks and frictional costs have a value of zero, unless the company demonstrates in the PBR Actuarial Report that “zero” is an appropriate expectation.

In circumstances where one or more material risk factors related to a derivative program are not fully captured within the cash-flow model used to calculate CTE 70, the company shall reflect such risk factors by increasing the stochastic reserve as described in Section 8.E.
4. If a SHS supporting the policies is not a CDHS but modeling it would result in a material increase to the company’s minimum reserve, then the company shall model the SHS as if it were a CDHS when calculating reserves under VM-20. In addition, if modeling the SHS as if it were a CDHS would result in a decrease in the company’s minimum reserve, the company may provide the documentation required for the SHS to be a CDHS as defined in VM-01 and then model the SHS as a CDHS.

Guidance Note: The intent of reflecting SHS is not to penalize any hedging strategies, but rather to reflect the company’s investment strategy and risk management strategies, including all material established hedging strategies supporting the policies, while requiring CDHS documentation for any such hedging strategies that reduce the minimum reserve.

VM-20 Section 7.L (Remove entire Section 7.L)

Deleted:

- Clearly Defined Hedging Strategy
  - The specific risks being hedged (e.g., cash flow, policy interest credits, delta, rho, vega, etc.).
  - The hedge objectives.
  - The risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.)
  - The financial instruments used to hedge the risks.
  - The hedge trading rules, including the permitted tolerances from hedging objectives.
  - The metrics for measuring hedging effectiveness.
  - The criteria used to measure hedging effectiveness.
  - The frequency of measuring hedging effectiveness.
  - The person or persons responsible for implementing the hedging strategy.
  - Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
  - The circumstances under which hedging strategy will not be effective in hedging the risks.

Guidance Note: For purposes of the above criteria, “effectiveness” need not be measured in a manner as defined in SSAP No. 86—Derivatives in the AP&P Manual.
VM-21 Section 1.D.2 (Delete entire definition and renumber subsequent sections VM-21 Section 1.D.3 and VM-21 Section 1.D.4)

VM-21 Section 4.A.4

Modeling of Hedges

a. For a company that does not have a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6:

i. The company shall not consider the cash flows from any future hedge purchases or any rebalancing of existing hedge assets in its modeling.

ii. Existing hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the starting assets. The hedge assets may then be considered in one of two ways:

a) Include the asset cash flows from any contractual payments and maturity values in the projection model; or

b) No hedge positions – in which case the hedge positions held on the valuation date are replaced with cash and/or other general account assets in an amount equal to the aggregate market value of these hedge positions.

Guidance Note: If the hedge positions held on the valuation date are replaced with cash, then as with any other cash, such amounts may then be invested following the company’s investment strategy.

A company may switch from method a) to method b) at any time, but it may only change from b) to a) with the approval of the domiciliary commissioner.

b. For a company following one or more CDHS or one or more SHS that are required to be modeled pursuant to Section 9.A.6, the detailed requirements for the modeling of hedges are defined in Section 9. The following paragraphs are a high-level summary and do not supersede the detailed requirements.

i. The appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the projections used in the determination of the stochastic reserve.

ii. The projections shall take into account the appropriate costs and benefits of hedge positions expected to be held in the future through the execution of a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6. Because models do not always accurately portray the results of hedge programs, the company shall, through back-testing and other means, assess the accuracy of the hedge modeling. The company shall determine a stochastic reserve as the weighted average of two CTE values; first, a CTE70 (“best efforts”) representing the company’s projection of all of the hedge cash flows, including future hedge purchases, and a second CTE70 (“adjusted”) which shall use only hedge assets held by the company on the valuation date and no future hedge purchases. These are discussed in greater detail in Section 9. The stochastic reserve shall be the weighted average of the two CTE70 values, where the weights reflect the error factor (E) determined following the guidance of Section 9.C.8.
iii. The company is responsible for verifying compliance with CDHS requirements or SHS requirements if required to be modeled pursuant to Section 9.A.6, and any other requirements in Section 9 for all hedging instruments included in the projections.

iv. The use of products not falling under the scope of these requirements (e.g., equity-indexed annuities) as a hedge shall not be recognized in the determination of accumulated deficiencies.

**VM-21 Section 4.D.4.b**

Notwithstanding the above requirements, the model investment strategy and any non-prescribed asset spreads shall be adjusted as necessary so that the aggregate reserve is not less than that which would be obtained by substituting an alternative investment strategy in which all fixed income reinvestment assets are public non-callable corporate bonds with gross asset spreads, asset default costs, and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of a CDHS (in compliance with the definition of CDHS in VM-01) or a SHS that is required to be modeled pursuant to Section 9.A.6 are not affected by this requirement.

**VM-21 Section 6.B.3.a.ii – Footnote (Footnote at Bottom of Page 21-22)**

Throughout this Section 6, references to CTE70 (adjusted) shall also mean the Stochastic Reserve for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6 as discussed in Section 4.A.4.a.

**VM-21 Section 6.B.3.b.ii**

Calculate the Prescribed Projections Amount as the CTE70 (adjusted) using the same method as that outlined in Section 9.C (which is the same as the stochastic reserves following Section 4.A.4.a for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6) but substituting the assumptions prescribed by Section 6.C. The calculation of this Prescribed Projections Amount also requires that the scenario reserve for any given scenario be equal to or in excess of the cash surrender value in aggregate on the valuation date for the group of contracts modeled in the projection.

**VM-21 Section 6.B.5**

Cash flows associated with hedging shall be projected in the same manner as that used in the calculation of the CTE70 (adjusted) as discussed in Section 9.C or Section 4.A.4.a for a company without a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6.

**VM-21 Section 9**

Section 9: Modeling of Hedges under a CDHS
A. Initial Considerations

1. Subject to Section 9.C.2, the appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the calculation of the stochastic reserve, determined in accordance with Section 3.D and Section 4.D.

2. If the company is following one or more CDHS, in accordance with an investment policy adopted by the board of directors, or a committee of board members, the company shall take into account the costs and benefits of hedge positions expected to be held by the company in the future along each scenario based on the execution of the hedging strategy, and it is eligible to reduce the amount of the stochastic reserve using projections otherwise calculated. The investment policy must clearly articulate the company’s hedging objectives, including the metrics that drive rebalancing/trading. This specification could include maximum tolerable values for investment losses, earnings, volatility, exposure, etc. in either absolute or relative terms over one or more investment horizons vis-à-vis the chance of occurrence. Company management is responsible for developing, documenting, executing and evaluating the investment strategy, including the hedging strategy, used to implement the investment policy.

3. For this purpose, the investment assets refer to all the assets, including derivatives supporting covered products and guarantees. This also is referred to as the investment portfolio. The investment strategy is the set of all asset holdings at all points in time in all scenarios. The hedging portfolio, which also is referred to as the hedging assets, is a subset of the investment assets. The hedging strategy is the hedging asset holdings at all points in time in all scenarios. There is no attempt to distinguish what is the hedging portfolio and what is the investment portfolio in this section. Nor is the distinction between investment strategy and hedging strategy formally made here. Where necessary to give effect to the intent of this section, the requirements applicable to the hedging portfolio or the hedging strategy are to apply to the overall investment portfolio and investment strategy.

4. This particularly applies to restrictions on the reasonableness or acceptability of the models that make up the stochastic cash-flow model used to perform the projections, since these restrictions are inherently restrictions on the joint modeling of the hedging and non-hedging portfolio. To give effect to these requirements, they must apply to the overall investment strategy and investment portfolio.

5. Before either a new or revised hedging strategy can be used to reduce the amount of the stochastic reserve otherwise calculated, the hedging strategy should be in place (i.e., effectively implemented by the company) for at least three months. The company may meet the time requirement by having evaluated the effective implementation of the hedging strategy for at least three months without actually having executed the trades indicated by the hedging strategy (e.g., mock testing or by having effectively implemented the strategy with similar annuity products for at least three months).

6. If a SHS supporting the contracts is not a CDHS but modeling it as if it were a CDHS would result in a material increase in the company’s TAR, then the company shall model the SHS as a CDHS when calculating reserves under AG43 and/or VM-21 and when calculating the C-3 RBC Amount under LR027. In addition, if modeling the SHS as a CDHS would result in a decrease in the company’s TAR, the company may provide the documentation required for the SHS to be a CDHS as defined in VM-01 and then model the SHS as a CDHS when calculating reserves under AG43 and/or VM-21 and when calculating the C-3 RBC Amount under LR027. The company shall not treat a SHS as a CDHS for purposes of SSAP 108 without providing the documentation required for the SHS to be a CDHS as defined in VM-01.

Guidance Note: The intent of reflecting SHS is not to penalize any hedging strategies, but rather to reflect the company’s investment strategy and risk management strategies, including all material established...
B. Modeling Approaches

1. The analysis of the impact of the hedging strategy on cash flows is typically performed using either one of two types of methods as described below. Although a hedging strategy normally would be expected to reduce risk provisions, the nature of the hedging strategy and the costs to implement the strategy may result in an increase in the amount of the stochastic reserve otherwise calculated.

2. The fundamental characteristic of the first type of method, referred to as the “explicit method,” is that hedging positions and their resulting cash flows are included in the stochastic cash-flow model used to determine the scenario reserve, as discussed in Section 3.D, for each scenario.

3. The fundamental characteristic of the second type of method, referred to as the “implicit method,” is that the effectiveness of the current hedging strategy on future cash flows is evaluated, in part or in whole, outside of the stochastic cash-flow model. There are multiple ways that this type of modeling can be implemented. In this case, the reduction to the stochastic reserve otherwise calculated should be commensurate with the degree of effectiveness of the hedging strategy in reducing accumulated deficiencies otherwise calculated.

4. Regardless of the methodology used by the company, the ultimate effect of the current hedging strategy (including currently held hedge positions) on the stochastic reserve needs to recognize all risks, associated costs, imperfections in the hedges and hedging mismatch tolerances associated with the hedging strategy. The risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, annuitization, etc.). Costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. In addition, the reduction to the stochastic reserve attributable to the hedging strategy may need to be limited due to the uncertainty associated with the company’s ability to implement the hedging strategy in a timely and effective manner. The level of operational uncertainty varies indirectly with the amount of time that the new or revised strategy has been in effect or mock tested.

Guidance Note: No hedging strategy is perfect. A given hedging strategy may eliminate or reduce some but not all risks, transform some risks into others, introduce new risks, or have other imperfections. For example, a delta-only hedging strategy does not adequately hedge the risks measured by the “Greeks” other than delta. Another example is that financial indices underlying typical hedging instruments typically do not perform exactly like the separate account funds, and hence the use of hedging instruments has the potential for introducing basis risk.

5. A safe harbor approach is permitted for CDHS reflection for those companies whose modeled hedge assets comprise only linear instruments not sensitive to implied volatility. For companies with option-based hedge strategies, electing this approach would require representing the option-based portion of the strategy as a delta-rho two-Greek hedge program. The normally modeled option portfolio would be replaced with a set of linear instruments that have the same first-order Greeks as the original option portfolio.

C. Calculation of Stochastic Reserve (Reported)

1. The company shall calculate CTE70 (best efforts)—the results obtained when the CTE70 is based on incorporating the CDHS (including both currently held and future hedge positions) into the stochastic cash-flow model on a best efforts basis, including all of the factors and assumptions needed to execute the CDHS.
2. The company shall calculate a CTE70 (adjusted) by recalculating the CTE70 assuming the company has no CDHS, therefore following the requirements of Section 4.A.4.a.

3. Because most models will include at least some approximations or idealistic assumptions, CTE70 (best efforts) may overstate the impact of the hedging strategy. To compensate for potential overstatement of the impact of the hedging strategy, the value for the stochastic reserve is given by:

\[
\text{Stochastic reserve} = \text{CTE70 (best efforts)} + E \times \max[0, \text{CTE70 (adjusted)} - \text{CTE70 (best efforts)}]
\]

4. The company shall specify a value for \( E \) (the “error factor”) in the range from 5% to 100% to reflect the company’s view of the potential error resulting from the level of sophistication of the stochastic cash-flow model and its ability to properly reflect the parameters of the hedging strategy (i.e., the Greeks being covered by the strategy), as well as the associated costs, risks and benefits. The greater the ability of the stochastic model to capture all risks and uncertainties, the lower the value of \( E \). The value of \( E \) may be as low as 5% only if the model used to determine the CTE70 (best efforts) effectively reflects all of the parameters used in the hedging strategy. If certain economic risks are not hedged, yet the model does not generate scenarios that sufficiently capture those risks, \( E \) must be in the higher end of the range, reflecting the greater likelihood of error. Likewise, simplistic hedge cash-flow models shall assume a higher likelihood of error.

5. The company shall conduct a formal back-test, based on an analysis of at least the most recent 12 months, to assess how well the model is able to replicate the hedging strategy in a way that supports the determination of the value used for \( E \).

6. Such a back-test shall involve one of the following analyses:
   a. For companies that model hedge cash flows directly (“explicit method”), replace the stochastic scenarios used in calculating the CTE70 (best efforts) with a single scenario that represents the market path that actually manifested over the selected back-testing period and compare the projected hedge asset gains and losses against the actual hedge asset gains and losses – both realized and unrealized – observed over the same time period. For this calculation, the model assumptions may be replaced with parameters that reflect actual experience during the back-testing period. In order to isolate the comparison between the modeled hedge strategy and actual hedge results for this calculation, the projected liabilities should accurately reflect the actual liabilities throughout the back-testing period; therefore, adjustments that facilitate this accuracy (e.g. reflecting actual experience instead of model assumptions, including new business, etc.) are permissible.

   To support the choice of a low value of \( E \), the company should ascertain that the projected hedge asset gains and losses are within close range of 100% (e.g., 80–125%) of the actual hedge asset gains and losses. The company may also support the choice of a low value of \( E \) by achieving a high R-squared (e.g., 0.80 or higher) when using a regression analysis technique.

   b. For companies that model hedge cash flows implicitly by quantifying the cost and benefit of hedging using the fair value of the hedged item (an “implicit method” or “cost of reinsurance method”), calculate the delta, rho and vega coverage ratios in each month over the selected back-testing period in the following manner:

      i. Determine the hedge asset gains and losses—both realized and unrealized—incurred over the month attributable to equity, interest rate, and implied volatility movements.
ii. Determine the change in the fair value of the hedged item over the month attributable to equity, interest rate, and implied volatility movements. The hedged item should be defined in a manner that reflects the proportion of risks hedged (e.g., if a company elects to hedge 50% of a contract’s market risks, it should quantify the fair value of the hedged item as 50% of the fair value of the contract).

iii. Calculate the delta coverage ratio as the ratio between (i) and (ii) attributable to equity movements.

iv. Calculate the rho coverage ratio as the ratio between (i) and (ii) attributable to interest rate movements.

v. Calculate the vega coverage ratio as the ratio between (i) and (ii) attributable to implied volatility movements.

vi. To support the company’s choice of a low value of E, the company should be able to demonstrate that the delta and rho coverage ratios are both within close range of 100% (e.g., 80–125%) consistently across the back-testing period.

vii. In addition, the company should be able to demonstrate that the vega coverage ratio is within close range of 100% in order to use the prevailing implied volatility levels as of the valuation date in quantifying the fair value of the hedged item for the purpose of calculating CTE70 (best efforts). Otherwise, the company shall quantify the fair value of the hedged item for the purpose of calculating CTE70 (best efforts) in a manner consistent with the realized volatility of the scenarios captured in the CTE (best efforts).

c. Companies that do not model hedge cash flows explicitly, but that also do not use the implicit method as outlined in Section 9.C.6.b above, shall conduct the formal back-test in a manner that allows the company to clearly illustrate the appropriateness of the selected method for reflecting the cost and benefit of hedging, as well as the value used for E.

7. A company that does not have 12 months of experience to date shall set E to a value that reflects the amount of experience available, and the degree and nature of any change to the hedge program. For a material change in strategy, with no history, E should be at least 0.50. However, E may be lower than 0.50 if some reliable experience is available and/or if the change in strategy is a refinement rather than a substantial change in strategy.

Guidance Note: The following examples are provided as guidance for determining the E factor when there has been a change to the hedge program:
- The error factor should be temporarily large (e.g., ≥ 50%) for substantial changes in hedge methodology (e.g., moving from a fair-value based strategy to a stop-loss strategy) where the company has not been able to provide a meaningful simulation of hedge performance based on the new strategy.
- A temporary moderate increase (e.g., 15–30%) in error factor should be used for substantial modifications to hedge programs or CDHS modeling where meaningful simulation has not been created (e.g., adding second-order hedging, such as gamma or rate convexity).
- No increase in the error factor may be used for incremental modifications to the hedge strategy (e.g., adding death benefits to a program that previously covered only living benefits, or moving from swaps to Treasury Department futures).

D. Additional Considerations for CTE70 (best efforts)

If the company is following a CDHS, the fair value of the portfolio of contracts falling within the scope of these requirements shall be computed and compared to the CTE70 (best efforts) and CTE70 (adjusted). If the CTE70 (best efforts) is below both the fair value and CTE70 (adjusted), the company should be prepared to explain why that result is reasonable.
For the purposes of this analysis, the stochastic reserve and fair value calculations shall be done without requiring the scenario reserve for any given scenario to be equal to or in excess of the cash surrender value in aggregate for the group of contracts modeled in the projection.

E. Specific Considerations and Requirements

1. As part of the process of choosing a methodology and assumptions for estimating the future effectiveness of the current hedging strategy (including currently held hedge positions) for purposes of reducing the stochastic reserve, the company should review actual historical hedging effectiveness. The company shall evaluate the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, the mix of business and other items that are likely to result in materially adverse results. This includes an analysis of model assumptions that, when combined with the reliance on the hedging strategy, are likely to result in adverse results relative to those modeled. The parameters and assumptions shall be adjusted (based on testing contingent on the strategy used and other assumptions) to levels that fully reflect the risk based on historical ranges and foreseeable future ranges of the assumptions and parameters. If this is not possible by parameter adjustment, the model shall be modified to reflect them at either anticipated experience or adverse estimates of the parameters.

2. A discontinuous hedging strategy is a hedging strategy where the relationships between the sensitivities to equity markets and interest rates (commonly referred to as the Greeks) associated with the guaranteed contract holder options embedded in the variable annuities and other in-scope products and these same sensitivities associated with the hedging assets are subject to material discontinuities. This includes, but is not limited to, a hedging strategy where material hedging assets will be obtained when the variable annuity account balances reach a predetermined level in relationship to the guarantees. Any hedging strategy, including a delta hedging strategy, can be a discontinuous hedging strategy if implementation of the strategy permits material discontinuities between the sensitivities to equity markets and interest rates associated with the guaranteed contract holder options embedded in the variable annuities and other in-scope products and these same sensitivities associated with the hedging assets. There may be scenarios that are particularly costly to discontinuous hedging strategies, especially where those result in large discontinuous changes in sensitivities (Greeks) associated with the hedging assets. Where discontinuous hedging strategies contribute materially to a reduction in the stochastic reserve, the company must evaluate the interaction of future trigger definitions and the discontinuous hedging strategy, in addition to the items mentioned in the previous paragraph. This includes an analysis of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.

3. A strategy that has a strong dependence on acquiring hedging assets at specific times that depend on specific values of an index or other market indicators may not be implemented as precisely as planned.

4. The combination of elements of the stochastic cash-flow model—including the initial actual market asset prices, prices for trading at future dates, transaction costs and other assumptions—should be analyzed by the company as to whether the stochastic cash-flow model permits hedging strategies that make money in some scenarios without losing a reasonable amount in some other scenarios. This includes, but is not limited to: a. Hedging strategies with no initial investment that never lose money in any scenario and in some scenarios make money.
   b. Hedging strategies that, with a given amount of initial money, never make less than accumulation at the one-period risk-free rates in any scenario but make more than this in one or more scenarios.

5. If the stochastic cash-flow model allows for such situations, the company should be satisfied that the results do not materially rely directly or indirectly on the use of such strategies. If the results do materially rely directly or indirectly on the use of such strategies, the strategies may not be used to reduce the stochastic reserve otherwise calculated.
6. In addition to the above, the method used to determine prices of financial instruments for trading in scenarios should be compared to actual initial market prices. In addition to comparisons to initial market prices, there should be testing of the pricing models that are used to determine subsequent prices when scenarios involve trading financial instruments. This testing should consider historical relationships. For example, if a method is used where recent volatility in the scenario is one of the determinants of prices for trading in that scenario, then that model should approximate actual historic prices in similar circumstances in history.

**VM-31 Section 3.C.5**

**Assets and Risk Management** – A brief description of the asset portfolio, and the approach used to model risk management strategies, such as hedging, and other derivative programs, including a description of any CDHS and any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4.

**VM-31 Section 3.D.6.f**

**Risk Management** – Detailed description of model risk management strategies, such as hedging and other derivative programs, specific to the groups of policies covered in this sub-report and not discussed in the Life Summary Section 3.C.5. This should include documentation for any hedging strategy that meets the requirements to be a CDHS. It should also include, for any SHS that is not a CDHS, documentation of any CDHS criteria met, listine of CDHS criteria not met, and documentation of the impact on minimum reserves of the SHS being modeled as if it were a CDHS. In particular, such documentation should address the directional impact on minimum reserves and whether the impact is material.


a. **Investment Officer on Investments** – A certification from a duly authorized investment officer that the modeled company investment strategy, including any CDHS and any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4, is representative of and consistent with the company’s investment policy.

b. **Qualified Actuary on Investments** – A certification by a qualified actuary, not necessarily the same qualified actuary that has been assigned responsibility for the PBR Actuarial Report or this sub-report, that the modeling of any CDHS and any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4 was performed in accordance with VM-20 and in compliance with all applicable ASOPs, and the alternative investment strategy as defined in VM-20 Section 7.E.1.g reflects the prescribed mix of assets with the same WAL as the reinvestment assets in the company investment strategy.

**VM-31 Section 3.E.5**

**Assets and Risk Management** – A brief description of the general account asset portfolio, and the approach used to model risk management strategies, such as hedging and other derivative programs, including a description of any CDHS or any SHS that is required to be modeled pursuant to VM-21 Section 9.A.5, and any material changes to the hedging strategy from the prior year.
VM-31 Section 3.F.8

Hedging and Risk Management – The following information regarding the hedging and risk management assumptions used by the company in performing a principle-based valuation under VM-21:

a. Strategies – Detailed description of risk management strategies, such as hedging and other derivative programs, including any CDHS or any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, specific to the groups of contracts covered in this sub-report.
   i. Descriptions of basis risk, gap risk, price risk and assumption risk.
   ii. Methods and criteria for estimating the a priori effectiveness of the strategy.
   iii. Results of any reviews of actual historical hedging effectiveness.

b. CDHS – Documentation for any hedging strategy that meets the requirements to be a CDHS.

c. Other Modeled Hedging Strategies – Documentation for any SHS that is not a CDHS, including documentation of any CDHS criteria met, listing of CDHS criteria not met, and documentation of the impact on TAR of the SHS being modeled as if it were a CDHS. In particular, such documentation should address the directional impact on TAR and whether the impact is material.

d. Strategy Changes – Discussion of any changes to the hedging strategy during the past 12 months, including identification of the change, reasons for the change, and the implementation date of the change.

e. Hedge Modeling – Description of how the hedge strategy was incorporated into modeling, including:
   i. Differences in timing between model and actual strategy implementation.
   ii. For a company that does not have a CDHS or a SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, disclosure of the method used to consider hedge assets included in the starting assets, either (1) including the asset cash flows in the projection model; or (2) replacing the hedge positions with cash and/or other general account assets in an amount equal to the market value of the hedge positions, as discussed in VM-21 Section 4.A.4.a.
   iii. Evaluations of the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, and other items that are likely to result in materially adverse results.
   iv. If residual risks and frictional costs are assumed to have a value of zero, a demonstration that a value of zero is an appropriate expectation.
   v. Any discontinuous hedging strategies modeled, and where such discontinuous hedging strategies contribute materially to a reduction in the stochastic reserve, any evaluations of the interaction of future trigger definitions and the discontinuous hedging strategy, including any analyses of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.
   vi. Disclosure of any situations where the modeled hedging strategies make money in some scenarios without losing a reasonable amount in some other scenarios, and an explanation of why the situations are not material for determining the CTE 70 (best efforts).
   vii. Results of any testing of the method used to determine prices of financial instruments for trading in scenarios against actual initial market prices, including how the testing considered historical relationships. If there are substantial discrepancies, disclosure of the substantial discrepancies and documentation as to why the model-based prices are appropriate for determining the stochastic reserve.
   viii. Any model adjustments made when calculating CTE 70 (adjusted), in particular, any liquidation or substitution of assets for currently held hedges.

e. Error Factor (E) and Back-Testing – Description of E, the error factor, and formal back-tests performed, including:
The value of $E$, and the approach and rationale for the value of $E$ used in the reserve calculation.

For companies that model hedge cash flows using the explicit method, as described in VM-21 Section 9.C.6.a, and have 12 months of experience, an analysis of at least the most recent 12 months of experience and the results of a back-test showing that the model is able to replicate the hedging results experienced in a way that justifies the value used for $E$. Include at least a ratio of the actual change in market value of the hedges to the modeled change in market value of the hedges at least quarterly.

For companies that model hedge cash flows using the implicit method, and have 12 months of experience, as described in VM-21 Section 9.C.6.b, the results of a back-test in which (a) actual hedge asset gains and losses are compared against (b) proportional fair value movements in hedged liability, including:

- Delta, rho and vega coverage ratios in each month over the back-testing period, which may be presented in a chart or graph.
- The implied volatility level used to quantify the fair value of the hedged item, as well as the methodology undertaken to determine the appropriate level used.

For companies that do not model hedge cash flows using either the explicit method or the implicit method, as described in VM-21 Section 9.C.6.c, and have 12 months of experience, the results of the formal back-test conducted to validate the appropriateness of the selected method and value used for $E$.

For companies that do not have 12 months of experience, the basis for the value of $E$ is chosen based on the guidance provided in VM-21 Section 9.C.7, considering the actual history available and the degree and nature of any changes made to the hedge strategy.

Safe Harbor for CDHS – If electing the safe harbor approach for CDHS, as discussed in VM-21 Section 9.C.8, a description of the linear instruments used to model the option portfolio.

Hedge Model Results – Disclosure of whether the calculated CTE 70 (best efforts) is below both the fair value and CTE 70 (adjusted), and if so, justification for why that result is reasonable, as discussed in VM-21 Section 9.D.

VM-31 Section 3.F.12.c

CTEPA – If using the CTEPA method, a summary including:

- Disclosure (in tabular form) of the scenario reserves using the same method and assumptions as those used by the company to calculate CTE 70 (adjusted) as outlined in VM-21 Section 9.C (or the stochastic reserves following VM-21 Section 4.A.4.a for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to VM-21 Section 9.A.6), as well as the corresponding scenarios reserves substituting the assumptions prescribed by VM-21 Section 6.C.

- Summary of results from a cumulative decrement projection along the scenario whose reserve value is closest to the CTE 70 (adjusted), as outlined in VM-21 Section 9.C (or the stochastic reserves following VM-21 Section 4.A.4.a for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to VM-21 Section 9.A.6), under the assumptions outlined in VM-21 Section 6.C. Such a cumulative decrement projection shall include, at the end of each projection year, the projected proportion (expressed as a percent of the total projected account value) of persisting contracts as well as the allocation of projected decrements across death, full surrender, account value depletion, elective annuitization, and other benefit election.
Summary of results from a cumulative decrement projection, identical to (ii) above, but replacing all assumptions outlined in VM-21 Section 6.C with the corresponding assumptions used in calculating the stochastic reserve.

**VM-31 Section 3.F.16.a and Section 3.F.16.b**

a. **Investment Officer on Investments** – A certification from a duly authorized investment officer that the modeled asset investment strategy, including any CDHS and any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, is consistent with the company’s current investment strategy except where the modeled reinvestment strategy may have been substituted with the alternative investment strategy, and also any CDHS meets the requirements of a CDHS.

b. **Qualified Actuary on Investments** – A certification by a qualified actuary, not necessarily the same qualified actuary that has been assigned responsibility for the PBR Actuarial Report or this sub-report, that the modeling of any CDHS and any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6 was performed in accordance with VM-21 and in compliance with all applicable ASOPs.
To: Mr. Mike Boerner, Chair, NAIC Life Actuarial Task Force (LATF)  
06.11.2021  
Regarding: Comments on APF 2020-12

Dear Mr. Boerner,

**Executive Summary**
Thank you for the opportunity to review and share feedback on the proposed changes to APF 2020-12. The collaboration between companies and regulators that we have in the insurance industry is extremely valuable.

I recognize that regulators are concerned with the optionality of including hedging cash flows within the principle-based framework. My understanding of the concern is that regulators want to have confidence that reserves are sufficient, but that can be challenging for a regulator to assess if a certain category of cash flows is excluded.

I understand and appreciate the goal, but I am concerned with the application as written in APF 2020-12. The Valuation Manual does not seem to address the difference in nature between long-term guarantee hedging vs. short-term index-credit hedging. The APF increases the scope of hedges included in the principles-based framework and pushes all hedging programs into a one-size-fits-all approach. The one-size-fits-all approach has some shortcomings when it is applied to index credit hedges. While these concerns exist with or without the adoption of APF 2020-12, the concerns are exaggerated by the proposed changes.

Some concerns with the proposed framework are: the VM-21 Adjusted run is not a good fit for index credit hedges, the VM-20 Stochastic Exclusion Test verbiage does not reflect the relatively lower risk in index credit hedges, and each of these concerns would be inappropriate to be used as precedent for VM-22 in the future.

**VM-21 – Adjusted Run**
My first concern is the application of the VM-21 adjusted run to index credit hedges. The Adjusted vs Best-Efforts runs are a good fit for long-term guarantees because there is often no dynamic interaction between the guarantees and the hedge that supports them. In the example of a GMDB, the company’s responsibility for policyholder benefits is identical with or without a hedge. The guarantee is explicitly stated in the contract.

On the other hand, the crediting strategies offered on Registered Index-Linked Annuities (RILas) have non-guaranteed elements (NGEs) – crediting caps, crediting floors, negative credit buffers, etc. – that are dependent on the company’s ability to hedge. The crediting features offered by the company are different if a hedge is not in place, which would
alter cash flows used in the reserve calculation. Modeling this alternate world in which a hedge does not exist does not provide a meaningful result for the company nor regulator.

It seems most appropriate that RILAs with a CDHS should only utilize the Best Efforts calculation for index-credit hedges due to the inappropriateness of separating the hedge from the liability cash flows.

**VM-20 – Stochastic Exclusion Test**
My second concern is that this change will limit the eligibility of companies to utilize the Stochastic Exclusion Test. The availability of the exclusion tests is to allow products that do not have significant exposure to equity and interest rate risks to limit the procedural complexity of the reserving process. The existence of a CDHS or SHS does not inherently mean that a company has significant equity or interest rate risk impacting their future solvency. Indexed crediting features are enhanced by the company’s ability to hedge. If the company could not hedge, crediting features may be different to reflect the assets supporting the benefits. Ultimately the contract guarantees determine a company’s risk exposure, not simply the existence of a hedge.

The existence of a hedge should not be preclude a product from Exclusion Tests.

**Alternate Path**
The current version of APF 2020-12 should not be adopted without adjusting for the different nature between short-term index credit hedges, which can be very tightly matched, and long-term guarantee-focused hedges, which have more risk of mis-estimation. I recommend an additional hedge category (in addition to CDHS & SHS) that only utilizes best-efforts runs and qualifies for Exclusion Tests. This category can be defined as hedges supporting benefits with non-guaranteed elements.

Sincerely,

Ken Christy, Assistant Actuary
Allianz Life Insurance Company of North America
The Life Actuarial (A) Task Force met June 10, 2021. The following Task Force members participated: Doug Slape, Chair, represented by Mike Boerner, Rachel Hemphill, and Karen Jiang (TX); Judith L. French, Vice Chair, represented by Jason Wade (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li and Steve Ostlund (AL); Ricardo Lara represented by Thomas Reedy and Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Rhonda Ahrens (NE); Marlene Caride represented by Dave Wolf (NJ); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Jonathan T. Pike represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. **Exposed Amendment Proposal 2021-10**

Angela McNabb (NAIC) said amendment proposal 2021-10 modifies the smoker status data element in Appendix 4 of VM-51, Experience Reporting Formats, to recognize the current smoker status instead of the smoker status at time of policy issuance.

Mr. Leung made a motion, seconded by Mr. Kupferman, to deem the amendment proposal non-substantive. The motion passed unanimously.

Mr. Leung made a motion, seconded by Ms. Ahrens, to expose amendment proposal 2021-10 (Attachment A) for a 10-day public comment period ending June 21. The motion passed unanimously.

2. **Extended the Public Comment Period for Amendment Proposal 2021-08**

Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI supports the Society of Actuaries (SOA) mortality table development efforts and understands its need to reflect as recent experience as possible. He said that considering the additional data elements expected in 2023 as part of the effort to support accelerated underwriting, adoption of the amendment proposal should be deferred. He said reducing the data lag now would stress the data submission process. Ms. Ahrens agreed that the adoption should be deferred until after the completion of this year’s data call.

Ms. Ahrens made a motion, seconded by Mr. Schallhorn, to extend the public comment period for amendment proposal 2021-08 (Attachment B) until June 15. The motion passed unanimously.

3. **Adopted Amendment Proposal 2020-10**

Mr. Carmello said the New York Department of Financial Services (NYDFS) comment letter (Attachment C) reiterates its position against allowing the use of future mortality improvement. He said the NYDFS believes that the $\frac{1}{2} \sigma_r$ is the appropriate reserve credit for yearly renewable term (YRT) reinsurance. Mr. Reedy said the California Department of Insurance (DOI) agrees with the position of the NYDFS. He specifically noted that given the impact of COVID-19, the timing is unusual for considering mortality improvement.

Ms. Hemphill said the amendment proposal allows for the Task Force adoption of mortality improvement in the future. She said the amendment proposal states that until the Task Force adopts factors, the mortality improvement factor is 0%. She said that the SOA will consider the impacts of COVID-19 in its factor development.

Mr. Wolf said the State of New Jersey Department of Banking and Insurance and the Arizona Department of Insurance and Financial Institutions support version 4 of the Section 8.C edits. He said they generally believe that grandfathering the YRT approach for policies issued prior to 2020 is appropriate for companies that have complied with existing regulatory requirements.
Ms. Hemphill recapped the four versions of edits to Section 8.C of VM-20, Requirements for Principle-Based Reserves for Life Products, designed to handle the 2017–2019 issue year carveout from the interim YRT solution, as provided in the proposal for commenters’ consideration. She detailed the differences between the approaches.

Ms. Ahrens said that while she understands Mr. Wolf’s position on grandfathering, there is precedence for the phase-in approach in version 3. She said the spirit of principle-based reserving (PBR) includes getting to more of an economic reserve basis for which the assumptions for old and new business are continually recalibrated. She expressed concern about proposals that segment the business and may require separate modeling. Mr. Leung said that because applying future mortality improvement results in a reserve reduction, he believes that makes other reserve credit methods inappropriate. Ms. Hemphill said phasing in the future mortality improvement avoids any double counting of the $ \frac{1}{2} c_x $ approach. Mr. Leung voiced his support for version 3.

Ms. Ahrens made a motion, seconded by Mr. Leung, to adopt amendment proposal 2020-10 (Attachment D) with version 3 of edits to Section 8.C of VM-20. The motion passed, with Mr. Carmello and Mr. Kupferman dissenting.

4. **Discussed Amendment Proposal 2019-33**

Mr. Chupp discussed his comment letter (Attachment E) on amendment proposal 2019-33 (Attachment F). Leonard Mangini (American Academy of Actuaries—Academy) said the Academy will accept Mr. Chupp’s editorial corrections, but his other comments will require further discussion. Mr. Boerner said the discussions will be continued during a future meeting.

Having no further business, the Life Actuarial (A) Task Force adjourned.

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

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

   Angela McNabb & Pat Allison – NAIC staff support

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

   January 1, 2021, version of the Valuation Manual – VM-51 Appendix 4

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

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<td>Smoker Status (at issue)</td>
<td>Smoker status should be submitted where reliable.</td>
</tr>
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<td></td>
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<td>1 = No tobacco usage</td>
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<td></td>
<td></td>
<td>2 = Nonsmoker</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3 = Cigarette smoker</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4 = Tobacco user</td>
</tr>
</tbody>
</table>

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

   In the event that additional underwriting is done after issue, it is possible that the preferred class would be
   inconsistent with the smoker status at issue. By removing the “at issue” specification, the smoker status would then
   be the current smoker status.

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

NAIC Staff Comments:

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<th>Distributed</th>
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</tbody>
</table>

Notes: APF 2021-10

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

Amendment Proposal Form*

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

Society of Actuaries Valuation Basic Table Team – Chair Larry Bruning

Revisions to VM-51 to allow for the data experience reporting observation calendar year to be one year prior to the reporting calendar year.

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


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

Section 2: Statistical Plan for Mortality

D. Process for Submitting Experience Data Under This Statistical Plan

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

Data for this statistical plan for mortality will be compiled using a calendar year method. The reporting calendar year is the calendar year of the experience data that is reported. The observation calendar year is the calendar year of the experience data that is reported. Revisions to VM-51 allow for the data experience reporting observation calendar year to be one year prior to the reporting calendar year. For example, if the current calendar year is 2022 and that is the reporting calendar year, the company is to report the experience data that was in-force or issued in calendar year 2021, which is the observation calendar year. For the 2022 reporting calendar year, companies that are required to submit data for this statistical plan for mortality will be required to submit two observation calendar years of data, namely observation calendar year 2020 and observation calendar year 2021. For reporting calendar years after 2022, companies that are required to submit data for this statistical plan for mortality will be required to submit one observation calendar year of data.

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

i. Report policies in force during or issued during calendar year 20XX.
ii. Report terminations that were incurred in calendar year 20XX and reported before July 1, 20XX+1. However, exclude rescinded policies (e.g., 10-day free look exercises) from the data submission.

For any reporting calendar year, the data call will occur during July of that reporting calendar year, and data is to be submitted according to the requirements of the Valuation Manual in effect during that calendar year. For the 2022 reporting calendar year, the requirements of the 2022 Valuation Manual will be used for both the 2020 and 2021 observation years. Data submissions must be made by Sept. 30 of the reporting calendar year. Corrections of data submissions must be completed by Dec. 31 of the reporting calendar year.

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

This APF is needed for the following reasons:

1. There is a need to shorten the time period between data observation and data collection to facilitate more timely analysis and reporting of mortality experience.
2. Under a Principle Based Reserving methodology, valuation basic tables should reflect recent and current mortality experience.
NY remains opposed to the adoption of APF 2020-10. This APF, which would allow future mortality improvement to be reflected in the reserves regardless of any reinsurance, was developed to address an issue with the reserve credit for YRT reinsurance. This approach generally results in lower gross reserves for all business regardless if it is reinsured. Mortality improvement through the valuation date may be incorporated but any future improvement that has not yet occurred should not be permitted within the reserves. Currently a reserve credit of just 1/2Cx is permitted for YRT reinsurance and most of the reinsurance reserve credit requirements do not apply. Allowing a credit greater than such amount may result in an inappropriate reserve credit and a distorted balance sheet. During the development of PBR it was decide that the current reinsurance rules would continue under PBR which would include those applicable for YRT reserve credit.

Amanda Fenwick, FSA, MAAA
Assistant Chief Life Actuary

NYS Department of Financial Services
One Commerce Plaza, Albany, NY 12257
(518) 474-7929 | amanda.fenwick@dfs.ny.gov

www.dfs.ny.gov
Life Actuarial (A) Task Force
Amendment Proposal Form 2020-10
Exposed for a 12-day public comment period ending June 7, 2021

Request for Comment: During the exposure, commenters are specifically asked to address the four versions exposed for the handling of YRT for the 2017-2019 issue years.

Please submit comments to Reggie Mazyck (RMazyck@naic.org) by COB 5/25/21.
Life Actuarial (A) Task Force / Health Actuarial (B) Task Force
Amendment Proposal Form

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


Reflect a prudent level of mortality improvement beyond the valuation date.

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


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

See attached Appendix.

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

We propose to reflect a prudent level of mortality improvement beyond the valuation date, using SOA analysis for best estimate future mortality improvement and margin. The requirements also need to be clarified for the handling of historical or anticipated future mortality deterioration (i.e., negative improvement).

With the reflection of a prudent level of future mortality improvement in the mortality assumption, the interim 1/2cx approach to YRT is a reasonable consideration for a long-term approach.

For LATF consideration for re-exposure, there are four versions of the handling of the 2017-2019 issue year carveout from the interim YRT solution: 1) the original exposure, removing the carveout with the 1/2cx being made a longer term approach, 2) a modified version that removes the carveout, but makes that removal contingent on the first set of SOA future mortality rates being adopted, in case of delay, 3) a modified version that removes the carveout, but allows for a phase-in of the effect of this change, and 4) a version making the carveout long-term. These versions are presented starting on Page 6 of this document, after the other edits which do not vary based on this options.
Appendix

VM-20 Section 6.A.2.b.v:

v. **Anticipated mortality improvement beyond the projection start date shall be reflected in the** mortality assumption for the purpose of calculating the stochastic exclusion ratio. **The future mortality improvement factors shall be no greater than the unloaded factors determined by the SOA, adopted by LATF, and published on the SOA website, at [link/reference to SOA site TBD].**

**Guidance Note:** Mortality improvement may be positive or negative (i.e., deterioration). The anticipated mortality improvement may be lower than the rates published by the SOA, for example, if the company’s best estimate for mortality improvement for a particular block, such as simplified issue, is lower. Prior to adoption by LATF of the first set of future mortality improvement factors, the future mortality improvement rates shall be 0%.

To allow time for companies to reflect the updated mortality improvement rates, the rates that are to be used in the year-end YYYY valuation should be adopted by LATF and published on the SOA website by September of YYYY. If this timeline is not met, then at the company’s option they may use the mortality improvement rates for the prior year (year YYYY-1).

VM-20 Section 9.C.2.h:

h. **Mortality improvement shall not be incorporated beyond the valuation date in the company experience mortality rates. However, historical mortality improvement from the central point of the underlying company experience data to the valuation date may be incorporated.**

**Guidance Note:** Future mortality improvement is not applied to the company experience mortality rates, since it would be duplicative of the future mortality improvement that is applied to the prudent estimate assumptions for mortality in Section 9.C.7.f.

VM-20 Section 9.C.3.g:

g. **Mortality improvement shall not be incorporated beyond the valuation date in the industry basic table. However, historical mortality improvement from the date of the industry basic table (e.g., Jan. 1, 2008, for the 2008 VBT and July 1, 2015, for the 2015 VBT) to the valuation date shall be incorporated using the improvement factors for the applicable industry basic table as determined by the SOA, adopted by LATF, and published on the SOA website, https://www.soa.org/research/topics/indiv-val-exp-study-list/ (Mortality Improvement Rates for AG-38 for Year-End YYYY).**

**Guidance Note:** Future mortality improvement is not applied to the industry basic table, since it would be duplicative of the future mortality improvement that is applied to the prudent estimate assumptions for mortality in Section 9.C.7.f.
To allow time for companies to reflect the updated mortality improvement rates, the rates that are to be used in the year-end YYYY valuation should be adopted by LATF and published on the SOA website by September of YYYY. If this timeline is not met, then at the company’s option they may use the most recent set of prior mortality improvement rates adopted by LATF and published on the SOA website.

VM-20 Section 9.C.7.a:
If applicable industry basic tables are used in lieu of company experience as the anticipated experience assumptions, or if the level of credibility of the data as provided in Section 9.C.5 is less than 20%, the prudent estimate assumptions for each mortality segment shall equal the respective mortality rates in the applicable industry basic tables as provided in Section 9.C.3, adjusted as necessary pursuant to Section 9.C.7.c and/or any applicable improvement pursuant to Section 9.C.3.g, plus the prescribed margin as provided in Section 9.C.6.c, plus any applicable additional margin pursuant to Section 9.C.6.d.v and/or Section 9.C.6.d.vi, future mortality improvement, pursuant to Section 9.C.7.f, shall be applied to the prudent estimate assumption for mortality.

Section 9.C.7.b.vi:
Beginning in the first policy duration after policy duration E, the prudent estimate mortality assumptions for each policy in a given mortality segment are determined as a weighted average of the company experience mortality rates with margins and the applicable industry basic table with margins, in which the weights on the company rates grade linearly from 100% down to 0%. This grading must be completed—i.e., must reach 100% of industry table—no later than the beginning of the first policy duration after policy duration Z (the determination of the applicable industry basic table is described in Section 9.C.3). Thus, the prudent estimate mortality rate, prior to any adjustments pursuant to Sections 9.C.7.c, 9.C.7.d, 9.C.7.e, and 9.C.7.f below, is:

VM-20 Section 9.C.7.f (new section):

Twenty years of future mortality improvement that the company anticipates beyond the valuation date shall be applied to the prudent estimate assumptions for mortality, using prudent future mortality improvement factors no greater than the loaded factors determined by the SOA, adopted by LATF, and published on the SOA website, at [link/reference to SOA site TBD].

Guidance Note: Mortality improvement may be positive or negative (i.e., deterioration). The anticipated mortality improvement may be lower than the rates published by the SOA, even zero, for example, if the company’s best estimate for mortality improvement for a particular block, such as simplified issue, is lower. Prior to adoption by LATF of the first set of future mortality improvement factors, the future mortality improvement rates shall be 0%.

To allow time for companies to reflect the updated mortality improvement rates, the rates that are to be used in the year-end YYYY valuation should be adopted by LATF and published on the SOA website by September of YYYY. If this timeline is not met, then at the company’s option they may use the mortality improvement rates for the prior year (year YYYY-1).
VM-31 Section 3.D.3.i:

i. **Mortality Improvement** – Description of and rationale for the mortality improvement assumptions applied up to the valuation date and the mortality improvement assumptions applied beyond the valuation date. Such a description shall include the assumed start and end dates of the improvements and a table of the annual improvement percentage(s) used, both without and with margin, separately for company experience and the industry basic table(s), along with a sample calculation of the adjustment (e.g., for a male preferred nonsmoker age 45).

VM-31 Section 3.D.11.c.i:

i. If the company believes the method used to determine anticipated experience mortality assumptions includes an implicit margin, the company can adjust the anticipated experience assumptions to remove this implicit margin for this reporting purpose only. If any such adjustment is made, the company shall document the rationale and method used to determine the anticipated experience assumption.
2017-2019 for Long-Term YRT – Version 1:

VM-20 Section 8.C, introductory paragraph:

C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled; see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.

VM-20 Section 8.C.18 and Guidance Note:

18. When the reinsurance ceded or assumed is on a non-guaranteed YRT or similar basis, the corresponding reinsurance cash flows do not need to be modeled. Rather, for a ceding company, the post-reinsurance-ceded DR or SR shall be the pre-reinsurance-ceded DR or SR pursuant to Section 8.D.2, plus any applicable provision pursuant to Section 8.C.15 and Section 8.C.17, minus the NPR reinsurance credit from Section 8.B. For an assuming company, the DR or SR for the business assumed on a non-guaranteed YRT or similar basis shall be set equal to the NPR from Section 3.B.8, plus any applicable provision pursuant to Section 8.C.16 and Section 8.C.17. In the case where there are also other reinsurance arrangements that are not on a non-guaranteed YRT or similar basis, the reinsurance credit shall include the modeled reinsurance credit reflecting those other reinsurance arrangements. In particular, where there are also other reinsurance arrangements that are dependent on the non-guaranteed YRT or similar actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.

Deleted: For policies issued on or after Jan. 1, 2020, and
optionally for policies issued on or after Jan. 1, 2017, and before Jan.
1, 2020.

Deleted: For policies issued on or after Jan. 1, 2020, and
optionally for policies issued on or after Jan. 1, 2017, and before Jan.
1, 2020.

Deleted: Guidance Note: The above method is an interim
approach. A longer-term solution to YRT is intended to be
adopted by state insurance regulators, after state insurance
regulators and industry have had additional time to consider and
evaluate the variety of approaches that have been put forward as a
potential longer-term solution.

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2017-2019 for Long-Term YRT – Version 2:

VM-20 Section 8.C, introductory paragraph:

C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020 up until adoption by LATF of the first set of unloaded future mortality improvement factors, at which point this shall apply for all policies issued on or after Jan. 1, 2017:

For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled, see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.

VM-20 Section 8.C.18 and Guidance Note:

18. For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020 up until adoption by LATF of the first set of unloaded future mortality improvement factors, at which point this shall apply for all policies issued on or after Jan. 1, 2017:

When the reinsurance ceded or assumed is on a non-guaranteed YRT or similar basis, the corresponding reinsurance cash flows do not need to be modeled. Rather, for a ceding company, the post-reinsurance-ceded DR or SR shall be the pre-reinsurance-ceded DR or SR pursuant to Section 8.D.2, plus any applicable provision pursuant to Section 8.C.15 and Section 8.C.17, minus the NPR reinsurance credit from Section 8.B. For an assuming company, the DR or SR for the business assumed on a non-guaranteed YRT or similar basis shall be set equal to the NPR from Section 3.B.8, plus any applicable provision pursuant to Section 8.C.16 and Section 8.C.17. In the case where there are also other reinsurance arrangements that are not on a non-guaranteed YRT or similar basis, the reinsurance credit shall include the modeled reinsurance credit reflecting those other reinsurance arrangements. In particular, where there are also other reinsurance arrangements that are dependent on the non-guaranteed YRT or similar actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.

The above method is an interim approach. A longer-term solution to YRT is intended to be adopted by state insurance regulators, after state insurance regulators and industry have had additional time to consider and evaluate the variety of approaches that have been put forward as a potential longer-term solution.
2017-2019 for Long-Term YRT – Version 3:

C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled; see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.

For policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020, the company may elect, with domiciliary commissioner approval, a phase-in of the current methodology for non-guaranteed YRT reinsurance with allowance for future mortality improvement from the methodology in the 2021 Valuation Manual for non-guaranteed YRT reinsurance without allowance for future mortality improvement, provided that the company uses a weighted average of the results from the two methodologies, with the weight for the prior methodology being no more than (20XX-YYYY)/(20XX-2021), where YYYY is the current valuation year and 20XX is the final year of the phase-in. A company may elect to phase in these requirements over a 3-year period beginning Jan. 1, 2022 and ending Dec. 31, 2024. A company may elect a longer phase-in period of up to seven years beginning Jan. 1, 2022 and ending Dec. 31, 2028, with approval of the domiciliary commissioner.

VM-20 Section 8.C.18 and Guidance Note:

18. When the reinsurance ceded or assumed is on a non-guaranteed YRT or similar basis, the corresponding reinsurance cash flows do not need to be modeled. Rather, for a ceding company, the post-reinsurance-ceded DR or SR shall be the pre-reinsurance-ceded DR or SR pursuant to Section 8.D.2, plus any applicable provision pursuant to Section 8.C.15 and Section 8.C.17, minus the NPR reinsurance credit from Section 8.B. For an assuming company, the DR or SR for the business assumed on a non-guaranteed YRT or similar basis shall be set equal to the NPR from Section 3.B.8, plus any applicable provision pursuant to Section 8.C.16 and Section 8.C.17. In the case where there are also other reinsurance arrangements that are not on a non-guaranteed YRT or similar basis, the reinsurance credit shall include the modeled reinsurance credit reflecting those other reinsurance arrangements. In particular, where there are also other reinsurance arrangements that are dependent on the non-guaranteed YRT or similar actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.

For policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020, the company may elect, with domiciliary commissioner approval, a phase-in of the current methodology for non-guaranteed YRT reinsurance with allowance for future mortality improvement from the methodology in the 2021 Valuation Manual for non-guaranteed YRT reinsurance without allowance for future mortality improvement, provided that the company uses a weighted average of the results from the two methodologies, with the weight for the prior methodology being no more than (20XX-YYYY)/(20XX-2021), where YYYY is the
current valuation year and 20XX is the final year of the phase-in. A company may elect to phase in these requirements over a 3-year period beginning Jan. 1, 2022 and ending Dec. 31, 2024. A company may elect a longer phase-in period of up to seven years beginning Jan. 1, 2022 and ending Dec. 31, 2028, with approval of the domiciliary commissioner.

VM-31 Section 3.D.8.g (new):

g. Phase-In: If electing a phase-in period as described in VM-20 Section 8.C, documentation of the length of the phase-in approved by the company’s domiciliary commissioner, the result of the current and prior methodologies, the weights applied to each result, and confirmation that reinsurance assumptions for the calculation of the prior methodology are discussed in Section 3.D.8.b above.
2017-2019 for Long-Term YRT – Version 4:

C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020:

For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled; see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.

VM-20 Section 8.C.18 and Guidance Note:

18. For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020:

When the reinsurance ceded or assumed is on a non-guaranteed YRT or similar basis, the corresponding reinsurance cash flows do not need to be modeled. Rather, for a ceding company, the post-reinsurance-ceded DR or SR shall be the pre-reinsurance-ceded DR or SR pursuant to Section 8.D.2, plus any applicable provision pursuant to Section 8.C.15 and Section 8.C.17, minus the NPR reinsurance credit from Section 8.B. For an assuming company, the DR or SR for the business assumed on a non-guaranteed YRT or similar basis shall be set equal to the NPR from Section 3.B.8, plus any applicable provision pursuant to Section 8.C.16 and Section 8.C.17. In the case where there are also other reinsurance arrangements that are not on a non-guaranteed YRT or similar basis, the reinsurance credit shall include the modeled reinsurance credit reflecting those other reinsurance arrangements. In particular, where there are also other reinsurance arrangements that are dependent on the non-guaranteed YRT or similar actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.

Deleted: Guidance Note: The above method is an interim approach. A longer-term solution to YRT is intended to be adopted by state insurance regulators, after state insurance regulators and industry have had additional time to consider and evaluate the variety of approaches that have been put forward as a potential longer-term solution.
Please allow me to submit the following comments regarding exposure APF 2019-33:

1. The word “in” should be inserted in subsection 1.F.2 as follows:

   “Business not described in subsection 1.D. otherwise...”

2. Footnote 1 at the bottom of subsection 1 in the VM is no longer needed and should be deleted.

3. In the Guidance Note under VM-20 Section 1.B.1, the third sentence reads awkward. I suggest the following wording:

   “Group insurance where the underwriting is based on the characteristics of the group and census data but where some individuals are subjected to individual risk selection...”

4. Under VM-20 Section 1.B.2, does “coverage amount” mean that the premiums or COI schedules are banded by face amount? Or does “coverage amount” simply mean that the premium or COI charges must be multiplied by the number of units or number of thousands of coverage to obtain the total premium or COI charge? Since the word “schedules” is used, it would seem to imply that the premiums or COI charges must be banded in order for the individual certificates to fall under VM-20 requirements. The word “schedules” would seem to imply that the premiums or COI charges are per unit of coverage or are per $1000. What if the premium schedule per unit or COI charges per $1000 are based on some but not all of these characteristics (issue age, duration, coverage amount, risk class)? For example, say the COI charges are based on issue age, duration and risk class, but not coverage amount (that is, they are not banded). The wording would seem to exclude these individual certificates from VM-20 requirements even though the COI charges vary by issue age, duration and risk class. Is this the intention?

Thank you.

Craig Chupp
Life and Health Insurance Actuary
Virginia Bureau of Insurance
Phone (804) 371-9131
Craig.chupp@scc.virginia.gov
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.
   
   American Academy of Actuaries, Life Reserves Work Group
   
   Addition of language to clarify the definition of individually underwritten life insurance and the
   applicability of Principle-Based Reserve (PBR) requirements for group insurance contracts with individual
   risk selection issued under insurance certificates.

2. Identify the document, including the date if the document is “released for comment,” and the location in
   the document where the amendment is proposed:
   
   January 1, 2021, version of the Valuation Manual, with the revisions to APF 2020-11 (adopted by LATF
   on 2/11/21) shown in blue text.

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and
   identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in
   Word®) version of the verbiage. (You may do this through an attachment.)
   
   See Appendix
   
   All proposed changes specific to this amendment proposal are shown in red text.

4. State the reason for the proposed amendment? (You may do this through an attachment.)
   
   Individual insurance certificates issued under a group contract which utilize an individual risk selection
   process, pricing, premium rate structures and product features are similar to individual life insurance
   policies. They are currently excluded from VM-20 because they are filed under a group contract, but they
   should be subject to VM-20 due to this similarity. See Appendix.

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

NAIC Staff Comments:

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Notes: APF 2019-33
Appendix

Issue

Certain contracts issued under a master group contract require individual risk selection in order to qualify for issuance of the group insurance certificate; the certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing, and risk classification; and they are managed in a similar manner as individual ordinary life insurance contracts. These individual certificates should follow the same reserve requirements as other individual life contracts of the same product type. Therefore, a change is needed within the *Valuation Manual* to bring these individual certificates into scope of VM-20.

Six changes are recommended:

1) Within the Reserve Requirements section (Section II), change the minimum reserve requirements to also apply to group life contracts which, other than the difference between issuing a policy and issuing a group certificate, have the same or mostly similar contract provisions, risk selection process, and underwriting as individual ordinary life contracts (Section II, subsection 1.D);

2) Within the Reserve Requirements section (Section II), add a transition period for individual group certificates issued on or before 1/1/2024 (Section II, subsections 1.F.1 and 1.F.2);

3) Within the Reserve Requirements section (Section II), add language and guidance note to subsection 1.G and the corresponding footnote to include premiums from group life contracts which have individual certificates that were issued using individual risk selection processes (Section II, subsection 1.G.1, footnote, and guidance note) and to clarify the Calculation for Exemption (Section II, subsection 1.G.2). Comment notes need to refer to NAIC Blanks (E) Working Group to update the PBR Supplement;

4) Add new paragraph, VM-20 Section 1.B (and reformat to make current paragraph Section 1.A) to clarify group life certificates issued using individual risk selection processes, including a definition and requirements to be met, are subject to the requirements of VM-20;

5) Add guidance note after first sentence in VM-20 Section 2.A.1 that group life certificates that meet the definition for individual risk selection process use the same VM-20 Reserving Categories as defined in Section 2;

6) Draft referral to the NAIC Blanks (E) Working Group to revise the VM-20 Reserves Supplement, Part 2 to report premiums for total Group Life and Group Life with certificates subjected to an individual risk selection process and which meet all of the conditions as defined in VM-20 Section 1.B separately.
VM Changes 1, 2 and 3 – II. Reserve Requirements

II. Reserve Requirements

This section provides the minimum reserve requirements by type of product, as set forth in the seven subsections below, as follows:

1. Life Insurance Products
2. Annuity Products
3. Deposit-Type Contracts
4. Health Insurance Products
5. Credit Life and Disability Products
6. Riders and Supplemental Benefits
7. Claim Reserves

All reserve requirements provided by this section relate to business issued on or after the operative date of the Valuation Manual. All reserves must be developed in a manner consistent with the requirements and concepts stated in the Overview of Reserve Concepts in Section I of the Valuation Manual.

Guidance Note: The terms “policies” and “contracts” are used interchangeably.

Subsection 1: Life Insurance Products

A. This subsection establishes reserve requirements for all contracts issued on and after the operative date of the Valuation Manual that are classified as life contracts as defined in SSAP No. 50 in the AP&P Manual, with the exception of annuity contracts and credit life contracts. Minimum reserve requirements for annuity contracts and credit life contracts are provided below in subsection 2 and subsection 5, respectively.

B. Minimum reserve requirements for variable and nonvariable individual life contracts—excluding guaranteed issue life contracts, preneed life contracts, industrial life contracts, and policies of companies exempt pursuant to the life PBR exemption in paragraph D below—subsection 1.G are provided by VM-20, Requirements for Principle-Based Reserves for Life Products, except for election of the transition period in paragraph C below subsection 1.F.2 below. For this purpose, joint life policies are considered individual life.

C. Minimum reserve requirements of VM-20 are considered principle-based valuation requirements for purposes of the Valuation Manual.

D. Minimum reserve requirements for individual certificates under group life contracts which meet all the requirements in VM-20 Section 1.B are provided by VM-20, except for election of the transition period in subsection 1.F.1 below.

E. Minimum reserve requirements for life contracts not subject to VM-20 are those pursuant to applicable requirements in VM-A and VM-C. For guaranteed issue life contracts issued after Dec. 31, 2018, mortality tables are defined in VM Appendix M, Mortality Tables (VM-M), and the same table shall be used for reserve requirements as is used for minimum nonforfeiture requirements as defined in VM-02, Minimum Nonforfeiture Mortality and Interest.
F. A company may elect to establish minimum reserves pursuant to applicable requirements in VM-A and VM-C for:

1. Business described in subsection 1.D above and issued on or after the operative date of the Valuation Manual and prior to 1/1/2024.

2. Business not described in subsection 1.D otherwise subject to VM-20 requirements and issued during the first three years following the operative date of the Valuation Manual.

A company electing to establish reserves using the requirements of VM-A and VM-C may elect to use the 2017 Commissioners’ Standard Ordinary (CSO) Tables as the mortality standard following the conditions outlined in VM-20 Section 3. If a company during the three years elects to apply VM-20 to a block of such business, then a company must continue to apply the requirements of VM-20 for future issues of this business.

G. Life PBR Exemption

1. A company meeting the at least one of the conditions in Dsubsection 1.G.2 below may file a statement of exemption for individual ordinary life insurance policies and certificates, except for policies in Dsubsection 1.G.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. If a company has no business issued directly or assumed during the current calendar year that would otherwise be subject to VM-20, a statement of exemption is not required. For a filed statement of exemption, the statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that at least one of the two conditions in Dsubsection 1.G.2 was met and the statement of exemption must also be included with the NAIC filing for the second quarter of that year.

The domiciliary commissioner may reject such statement prior to September 1 and require the company to follow the requirements of VM-20 for the ordinary life policies covered by the statement.

If a filed statement of exemption is not rejected by the domiciliary commissioner, the filing of subsequent statements of exemption is not required as long as the company continues to qualify for the exemption; rather, ongoing statements of exemption for each new calendar year will be deemed to not be rejected, unless: 1) the company does not meet either condition in Dsubsection 1.G.2 below; 2) the policies contain those in Dsubsection 1.G.3 below; or 3) the domiciliary commissioner contacts the company prior to Sept. 1 and notifies them that the statement of exemption is rejected. If any of these three events occur, then the statement of exemption for the current calendar year is rejected and a new statement of exemption must be filed and not rejected in order for the company to exempt additional policies. In the case of an ongoing statement of exemption, rather than include a statement of exemption with the NAIC filing for the second quarter of that year, the company should enter “SEE EXPLANATION” in response to the Life PBR Exemption supplemental interrogatory and provide as an explanation that the company is utilizing an ongoing statement of exemption.

2. Condition for Exemption:

The company has less than $300 million of ordinary life exemption premiums, and if the company is a member of an NAIC group of life insurers, which includes other life insurance companies, the group has combined ordinary life exemption premiums of less than $600 million; or

The only new policies that would otherwise be subject to VM-20 being issued or assumed by the company are due to election of policy benefits or features from existing policies valued under VM-A and VM-C and the company was exempted from, or otherwise not subject to, the requirements of VM-20 in the prior year.

Exemption premium is determined as follows:
a. The amount reported in the prior calendar year life/health annual statement, Exhibit 1, Part 1, Column 3 (“Ordinary Life Insurance”), line 20.1; plus
b. The portion of the amount in the prior calendar year life/health annual statement, Exhibit 1, Part 1, Column 3 (“Ordinary Life Insurance”), line 20.2 assumed from unaffiliated companies; minus
c. Amounts included in either (a) or (b) that are associated with guaranteed issue insurance policies and/or preneed life insurance policies; minus
d. Amounts included in either (a) or (b) that represent transfers of reserves in force as of the effective date of a reinsurance assumed transaction; plus
e. Amounts of premium for individual life certificates issued under a group life certificate which meet the conditions defined in VM-20, Section 1.B, and that are not included in either (a) or (b).

Guidance Note:
(i) Definitions of preneed and guaranteed issue insurance policy are in VM-01.
(ii) For statements of exemption filed for calendar year 2022 and beyond, the amount in subsection 2.e was reported in the prior calendar year life/health annual statement, VM-20 Reserve Supplement, Part 2, if applicable.

3. Policies Excluded from the Life PBR Exemption:
   a. Universal life with secondary guarantee (ULSG) policies, or policies – other than ULSG – that contain a rider with a secondary guarantee, in which the secondary guarantee does not meet the VM-01 definition of a “non-material secondary guarantee.”

4. Each exemption, or lack of an exemption, outlined in D. subsection 1.G.1 – D. subsection 1.G.3 above applies only to policies issued or assumed in the current year, and it applies to all future valuation dates for those policies. However, if policies did not qualify for the Life PBR Exemption during the year of issue but would have qualified for the Life PBR Exemption if the current Valuation Manual requirements had been in effect during the year of issue, then the domiciliary commissioner may allow an exemption for such policies. The minimum reserve requirements for the ordinary life policies subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.

VM Change 4 – VM-20: Requirements for Principle-Based Reserves for Life Products

VM-20: Requirements for Principles-Based Reserves for Life Products

Section 1: Purpose

A. These requirements establish the minimum reserve valuation standard for individual life insurance policies issued on or after the operative date of the Valuation Manual and subject to a principle-based valuation with an NPR floor under Model #820. These requirements constitute the Commissioners Reserve Valuation Method (CRVM) for policies of individual life insurance.
B. Individual life certificates under a group life contract shall be subject to the requirements of VM-20 if all of the following are met. These requirements constitute the Commissioners Reserve Valuation Method (CRVM) for such certificates.

1. An individual risk selection process, defined as follows, is used to obtain group life insurance coverage;

An individual risk selection process is one that is based on characteristics of the insured(s) beyond sex, gender, age, tobacco usage, and membership in a particular group. This may include, but is not limited to, completion of an application (beyond acknowledgement of membership to the group, sex, gender and age), questionnaire(s), online health history or tele-interview to obtain non-medical and medical or health history information, prescription history information, avocations, usage of tobacco, family history, or submission of fluids such as blood, Home Office Specimens (HOS), or oral fluid. The resulting risk classification is determined based on the characteristics of the individual insured(s) rather than the group, if any, of which it is a member (e.g., employer, affinity, etc.). The individual certificate holder is charged a premium rate based solely on the individual risk selection process and not on membership in a specific group.

**Guidance Note:** The use of evidence of insurability does not by itself constitute an individual risk selection process. Use of information obtained from a census or questionnaire regarding gender, occupation, age, income and/or tobacco usage solely for purposes of determining a rate classification does not by itself qualify a group as having used an individual risk selection process. Group insurance where the underwriting based on the characteristics of the group and census data but where some individuals are subjected to individual risk selection as a result of compensation level, age, an existing medical condition or impairment, late entry into the group, failure of the group to meet minimum participation requirements or voluntary buy-up of increased coverage does not meet the definition of an individual risk selection process.

2. The individual certificates utilize premiums or cost of insurance schedules and charges based on the individual applicant’s issue age, duration from underwriting, coverage amount and risk classification and there is a stated or implied schedule of maximum gross premiums or net cash surrender value required in order to continue coverage in force for a period in excess of one year;

3. The group master contract is designed, priced, solicited, and managed similar to individual ordinary life insurance policies rather than specific to the group as a whole;

4. The individual certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing, and risk classification to individual ordinary life insurance contracts.

5. The individual certificates are issued on or after the operative date of the Valuation Manual except election of the transition period in Section 2, subsection 1.F.1.


VM Change 5 - VM-20: Requirements for Principle-Based Reserves for Life Products

Section 2: Minimum Reserve

A. All policies subject to these requirements shall be included in one of the VM-20 Reserving Categories, as specified in Section 2.A.1, Section 2.A.2 and Section 2.A.3 below.

Guidance Note: Since group insurance subject to an individual risk selection process and meeting all the requirements in Section 1.B is subject to VM-20 requirements, Section 2.A shall apply—meaning that any such contracts will be included in one of the VM-20 Reserving Categories defined by Section 2.A.1, Section 2.A.2, and 2.A.3. All requirements in VM-31 which apply to a VM-20 Reserving Category shall apply to any group insurance subject to individual risk selection that has been included in that VM-20 Reserving Category.

The company may elect to exclude one or more groups of policies from the stochastic reserve calculation and/or the deterministic reserve calculation. When excluding a group of policies from a reserve calculation, the company must document that the applicable exclusion test defined in Section 6 is passed for that group of policies. The minimum reserve for each VM-20 Reserving Category is defined by Section 2.A.1, Section 2.A.2 and Section 2.A.3, and the total minimum reserve equals the sum of the Section 2.A.1, Section 2.A.2 and Section 2.A.3 results below, defined as:
Refer to NAIC Blanks (E) Working Group, request for modification to the supplemental report for the Life PBR Exemption, to show the premiums for group life that utilized an individual risk selection process and meets all of the requirements in VM-20 Section 1.B. as these premiums are currently grouped together with other group insurance in Exhibit 1. As there are other instances where the ordinary life premiums are not included in the determination of the Life PBR Exemption (e.g., for guaranteed issue policies), it may be useful to request addition of the breakdown of premiums used to determine the exemption.

Possible insertion between questions 1 and 2 for disclosure of premiums used in the determination of eligibility for the Life PBR exemption, split by ordinary life and group subject to an individual risk selection process and meeting all of the requirements in VM-20 Section 1.B.

<table>
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<th>VM Change 6 – VM-20 Reserves Supplement, Part 2: Life PBR Exemption</th>
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<td>Life PBR Exemption as defined in the NAIC adapted Valuation Manual (VM)</td>
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<td>1. If the company filed and keeps group Life PBR Exemption forms the upper requirement of VM 4.75 of the Valuation Manual by their individual risk selections?</td>
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<td>2. If the answer to Question 1 is &quot;Yes&quot;, then check the box of the appropriate Life PBR Exemption definition (Check at least 1, 2, or 3)</td>
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The Life Actuarial (A) Task Force met May 27, 2021. The following Task Force members participated: Doug Slape, Chair, represented by Mike Boerner, Rachel Hemphill, and Karen Jiang (TX); Judith L. French, Vice Chair, represented by Jason Wade (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li and Steve Ostlund (AL); Ricardo Lara represented by Ben Bock and Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Stephen W. Robertson represented by Karl Knable (IN); Grace Arnold represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Rhonda Ahrens (NE); Marlene Caride represented by Kevin Clarkson (NJ); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Jonathan T. Pike represented by Tomasz Serbinowski (UT); Scott A. White represented by Craig Chupp (VA); and James A. Dodrill represented by Joylynn Fix (WV).

1. **Re-Exposed Amendment Proposal 2021-09**

Ms. Hemphill said amendment proposal 2021-09 addresses the determination of materiality and the use of simplifications and approximations in a new VM-21, Requirements for Principle-Based Reserves for Variable Annuities. She said the proposed changes require the addition of a new paragraph to VM-21 Section 1, a new paragraph to VM-21 Section 3, and two revisions to Section 3 of VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation. Connie Tang (Prudential) asked if simplifications related to hedge modeling will require additional demonstrations of the materiality. Ms. Hemphill said those simplifications should be covered by the back-testing documentation.

Mr. Chou made a motion, seconded by Mr. Leung, to re-expose amendment proposal 2021-09 (Attachment A) for a 21-day public comment period ending June 16. The motion passed unanimously.

2. **Re-Exposed Amendment Proposal 2020-10**

Ms. Hemphill said amendment proposal 2020-10 recommends reflecting a prudent level of mortality improvement beyond the valuation date. She noted that reflecting a prudent level of future mortality improvement in the mortality assumption makes the interim $\frac{1}{2}$ $c_x$ approach for determining the yearly renewable term (YRT) reinsurance reserve credit a reasonable consideration for a long-term approach for determining the reserve credit. She said four versions of edits to Section 8.C of VM-20, Requirements for Principle-Based Reserves for Life Products, designed to handle the 2017-2019 issue year carveout from the interim YRT solution, are provided in the proposal for commenters’ consideration. She discussed the details of the differences between the approaches.

Mr. Chupp said the edits in the revised amendment proposal address most of the issues raised in his comment letter (Attachment B). Sheldon Summers (Claire Thinking Inc.), said his comments (Attachment C) represent his own thoughts and not those of his organization. He said using the $\frac{1}{2}$ $c_x$ approach as the long-term solution may result in understated reserves for some companies. He said there are situations for which the ceding company should model the YRT reinsurance cash flows, using the $\frac{1}{2}$ $c_x$ as the reserve credit cap, and there are situations for which the assuming company should model the YRT reinsurance cash flows, with the $\frac{1}{2}$ $c_x$ as the reserve credit floor. Ms. Hemphill suggested addressing that issue in a separate amendment proposal.

Sharon Brody (Prudential) and Catherine Murphy (John Hancock) discussed the comment letter (Attachment D) jointly submitted by their companies. Ms. Brody said their comments were addressed in the version 3 and version 4 of the Section 8.C edits Ms. Hemphill presented. She voiced disappointment that a more principle-based solution could not be reached. Ms. Murphy noted John Hancock’s appreciation for the grandfathering options and the continuing conversation.

Leonard Mangini (American Academy of Actuaries—Academy) said the revised amendment proposal addressed the Academy comments (Attachment E). Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI comments (Attachment F) were also addressed.
Ms. Fenwick said the New York Department of Financial Services (NYDFS) is against allowing the use of future mortality improvement. She said the NYDFS prefers version 1 of the Section 8.C edits, which removes the option for grandfathering.

Ms. Hemphill said that a motion to expose the amendment proposal should include revisions to the guidance notes in Section 6.A.2.b.v and Section 9.C.7.f that add the phrase “prior to the adoption by LATF of the first set of future mortality improvement factors, the future mortality improvement rate shall be zero percent.”

Mr. Chupp made a motion, seconded by Mr. Leung, to re-expose amendment proposal 2020-10 (Attachment G), including the additional language provided by Ms. Hemphill, for a 12-day public comment period ending June 8. The motion passed, with Ms. Fenwick dissenting.

3. **Heard a Status Update on the ESG Project**

Mr. Boerner said a drafting group of Task Force members, NAIC staff, and Conning Inc. staff have been meeting regularly to facilitate the implementation of the economic scenario generator (ESG). He said future meetings will include industry subject matter experts (SMEs) from the ACLI and the Academy.

4. **Adopted Amendment Proposal 2021-06**

Angela McNabb (NAIC) said amendment proposal 2021-06 allows for a third party to submit experience data on behalf of the company participating in the mortality experience data call.

Mr. Chou made a motion, seconded by Mr. Sartain, to adopt amendment proposal 2021-06 (Attachment H). The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

**Identification:**
PBR Staff of Texas Department of Insurance

**Title of the Issue:**
1. Address determination of materiality. VM-21 often refers to materiality but is missing a discussion on how materiality is determined.
2. Address use of approximations and simplifications in VM-21.

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

VM-21 Section 1.E (new), VM-21 Section 3.H (new), VM-31 Section 3.E.1, VM-31 Section 3.F.2.e

January 1, 2021 NAIC Valuation Manual

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

See attached.

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

1. VM-21 often refers to materiality but is missing a discussion on how materiality is determined (a materiality standard), as VM-20 has in VM-20 Section 2.H. Moreover, the current language of Materiality in the VA Summary in VM-31 Section 3.E.1 (2021 edition) is based on the Life PBR Summary in VM-31 (2019 edition). The language of Materiality in the VA Summary in Section 3.E.1 of VM-31 should be updated, consistent with adding a new section to VM-21 to address materiality.

For reference, here are the relevant VM-20 passages:

**VM-20 Section 2.H**
The company shall establish, for the DR and SR, a standard containing the criteria for determining whether an assumption, risk factor or other element of the principle-based valuation has a material impact on the size of the reserve. This standard shall be applied when identifying material risks. Such a standard shall also apply to the NPR with respect to VM-20 Section 2.G.
VM-31 Section 3.C.1

Life Summary – The PBR Actuarial Report shall contain a Life Summary of the critical elements of all sub-reports of the Life Report as detailed in Section 3.D. In particular, this Life Summary shall include:

1. VM-20 Materiality – The standard established by the company pursuant to VM-20 Section 2.H.

2. While it is common for companies to use a significant number of approximations, simplifications, and modeling efficiency techniques for their VM-21 valuation, VM-21 is missing an explicit allowance of approximations, simplifications, or modeling efficiency techniques. To understand the impact of the large number of approximations, simplifications, and modeling efficiency techniques, they should be covered in one location in the PBR reporting for VA, in contrast to the current reporting where they are scattered throughout the PBR Report. VM-20 Section 2.G does not allow simplifications to bias the reserve downward. This addresses the concern that a large number of immaterial simplifications could add up to a material understatement. VM-21 needs an assurance that simplifications do not compound one another to become material even more than VM-20, due to the very larger number of simplifications commonly used.

VM-21 Section 1.E (new)

Materiality

The company shall establish a standard containing the criteria for determining whether an assumption, risk factor or other element of the principle-based valuation has a material impact on the size of the reserve or TAR. This standard shall be applied when identifying material risks.

VM-21 Section 3.H (new)

H. A company may use simplifications, approximations and modeling efficiency techniques to calculate the stochastic reserve and/or the additional standard projection amount required by this section if the company can demonstrate that the use of such techniques does not understate TAR by a material amount, and the expected value of TAR calculated using simplifications, approximations and modeling efficiency techniques is not less than the expected value of TAR calculated that does not use them.

 Guidance Note:

Examples of modeling efficiency techniques include, but are not limited to:

1. Choosing a reduced set of scenarios from a larger set consistent with prescribed models and parameters.
2. Generating a smaller liability or asset model to represent the full seriatim model using grouping compression techniques or other similar simplifications.

There are multiple ways of providing the demonstration required by Section 3.H. The complexity of the demonstration depends upon the simplifications, approximations or modeling efficiency techniques used.

Examples include, but are not limited to:

1. Rounding at a transactional level in a direction that is clearly and consistently conservative or is clearly and consistently unbiased with an obviously immaterial impact on the result (e.g., rounding to the nearest dollar) would satisfy 3.H without needing a demonstration. However,
rounding to too few significant digits relative to the quantity being rounded, even in an unbiased way, may be material and in that event, the company may need to provide a demonstration that the rounding would not produce a material understatement of TAR.

2. A brute force demonstration involves calculating the minimum reserve both with and without the simplification, approximation or modeling efficiency technique, and making a direct comparison between the resulting TAR. Regardless of the specific simplification, approximation or modeling efficiency technique used, brute force demonstrations always satisfy the requirements of Section 3.H.

3. Choosing a reduced set of scenarios from a larger set consistent with prescribed models and parameters and providing a detailed demonstration of why it did not understate TAR by a material amount and the expected value of TAR would not be less than the expected value of TAR that would otherwise be calculated. This demonstration may be a theoretical, statistical or mathematical argument establishing, to the satisfaction of the insurance commissioner, general bounds on the potential deviation in the TAR estimate rather than a brute force demonstration.

4. Justify the use of randomly sampling withdrawal ages for each contract instead of following the exact prescribed WDCM method by demonstrating that the random sampling method is materially equivalent to the exact prescribed approach, and the simplification does not materially reduce the Additional Standard Projection Amount and the final reported TAR. In particular, the company should demonstrate that the statistical variability of the results based on the random sampling approach is immaterial by testing different random sets, e.g., if randomly selecting a withdrawal age for each contract, the probability distribution of the withdrawal age should be stable and not vary significantly when using different random number sets.

VM-31 Section 3.E.1

VA Summary – The PBR Actuarial Report shall contain a VA Summary of the critical elements of all sub-reports of the VA Report as detailed in Section 3.F. In particular, this VA Summary shall include:

1. Materiality – The Standard established by the company pursuant to VM-21 Section 1.E.

VM-31 Section 3.F.2.e

e. Approximations, Simplifications, and Modeling Efficiency Techniques – A description of each approximation, simplification or modeling efficiency technique used in reserve or TAR calculations, and a statement that the required VM-21 Section 3.H demonstration is available upon request and shows that: 1) the use of each approximation, simplification, or modeling efficiency technique does not understate TAR by a material amount; and 2) the expected value of TAR is not less than the expected value of TAR calculated without using the approximation, simplification, or modeling efficiency technique.

Deleted: A description of the rationale for determining whether a decision, information, assumption, risk or other element of a principle-based valuation under VM-21 has a material impact on the modeled reserve. Such rationale could include criteria such as a percentage of reserves, a percentage of surplus, and/or a specific monetary value, as appropriate.

Deleted: Approximations and Simplifications – Description of any approximations and simplifications used in each line projection calculation and their description in a different section of this report, including documentation that these did not materially reduce the modeled reserve.
Virginia is submitting comments regarding the following exposure:

**APF 2020-10 (Reflect Mortality Improvement)**

**Comment:**

Mortality improvement should be applied to the anticipated experience, rather than prudent estimate, mortality assumption. The VM is based on principles and guidelines. One of the most foundational principles is the relationship between anticipated experience and prudent estimate assumptions. Anticipated experience is to represent “an expectation of future experience”, while a prudent estimate assumption is “developed by applying a margin to the anticipated experience.” The margin “incorporates conservatism” and “is intended to provide for estimation error and adverse deviation”. APF 2020-10 is not consistent with this principle and violates many provisions of the VM. For example, Section 9.A.1 requires the use of prudent estimate assumptions for every risk factor not stochastically modeled by applying a margin to the anticipated experience. The prudent estimate mortality assumption in APF 2020-10 reflects mortality improvement past the valuation date while the anticipated mortality experience does not. This will result in negative margins in the mortality rates that are used past the valuation date and prudent estimate mortality rates that are lower than the rates based on anticipated experience. This will occur whenever the reduction produced by the mortality improvement factor exceeds the prescribed margin. Because of the violation of these principles, APF 2020-10, if adopted, could have unintended consequences and require further material edits to the VM in the future.

In the case where the anticipated experience mortality assumption is the industry basic table, since companies have the option, but are not required, to incorporate mortality improvement in the industry basic tables from the date of the table to the valuation date, the proposed APF 2020-10 could result in the company using an industry basic table which does not have mortality improvement reflected from the date of the table to the valuation date, but does have mortality improvement reflected beyond the valuation date. This does not make sense.

The proposed APF 2020-10 applies mortality improvement to the prudent estimate mortality assumption which contains a margin. This results in a higher reduction due to mortality improvement than if the improvement factors were applied to the anticipated experience, which does not contain a margin. This would serve to reduce and possibly eliminate the margin that is included in the mortality improvement factors.

The following alternative edits to the VM are consistent with these principles and maintain the appropriate relationship between anticipated experience and prudent estimate assumptions. The proposed edits to VM-20 Section 8.C and VM-31 in APF 2020-10 should be retained. The proposed edits to VM-20 Section 6 and VM-20 Section 9 should be replaced with the following alternative edits 1, 2 and 3.
Suggested Edits to VM:

EDIT #1, VM-20 Section 6.A.2.b.v:

v. Mortality improvement shall be incorporated as outlined in VM-20 Section 9.C.2.h for company experience and as outlined in VM-20 Section 9.C.3.g for the industry basic table, beyond the projection start date. No additional mortality improvement, other than what is allowed in Sections 9.C.2.h and 9.C.3.g, may not be reflected in the mortality assumption for the purpose of calculating the stochastic exclusion ratio.

EDIT #2, VM-20 Section 9.C.2.h:

h. Mortality improvement shall not be incorporated beyond the valuation date. However, historical mortality improvement from the central point of the underlying company experience to the valuation date may be incorporated. In addition, 20 years of mortality improvement beyond the valuation date shall be incorporated using future mortality improvement factors no greater than the loaded factors determined by the SOA, adopted by LATF, and published on the SOA website, at [link/reference to SOA site TBD].

Guidance Note: Mortality improvement may be positive or negative (i.e., deterioration).

To allow time for companies to reflect the updated future mortality improvement rates, the rates that are to be used in the year-end YYYY valuation should be adopted by LATF and published on the SOA website by September of YYYY. If this timeline is not met, then at the company’s option they may use the mortality improvement rates for the prior year (year YYYY-1).

Guidance Note: YYYY is the calendar year of valuation.

EDIT #3, VM-20 Section 9.C.3.g:

g. Mortality improvement shall not be incorporated beyond the valuation date. However, historical mortality improvement from the date of the industry basic table (e.g., Jan. 1, 2008, for the 2008 VBT and July 1, 2015, for the 2015 VBT) to the valuation date may be incorporated using the improvement factors for the applicable industry basic table as determined by the SOA, adopted by LATF, and published on the SOA website, https://www.soa.org/research/topics/indiv-val-exp-study-list/ (Mortality Improvement Rates for AG-38 for Year-End YYYY).

Guidance Note: The improvement factors for the industry basic table will be determined by the SOA. YYYY is the calendar year of valuation.

Guidance Note: The start date for the historical improvement factors to be applied to the industry basic tables differs from that used for determining company experience mortality rates as described in Section 9.C.2.h, as the industry basic tables have already been improved from the mid-point of the exposure period of the data underlying the table to the year of the table; e.g., the 2015 VBT has already been improved from the mid-point of the underlying data supporting the table to 2015.

In addition, 20 years of mortality improvement beyond the valuation date shall be incorporated using future mortality improvement factors no greater than the loaded factors determined by the SOA, adopted by LATF, and published on the SOA website, at [link/reference to SOA site TBD].
Guidance Note: Mortality improvement may be positive or negative (i.e., deterioration).

To allow time for companies to reflect the updated mortality improvement rates, the rates that are to be used in the year-end YYYY valuation should be adopted by LATF and published on the SOA website by September of YYYY. If this timeline is not met, then at the company’s option they may use the mortality improvement rates for the prior year (year YYYY-1).

Thank you for your consideration of these comments.

Craig Chupp, FSA, MAAA
Life and Health Insurance Actuary
Virginia Bureau of Insurance
craig.chupp@scc.virginia.gov
Phone: (804) 371-9131
May 12, 2021

Mr. Mike Boerner
Chair, Life Actuarial (A) Task Force
National Association of Insurance Commissioners

Re: Comments on APF 2020-10

Dear Mr. Boerner:

I offer the following comments regarding APF 2020-10, which is under exposure through May 25, 2021. My comments pertain only to the changes to paragraph 18 of Section 8.C.18 of VM-20, which make the “interim approach” regarding the calculation of the YRT reinsurance reserve credit and the assumed YRT reinsurance reserve a longer-term solution.

1. Reserve credit provided to the ceding company:

A reserve credit of $\frac{1}{2}$ $cx$ (assuming an annual YRT reinsurance premium is paid in advance) may in some situations overstate the proper reserve credit. I recommend that in certain cases the YRT reinsurance cash flows (based on actuarial judgment following the requirements of VM-20) should be included in the determination of the deterministic and stochastic reserves, with the resulting reserve credit capped at $\frac{1}{2}$ $cx$ based on the applicable Commissioners Standard Mortality Table used for the NPR reserve:

The YRT reinsurance agreements that would be subject to a modeling requirement are those with one or more features described below, as of the valuation date (note that the reference to treaty termination includes in-force business, and the reference to termination on a reinsurance premium due date does not preclude a treaty requirement for prior written notification):

i. The ceding company does not have an option to terminate the agreement on each reinsurance premium due date with no payment required other than for outstanding balances that would be due (excluding any reinsurance premium due to be paid in advance) in the absence of treaty termination (in other words, there would be no penalty for recapture) AND current non-guaranteed reinsurance premium rates have a larger present value than the present value, using prudent estimate assumptions, of the corresponding projected death claims.

ii. The ceding company does not have an option to terminate the agreement on each reinsurance premium due date with no payment required other than for outstanding balances that would be due (excluding any reinsurance premium due to be paid in advance) in the absence of treaty termination AND the agreement contains an experience refund provision that is still in effect.

iii. The ceding company does not have an option to terminate the agreement on each reinsurance premium due date with no payment required other than for outstanding balances that would be due (excluding any reinsurance premium due to be paid in advance) in the absence of treaty termination AND the agreement covers universal life policies with material secondary guarantees.

iv. The ceding company does not have an option to terminate the agreement on the due date of a premium rate increase that is not fully supported by a change in anticipated mortality,
with no payment required other than for outstanding balances that would be due (excluding any reinsurance premium due to be paid in advance) in the absence of treaty termination.

2. Reserve set up by the assuming company:
A reserve of $\frac{1}{2} \, cx$ (assuming an annual YRT reinsurance premium is paid in advance) for mortality risk assumed under a YRT reinsurance agreement may in some situations understate the proper reserve. My recommendation is that in those cases the YRT reinsurance cash flows (based on actuarial judgment following the requirements of VM-20) should be included in the determination of the deterministic and stochastic reserves, with the resulting reserve floored at $\frac{1}{2} \, cx$ based on the applicable CSO mortality table used for the NPR reserve.

The YRT reinsurance agreements that would be subject to a modeling requirement are those with one or more features described below, as of the valuation date:

i. The reinsurance agreement contains a limitation or condition on the right of the reinsurer to increase the non-guaranteed premium rate scale up to the maximum specified in the reinsurance agreement. A provision in the reinsurance agreement that requires that reinsurance premium rate increases be supported by increases in anticipated mortality shall not be considered to be a condition or limitation for the purposes of this paragraph.

ii. The reinsurance agreement contains language that implicitly or explicitly states that it intends on continuing to charge the current rates. This does not include language that states that the reinsurer intends on continuing to charge the current rates unless there is an increase in anticipated experience.

iii. The reinsurance agreement is silent regarding its right to raise the YRT reinsurance premium rate scale.

iv. The maximum non-guaranteed reinsurance premiums allowed to be charged have a smaller present value, as of the valuation date, than the present value, using prudent estimate assumptions, of the corresponding projected death claims.

3. The ceding company’s reserve credit and the reinsurer’s reserve:
I also recommend that, notwithstanding items 1 and 2 above, VM-20 should specify that the regulator may require that YRT reinsurance cash flows be modeled if a YRT reinsurance agreement contains characteristics that, if modeled, may result in a reserve credit smaller than $\frac{1}{2} \, cx$ or a reserve greater than $\frac{1}{2} \, cx$. The reserve credit cap and the reserve floor specified above would still apply. This is intended to apply to YRT reinsurance agreements that have features that are not common or that appear to only be included for the purpose of preventing the treaty from being subject to the modeling requirement.

4. Guaranteed YRT reinsurance premium rates:
I also recommend, notwithstanding the above, that the ceding company’s reserve credit and the reinsurer’s reserve be modified to reflect reinsurance premium rates that are fully guaranteed.

Thank you for considering these comments.

Sheldon Summers
Claire Thinking, Inc.
(661) 367-7392
May 25, 2021

Mike Boerner
Chair, NAIC Life Actuarial (A) Task Force

Attention: Reggie Mazyck (rmazyck@naic.org)

Re: APF 2020-10

Dear Mr. Boerner,

We appreciate the opportunity to share our thoughts on Amendment Proposal Form (APF) 2020-10 which was exposed for public comment on April 8th, 2021.

Within the proposal, we are fully supportive of the new Section 9.C.7.f which allows prudent future mortality improvement to be reflected for up to 20 years beyond the valuation date. We believe that this is a step in the right direction by addressing one of the implicit margins inherent within VM-20. Publishing the rates on the Society of Actuaries website by September of the valuation year will also provide insurers with adequate time to implement the rates within their model governance frameworks. As the framework is finalized, we ask that regulators consider the margins already inherent in the base mortality assumptions and the multiplicative impact of additional margins on the mortality improvement.

We do not, however, believe that the inclusion of prudent future mortality improvement in gross reserve calculations adequately addresses the treatment of non-guaranteed YRT reinsurance within VM-20. We believe that applying a formulaic reserve credit equal to ½ Cx (equivalent to the NPR reinsurance credit from Section 8.B) moves VM-20 away from a principles-based framework and should continue to be considered as an interim methodology.

The ½ Cx reserve credit is an accounting consideration which only takes a one-year perspective of a multi-year YRT arrangement. It presumes that the reinsurer will reprice the risk annually. It does not consider the underlying reinsurance cashflows and is misaligned with the economics and risk-sharing of a non-guaranteed YRT arrangement.

Finally, under the current interim ½ Cx approach, optional grandfathering is permitted for policies issued on or after 1/1/2017 and before 1/1/2020. The inclusion of a grandfathering provision supports early adopters of VM-20 by not penalizing them for following the principle-based VM-20 rules in place at that time. A long-term solution that incorporates a formulaic approach, such as ½ Cx, rather than a principles-based solution, should apply on a prospective basis only where insurers can price and manage to the new rules, while maintaining optional grandfathering, subject to domestic regulatory approval, for policies issued on or after 1/1/2017 and before 1/1/2020. If optional grandfathering is not permitted, a transition period should be included that allows for a company to elect to phase new requirements. The phase in adopted as part of the NAIC’s Variable Annuity Framework (VM-21, Section 2.B) is a precedent that can inform a phase in to gradually and appropriately reflect the impacts of any long-term approach.
Thank you for consideration of these comments.

If you have any questions, please contact Sharon Brody from Prudential (sharon.brody@prudential.com) and/or Catherine Murphy from John Hancock (catherine_murphy@jhancock.com).

Catherine Murphy, FSA, CIA, MAAA
VP & US Deputy Appointed Actuary
John Hancock

Todd Bryden, FSA, MAAA
Chief Actuary, Individual Life Insurance
Prudential
May 25, 2021

Mr. Mike Boerner
Chair, Life Actuarial (A) Task Force
National Association of Insurance Commissioners

Re: APF 2020-10

Dear Mike,

The Life Reserves Work Group (LRWG) of the American Academy of Actuaries\(^1\) is pleased to have the opportunity to submit the following comments regarding exposed amendment proposal form (APF) 2020-10, which addresses inclusion of future mortality improvement (FMI) into principle-based reserving (PBR) valuation. The exposure specifically asks that comments address whether the “may” language proposed for 9.C.7.f and 9.C.3.g should be changed to “shall.”

The LRWG strongly agrees with the supporting rationale of this APF—namely that the reserve requirements in the current Valuation Manual exceed moderately adverse conditions in not allowing FMI to be incorporated into mortality assumptions.

We believe that the APF, as proposed, provides several protective “guardrails”:

- a prescribed margin that must be applied by the actuary to the promulgated FMI rates;
- a process whereby LATF would review and approve any periodic proposed FMI scale updates before they become effective and used in valuation;
- periodic studies which ensure that the FMI scale reflects recent trends, because PBR assumptions are required to be current, relevant, and credible; and
- a “bi-directional” structure in which the FMI scale could increase reserves if the underlying experience were to show slowing or negative improvement and lower reserves if the underlying experience were to show increasing or positive improvement.

The LRWG believes such a “bi-directional” impact works toward the overall goal of a principle-based valuation system producing “right-sized” reserves.

One might think that simply inserting “shall” language into sections 9.C.7.f and 9.C.3.g would be sufficient to accomplish the goal of including unfavorable FMI because this would require the actuary to incorporate FMI if it tended to raise reserves, while “may” language would not.

\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
We believe the situation is more complex, because using only “shall” language would not permit the actuary to ignore FMI if including its impacts produced lower mortality than what would be considered a prudent estimate for the insurer’s situation.

We do suggest rewording sections 9.C.7.f and 9.C.3.g to use “shall” language if incorporating FMI increases reserves and use “may” language if incorporating FMI would reduce reserves. In doing so, if the FMI scale were clearly an improvement to mortality rates, the actuary would not need to perform extra work to effectively hold a higher reserve than required. We recognize that an actuary could raise the margin beyond the prescribed level to 100% of the applicable FMI scale so as to eliminate the beneficial impact of FMI. Further, we recognize that the actuary could point to Section 2.G and use a “modeling simplification” that ignores FMI, as doing so would increase reserves. Use of a Section 2.G modeling simplification, however, would require the actuary to provide additional demonstrations and documentation.

To summarize, we believe the inclusion of FMI in the Valuation Manual, as described in this APF is a positive move. We suggest rewording sections 9.C.7.f and 9.C.3.g to use “shall” if FMI increases reserves and use “may” if FMI decreases reserves.

Thank you for your consideration. Please contact Khloe Greenwood, the Academy’s life policy analyst, with any questions at greenwood@actuary.org.

Leonard Mangini, MAAA, FSA
Chairperson, Life Reserves Work Group
American Academy of Actuaries
Brian Bayerle
Senior Actuary

May 25, 2021

Mr. Mike Boerner
Chair, NAIC Life Actuarial (A) Task Force (LATF)

Re: ACLI Comments on AFP 2020-10

Dear Mr. Boerner:

The American Council of Life Insurers (ACLI) appreciates the opportunity to provide comments on AFP 2020-10. The ACLI supports changes consistent with the spirit of a principles-based framework. Such a framework allows for prudent actuarial judgment in the setting of assumptions, and appropriate margin to capture uncertainty around those assumptions. ACLI has previously expressed concern around the level of margin currently within the VM-20 framework, and in particular the mortality margins.

We believe this amendment is an important step towards better alignment with a true principles-based framework. Recognition of future mortality improvement better aligns the framework with company and industry expectations and reduces disparities with market-driven provisions (such as current YRT premium rates).

We note that if ½ cx is adopted as the long-term approach for YRT, it would change applicable requirements for the 2017-2019 issues that were allowed to continue using the pre-interim approach language. In order to ease the transition for these blocks, we would suggest consideration of an optional transition to implement the change, similar to what was done for the revisions of the variable annuity framework.

We look forward to a discussion of this amendment on a future call. We appreciate the consideration of our comments.

Sincerely,

cc: Reggie Mazyck, NAIC

The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 94 percent of industry assets in the United States.

acli.com
Life Actuarial (A) Task Force
Amendment Proposal Form 2020-10
Exposed for a 12-day public comment period ending June 7, 2021

Request for Comment: During the exposure, commenters are specifically asked to address the four versions exposed for the handling of YRT for the 2017-2019 issue years.

Please submit comments to Reggie Mazyck (RMazyck@naic.org) by COB 5/25/21.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

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


Reflect a prudent level of mortality improvement beyond the valuation date.

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


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

See attached Appendix.

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

We propose to reflect a prudent level of mortality improvement beyond the valuation date, using SOA analysis for best estimate future mortality improvement and margin. The requirements also need to be clarified for the handling of historical or anticipated future mortality deterioration (i.e., negative improvement).

With the reflection of a prudent level of future mortality improvement in the mortality assumption, the interim 1/2cx approach to YRT is a reasonable consideration for a long-term approach.

For LATF consideration for re-exposure, there are four versions of the handling of the 2017-2019 issue year carveout from the interim YRT solution: 1) the original exposure, removing the carveout with the 1/2cx being made a longer term approach, 2) a modified version that removes the carveout, but makes that removal contingent on the first set of SOA future mortality rates being adopted, in case of delay, 3) a modified version that removes the carveout, but allows for a phase-in of the effect of this change, and 4) a version making the carveout long-term. These versions are presented starting on Page 6 of this document, after the other edits which do not vary based on this options.
Appendix

VM-20 Section 6.A.2.b.v:

v. Anticipated mortality improvement beyond the projection start date shall be reflected in the mortality assumption for the purpose of calculating the stochastic exclusion ratio. The future mortality improvement factors shall be no greater than the unloaded factors determined by the SOA, adopted by LATF, and published on the SOA website, at [link/reference to SOA site TBD].

Guidance Note: Mortality improvement may be positive or negative (i.e., deterioration). The anticipated mortality improvement may be lower than the rates published by the SOA, for example, if the company’s best estimate for mortality improvement for a particular block, such as simplified issue, is lower. Prior to adoption by LATF of the first set of future mortality improvement factors, the future mortality improvement rates shall be 0%.

To allow time for companies to reflect the updated mortality improvement rates, the rates that are to be used in the year-end YYYY valuation should be adopted by LATF and published on the SOA website by September of YYYY. If this timeline is not met, then at the company’s option they may use the mortality improvement rates for the prior year (year YYYY-1).

VM-20 Section 9.C.2.h:

h. Mortality improvement shall not be incorporated beyond the valuation date in the company experience mortality rates. However, historical mortality improvement from the central point of the underlying company experience data to the valuation date may be incorporated.

Guidance Note: Future mortality improvement is not applied to the company experience mortality rates, since it would be duplicative of the future mortality improvement that is applied to the prudent estimate assumptions for mortality in Section 9.C.7.f.

VM-20 Section 9.C.3.g:

g. Mortality improvement shall not be incorporated beyond the valuation date in the industry basic table. However, historical mortality improvement from the date of the industry basic table (e.g., Jan. 1, 2008, for the 2008 VBT and July 1, 2015, for the 2015 VBT) to the valuation date shall be incorporated using the improvement factors for the applicable industry basic table as determined by the SOA, adopted by LATF, and published on the SOA website, https://www.soa.org/research/topics/indiv-val-exp-study-list/ (Mortality Improvement Rates for AG-38 for Year-End YYYY).

Guidance Note: Future mortality improvement is not applied to the industry basic table, since it would be duplicative of the future mortality improvement that is applied to the prudent estimate assumptions for mortality in Section 9.C.7.f.
To allow time for companies to reflect the updated mortality improvement rates, the rates that are to be used in the year-end YYYY valuation should be adopted by LATF and published on the SOA website by September of YYYY. If this timeline is not met, then at the company’s option they may use the most recent set of prior mortality improvement rates adopted by LATF and published on the SOA website.

VM-20 Section 9.C.7.a:
If applicable industry basic tables are used in lieu of company experience as the anticipated experience assumptions, or if the level of credibility of the data as provided in Section 9.C.5 is less than 20%, the prudent estimate assumptions for each mortality segment shall equal the respective mortality rates in the applicable industry basic tables as provided in Section 9.C.3, adjusted as necessary pursuant to Section 9.C.7.e and for any applicable improvement pursuant to Section 9.C.3.g, plus the prescribed margin as provided in Section 9.C.6.c, plus any applicable additional margin pursuant to Section 9.C.6.d.v and/or Section 9.C.6.d.vi. Future mortality improvement, pursuant to Section 9.C.7.f, shall be applied to the prudent estimate assumption for mortality.

Section 9.C.7.b.vi
Beginning in the first policy duration after policy duration E, the prudent estimate mortality assumptions for each policy in a given mortality segment are determined as a weighted average of the company experience mortality rates with margins and the applicable industry basic table with margins, in which the weights on the company rates grade linearly from 100% down to 0%. This grading must be completed—i.e., must reach 100% of industry table—no later than the beginning of the first policy duration after policy duration Z (the determination of the applicable industry basic table is described in Section 9.C.3). Thus, the prudent estimate mortality rate, prior to any adjustments pursuant to Sections 9.C.7.c, 9.C.7.d, 9.C.7.e and 9.C.7.f below, is:

VM-20 Section 9.C.7.f (new section):
Twenty years of future mortality improvement that the company anticipates beyond the valuation date shall be applied to the prudent estimate assumptions for mortality, using prudent future mortality improvement factors no greater than the loaded factors determined by the SOA, adopted by LATF, and published on the SOA website. (Link/reference to SOA site TBD).

**Guidance Note:** Mortality improvement may be positive or negative (i.e., deterioration). The anticipated mortality improvement may be lower than the rates published by the SOA, even zero, for example, if the company’s best estimate for mortality improvement for a particular block, such as simplified issue, is lower.

Prior to adoption by LATF of the first set of future mortality improvement factors, the future mortality improvement rates shall be 0%.

To allow time for companies to reflect the updated mortality improvement rates, the rates that are to be used in the year-end YYYY valuation should be adopted by LATF and published on the SOA website by September of YYYY. If this timeline is not met, then at the company’s option they may use the mortality improvement rates for the prior year (year YYYY-1).
VM-31 Section 3.D.3.i:

i. **Mortality Improvement** – Description of and rationale for the mortality improvement assumptions applied up to the valuation date and the mortality improvement assumptions applied beyond the valuation date. Such a description shall include the assumed start and end dates of the improvements and a table of the annual improvement percentage(s) used, both without and with margin, separately for company experience and the industry basic table(s), along with a sample calculation of the adjustment (e.g., for a male preferred nonsmoker age 45).

VM-31 Section 3.D.11.c.i:

i. If the company believes the method used to determine anticipated experience mortality assumptions includes an implicit margin, the company can adjust the anticipated experience assumptions to remove this implicit margin for this reporting purpose only. If any such adjustment is made, the company shall document the rationale and method used to determine the anticipated experience assumption.

Deleted: Adjustments for
Deleted: any adjustments to
Deleted: mortality assumptions for

Deleted: For example, to the extent the company expects mortality improvement after the valuation date, any such mortality improvement is an implicit margin and, therefore, is an acceptable adjustment to the anticipated experience assumptions.
2017-2019 for Long-Term YRT – Version 1:

VM-20 Section 8.C, introductory paragraph:

C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled; see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.

VM-20 Section 8.C.18 and Guidance Note:

18. When the reinsurance ceded or assumed is on a non-guaranteed YRT or similar basis, the corresponding reinsurance cash flows do not need to be modeled. Rather, for a ceding company, the post-reinsurance-ceded DR or SR shall be the pre-reinsurance-ceded DR or SR pursuant to Section 8.D.2, plus any applicable provision pursuant to Section 8.C.15 and Section 8.C.17, minus the NPR reinsurance credit from Section 8.B. For an assuming company, the DR or SR for the business assumed on a non-guaranteed YRT or similar basis shall be set equal to the NPR from Section 3.B.8, plus any applicable provision pursuant to Section 8.C.16 and Section 8.C.17. In the case where there are also other reinsurance arrangements that are not on a non-guaranteed YRT or similar basis, the reinsurance credit shall include the modeled reinsurance credit reflecting those other reinsurance arrangements. In particular, where there are also other reinsurance arrangements that are dependent on the non-guaranteed YRT or similar actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.

Deleted: For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020:

Deleted: For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020:

Deleted: Guidance Note: The above method is an interim approach. A longer-term solution to YRT is intended to be adopted by state insurance regulators, after state insurance regulators and industry have had additional time to consider and evaluate the variety of approaches that have been put forward as a potential longer-term solution.
2017-2019 for Long-Term YRT – Version 2:

VM-20 Section 8.C, introductory paragraph:

C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020 up until adoption by LATF of the first set of unloaded future mortality improvement factors, at which point this shall apply for all policies issued on or after Jan. 1, 2017:

For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled; see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.

VM-20 Section 8.C.18 and Guidance Note:

18. For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020 up until adoption by LATF of the first set of unloaded future mortality improvement factors, at which point this shall apply for all policies issued on or after Jan. 1, 2017:

When the reinsurance ceded or assumed is on a non-guaranteed YRT or similar basis, the corresponding reinsurance cash flows do not need to be modeled. Rather, for a ceding company, the post-reinsurance-ceded DR or SR shall be the pre-reinsurance-ceded DR or SR pursuant to Section 8.D.2, plus any applicable provision pursuant to Section 8.C.15 and Section 8.C.17, minus the NPR reinsurance credit from Section 8.B. For an assuming company, the DR or SR for the business assumed on a non-guaranteed YRT or similar basis shall be set equal to the NPR from Section 3.B.8, plus any applicable provision pursuant to Section 8.C.16 and Section 8.C.17. In the case where there are also other reinsurance arrangements that are not on a non-guaranteed YRT or similar basis, the reinsurance credit shall include the modeled reinsurance credit reflecting those other reinsurance arrangements. In particular, where there are also other reinsurance arrangements that are dependent on the non-guaranteed YRT or similar actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.

**Deleted:**

**Guidance Note:** The above method is an interim approach. A longer-term solution to YRT is intended to be adopted by state insurance regulators, after state insurance regulators and industry have had additional time to consider and evaluate the variety of approaches that have been put forward as a potential longer-term solution.
2017-2019 for Long-Term YRT – Version 3:

C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled; see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.

For policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020, the company may elect, with domiciliary commissioner approval, a phase-in of the current methodology for non-guaranteed YRT reinsurance with allowance for future mortality improvement from the methodology in the 2021 Valuation Manual for non-guaranteed YRT reinsurance without allowance for future mortality improvement, provided that the company uses a weighted average of the results from the two methodologies, with the weight for the prior methodology being no more than \((20XX-YYYY)/(20XX-2021)\), where YYYY is the current valuation year and 20XX is the final year of the phase-in. A company may elect to phase in these requirements over a 3-year period beginning Jan. 1, 2022 and ending Dec. 31, 2024. A company may elect a longer phase-in period of up to seven years beginning Jan. 1, 2022 and ending Dec. 31, 2028, with approval of the domiciliary commissioner.

VM-20 Section 8.C.18 and Guidance Note:

18. When the reinsurance ceded or assumed is on a non-guaranteed YRT or similar basis, the corresponding reinsurance cash flows do not need to be modeled. Rather, for a ceding company, the post-reinsurance-ceded DR or SR shall be the pre-reinsurance-ceded DR or SR pursuant to Section 8.D.2, plus any applicable provision pursuant to Section 8.C.15 and Section 8.C.17, minus the NPR reinsurance credit from Section 8.B. For an assuming company, the DR or SR for the business assumed on a non-guaranteed YRT or similar basis shall be set equal to the NPR from Section 3.B.8, plus any applicable provision pursuant to Section 8.C.16 and Section 8.C.17. In the case where there are also other reinsurance arrangements that are not on a non-guaranteed YRT or similar basis, the reinsurance credit shall include the modeled reinsurance credit reflecting those other reinsurance arrangements. In particular, where there are also other reinsurance arrangements that are dependent on the non-guaranteed YRT or similar actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.

For policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020, the company may elect, with domiciliary commissioner approval, a phase-in of the current methodology for non-guaranteed YRT reinsurance with allowance for future mortality improvement from the methodology in the 2021 Valuation Manual for non-guaranteed YRT reinsurance without allowance for future mortality improvement, provided that the company uses a weighted average of the results from the two methodologies, with the weight for the prior methodology being no more than \((20XX-YYYY)/(20XX-2021)\), where YYYY is the
current valuation year and 20XX is the final year of the phase-in. A company may elect to phase in these requirements over a 3-year period beginning Jan. 1, 2022 and ending Dec. 31, 2024. A company may elect a longer phase-in period of up to seven years beginning Jan. 1, 2022 and ending Dec. 31, 2028, with approval of the domiciliary commissioner.

VM-31 Section 3.D.8.g (new):

g. Phase-In: If electing a phase-in period as described in VM-20 Section 8.C, documentation of the length of the phase-in approved by the company’s domiciliary commissioner, the result of the current and prior methodologies, the weights applied to each result, and confirmation that reinsurance assumptions for the calculation of the prior methodology are discussed in Section 3.D.8.b above.
2017-2019 for Long-Term YRT – Version 4:

C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020:

For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled; see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.

VM-20 Section 8.C.18 and Guidance Note:

18. For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020:

When the reinsurance ceded or assumed is on a non-guaranteed YRT or similar basis, the corresponding reinsurance cash flows do not need to be modeled. Rather, for a ceding company, the post-reinsurance-ceded DR or SR shall be the pre-reinsurance-ceded DR or SR pursuant to Section 8.D.2, plus any applicable provision pursuant to Section 8.C.15 and Section 8.C.17, minus the NPR reinsurance credit from Section 8.B. For an assuming company, the DR or SR for the business assumed on a non-guaranteed YRT or similar basis shall be set equal to the NPR from Section 3.B.8, plus any applicable provision pursuant to Section 8.C.16 and Section 8.C.17. In the case where there are also other reinsurance arrangements that are not on a non-guaranteed YRT or similar basis, the reinsurance credit shall include the modeled reinsurance credit reflecting those other reinsurance arrangements. In particular, where there are also other reinsurance arrangements that are dependent on the non-guaranteed YRT or similar actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.

Guidance Note: The above method is an interim approach. A longer-term solution to YRT is intended to be adopted by state insurance regulators, after state insurance regulators and industry have had additional time to consider and evaluate the variety of approaches that have been put forward as a potential longer-term solution.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force

Amendment Proposal Form*

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

   Angela McNabb & Pat Allison – NAIC staff support

   Revisions to VM-50 and VM-51 to allow for data experience reporting to be performed by a reinsurer or third-party administrator and a correction to VM-51 Appendix 4.

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


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

   See attached redline document.

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

   This APF is needed for the following reasons:

   1. VM-51 Appendix 4 includes a column indicating the position within the data file for each field. This is not valid as the NAIC’s RDC system was designed to accept comma delimited files. This APF will remove that column.

   2. The VM-51 Section 2.B states that companies must submit data for all their direct written business prior to reinsurance ceded. The only exception is in the case of assumption reinsurance where policies have been legally novated. The NAIC has received feedback from a number of companies indicating that they have business that is reinsured and fully administered by the reinsurer. Since the ceding companies do not have the data, it represents a hardship for them to submit this business.

   3. Currently, VM-51 Appendix 4 only allows one company code. In order to allow a reinsurer or third-party administrator to submit data on behalf of the direct writer, the NAIC must be able to identify both the submitting company and the direct writer of the block of business. This APF adds an additional field to accomplish this. By having the submitting company’s code, any questions the NAIC has regarding the data can be directed to the submitting company without fear of breaching confidentiality.

   4. Having separate identifiers for the submitting company and direct writer will allow the NAIC to validate the reconciliations required by VM-50 Section 4.B.3.

   Below are examples showing how the reconciliations would work according to the amended language in VM-50 Section 4.B.3.

   Example 1: This example illustrates the scenario described in redlined language in VM-50 Section 4.B.3.c. Company A is a direct writer selected for VM-51 reporting.

   o The company has retained and administers 35,000 policies (out of a total of 100,000).
   o Company B (a reinsurer not selected to submit their own business) administers 50,000 policies for Company A.
Experience Reporting Requirements VM-50

- Company C (a reinsurer selected to submit their own direct business) administers 15,000 policies for Company A.

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<th>RECONCILIATION FOR COMPANY A (Direct Writer)</th>
<th>Policy Count</th>
<th>Insurance Amount</th>
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<td>Total Business as Reported in Company A's Annual Statement</td>
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<td>2,500,000,000</td>
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<tr>
<td>Business being reported by Company B</td>
<td>(50,000)</td>
<td>(1,250,000,000)</td>
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<tr>
<td>Business being reported by Company C</td>
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<td>(50,000,000)</td>
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<tr>
<td>Totals included in Company A’s data submissions</td>
<td>35,000</td>
<td>1,200,000,000</td>
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</table>

Example 2: This example illustrates the scenario described in the redlined language in VM-50 Section 4.B.3.a. Company D is another direct writing company selected for VM-51 reporting. Company B has been asked by Companies A and D to submit data Company B has assumed and administers.

- Company B administers 50,000 policies for Company A.
- Company B administers 100,000 policies for Company D.
- Company B is not required to reconcile to their Annual Statement since they were not selected to submit their direct business.
- In this example, Company B is a reinsurer. However, Company B could also be a third-party administrator that is not an insurance company.

<table>
<thead>
<tr>
<th>RECONCILIATION FOR COMPANY B</th>
<th>Policy Count</th>
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<tbody>
<tr>
<td>Business being reported on behalf of Company A</td>
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<tr>
<td>Business being reported on behalf of Company D</td>
<td>100,000</td>
<td>1,500,000,000</td>
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<tr>
<td>Totals included in Company B’s data submission</td>
<td>150,000</td>
<td>2,750,000,000</td>
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</table>

Example 3: This example illustrates the scenario described in redlined language in VM-50 Section 4.B.3.b. Company C has also been asked by company A to submit data Company C has assumed and administers.

- Company C has 1,500,000 policies reported in their Annual Statement.
- Company C has 250,000 of reinsurance assumed policies which should not be included in their submission. Reinsurance assumed should only be included when the ceding company requests that the reinsurer report it on their behalf.
- Company C has 1,250,000 policies of direct written business that they must report.
- In addition to Company C’s direct written business, they will also be reporting 15,000 policies that they administer on behalf of Company A (per Company A’s request).

<table>
<thead>
<tr>
<th>RECONCILIATION FOR COMPANY C</th>
<th>Policy Count</th>
<th>Insurance Amount</th>
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</thead>
<tbody>
<tr>
<td>Total Business as Reported in Company C’s Annual Statement</td>
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<tr>
<td>Assumed Reinsurance Total</td>
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<td>(6,000,000,000)</td>
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<tr>
<td>Subtotal - Direct Written Business for Company C</td>
<td>1,250,000</td>
<td>174,000,000,000</td>
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<tr>
<td>Business being reported on behalf of Company A</td>
<td>15,000</td>
<td>50,000,000</td>
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<tr>
<td>Totals included in Company C’s data submissions</td>
<td>1,265,000</td>
<td>174,050,000,000</td>
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### Dates:

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**Notes:** APF 2021-06
Section 1: Overview

A. Purpose of the Experience Reporting Requirements

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

B. PBR and the Need for Experience Data

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

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

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

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

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

5. The collection of experience data will provide a basis for establishing and updating the assumptions and margins prescribed by regulators in the Valuation Manual.

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

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

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

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

Section 2: Statutory Authority and Experience Reporting Agent

A. Statutory Authority

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

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

3. Section 4A(5) of Model #820 defines the data to be collected to be confidential.

B. Experience Reporting Agent

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

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

Section 3: Experience Reporting Requirements

A. Statistical Plans

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

2. Statistical plans are detailed instructions that define the type of experience data being collected (e.g., mortality; elective policyholder behavior, such as surrenders, lapses,
Experience Reporting Requirements

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

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

B. Role and Responsibilities of the Experience Reporting Agent

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

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

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

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

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

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

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

6. The Experience Reporting Agent will obtain and undergo at least annual external audits to validate that controls with respect to data security and related topics are consistent with industry standards and best practices. The Experience Reporting Agent will provide a copy of any report prepared in connection with such an audit, upon a company’s request. In the event of a material deficiency identified in the external audit or in the event of an identified security breach affecting the Experience Reporting Data, the Experience Reporting Agent shall notify the NAIC, and the states that have directed the Experience Reporting Agent to collect this information, of the nature and extent of such an issue. In the event of an identified security breach affecting Experience Reporting Data, the Experience Reporting Agent shall also notify any insurer whose data was affected. Upon good cause shown, the Experience Reporting Agent will take reasonable actions to protect the data under its control, including that the data submission process may be suspended until the security issue has been remediated. If data submission is suspended under this section, the Experience Reporting Agent will work with the states that have directed collection to issue appropriate guidance modifying the requirements of VM 51, Section 2.D. The term “good cause” shall mean that there is the chance of irreparable harm upon continuing the transmission of the data to the Experience Reporting Agent. Once the security issue has been remediated, the Experience Reporting Agent shall notify the NAIC and the states that have directed the Experience Reporting Agent to collect this information. The Experience Reporting Agent shall work in conjunction with the NAIC and the states that have directed the Experience Reporting Agent to collect this information to develop a revised data submission schedule for any deferred submissions. The revised schedule shall provide for reasonable timing for companies to provide such data.

C. Role of Other Organizations

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

1. Consult with the NAIC (as appropriate) in the design and implementation of the experience retrieval process;
2. Assist with the data validation process for data intended to be forwarded to the SOA or other actuarial professional organizations to develop industry experience tables;
3. Analyze data, including any summarized or aggregated data, produced by the Experience Reporting Agent;
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4. Create initial experience tables and any revised tables;

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

6. Create statutory valuation tables as appropriate and necessary;

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

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

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

Section 4: Data Quality and Ownership

A. General Requirements

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

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

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

B. Specific Requirements

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

2. Each submission of data filed by an insurance company with the Experience Reporting Agent shall be balanced against a set of control totals provided by the company with the data submission. At a minimum, these control totals shall include applicable record counts, claim counts, amounts insured and claim amounts. Any submission that does not balance to the control totals shall be referred to the company for review and resolution.

3. Each company submitting experience data and each company on whose behalf data is being submitted as required in VM-51 will perform a reconciliation between its submitted experience data with its statistical and financial data, and provide an explanation of differences, to the Experience Reporting Agent. The reconciliation must include policy count and insurance amount.
   a. If a third-party administrator that is not an insurance company or an insurance company not required to submit their direct data is submitting data on behalf of an insurance company, the reconciliation will consist of separate lines identifying each insurance company for whom this entity is submitting data.
   b. If the third-party administrator is an insurance company that is required to submit their direct data, the reconciliation must include separate lines identifying each additional company whose data is being submitted.
   c. The reconciliation to company statistical and financial data for both the direct writer and the reinsurer or third-party administrator must include lines indicating the amount of business that is being reported by the reinsurer or third-party administrator. The NAIC will use this information to confirm that all in-scope business is reported and there is no double counting of policies.

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

5. Where quality would not appear to be significantly compromised, the Experience Reporting Agent may use records with missing or invalid data if such invalid or missing data do not involve a field that is relevant or would affect the credibility of the report. For companies with a body of data for a state, line of business, product type or observation period that fails to meet these standards, the Experience Reporting Agent will use its discretion, with regulatory disclosure of key decisions made, regarding the omission of the entire body of data or only including records with valid data. Completeness of reports is desirable, but not at the risk of including a body of data that appears to have an unreasonably high chance of significant errors.
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6. Errors of a consistent nature are referred to as “systematic.” Incorrect coding instructions can introduce errors of a consistent nature. Programming errors within the data processing system of insurer company can also produce systematic miscoding as the system converts data to the required formats for experience reporting. Most systematic errors will produce data that, when reviewed using tests designed to reveal various types of systematic errors, will appear unreasonable and likely to be in error. In addition, some individual coding errors may produce erroneous results that show up when exposures and losses are compared in a systematic fashion. Such checking often cannot, however, provide a conclusive indication that data with unusual patterns is incorrect. The Experience Reporting Agent will perform tests and look at trends using previously reported data to determine if systematic errors or unusual patterns are occurring.

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

8. At a minimum, reasonability checks by the Experience Reporting Agent will include:
   a. An unusually large percentage of company data reported under a single or very limited number of categories;
   b. Unusual or unlikely reporting patterns in a company’s data;
   c. Claim amounts that appear unusually high or low for the corresponding exposures;
   d. Reported claims without corresponding policy values and exposures;
   e. Unreasonable loss frequencies or amounts in comparison to ranges of expectation that recognize statistical fluctuation;
   f. Unusual shifts in the distribution of business from one reporting period to the next.

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

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

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

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

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

C. Ownership of Data

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

2. The Experience Reporting Agent will be responsible for maintaining data, error reports, logs and other intermediate work products, and reports for use in processing, documentation, production and reproduction of reports provided to state insurance regulators in accordance with the Valuation Manual. The Experience Reporting Agent will be responsible for demonstrating such reproducibility at the request of state insurance regulators or an auditor designated by state insurance regulators.

Section 5: Experience Data

A. Introduction

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

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

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

B. Design of Reports Linked to Purpose

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

C. Basic Report Designs

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

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

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

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

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

D. Supplemental Reports

1. For specific lines of business and types of experience data, state insurance regulators may request additional reports from the Experience Reporting Agent. State insurance regulators also may request custom reports, which may contain specific data or experience not regularly produced in other reports.
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2. The regulator and the Experience Reporting Agent must negotiate time schedules for producing supplemental reports. The information in these reports is limited by the amount of data actually available and the manner in which it has been reported.

E. Reports to State Insurance Departments

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

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

Section 6: Confidentiality of Data

A. Confidentiality of Experience Data

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

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

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

B. Treatment of Confidential Information

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

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

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

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

c. The NAIC, and its affiliates and subsidiaries;

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

e. Other individuals or entities, including contractors or subcontractors of the Experience Reporting Agent, otherwise assisting the Experience Reporting Agent or state insurance regulators in fulfilling the purposes of VM-50. These other individuals or entities may provide services related to a variety of areas of expertise, such as assisting with performing industry experience studies, developing valuation mortality tables, data editing and data quality review. These other individuals and entities shall be subject to the same standards as the Experience Reporting Agent with respect to the maintenance of confidential information.
VM-51: Experience Reporting Formats

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Section 1: Introduction

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

B. Each statistical plan shall contain the following information:

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

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

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

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

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

6. The experience data reports to be produced.

Section 2: Statistical Plan for Mortality

A. Type of Experience Collected Under This Statistical Plan
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The type of experience to be collected under this statistical plan is mortality experience.

B. Scope of Business Collected Under This Statistical Plan

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

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

   a. As defined in VM-50 Section 4.B.3, the reconciliation to company statistical and financial data for both the direct writing company and all reinsurers and/or third-party administrators must include lines indicating the amount of business that is being reported by the reinsurers and/or third-party administrators. The Experience Reporting Agent will compare the reconciliations for all business submitted by the direct writer and any reinsurers and/or third-party administrators to ensure that all business is included and there is no double counting of policies.

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

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

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

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

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

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

Data for this statistical plan for mortality will be compiled using a calendar year method. The reporting calendar year is the calendar year that the company submits the experience data. The observation calendar year is the calendar year of the experience data that is reported. The observation calendar year will be two years prior to the reporting calendar year. For example, if the current calendar year is 2018 and that is the reporting calendar year, the company is to report the experience data that was in-force or issued in calendar year 2016, which is the observation calendar year.

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

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

ii. Report terminations that were incurred in calendar year 20XX and reported before July 1, 20XX+1. However, exclude rescinded policies (e.g., 10-day free look exercises) from the data submission.

For any reporting calendar year, the data call will occur during the second quarter, and data is to be submitted according to the requirements of the Valuation Manual in effect during that calendar year. Data submissions must be made by Sept. 30 of the reporting calendar year. Corrections of data submissions must be completed by Dec. 31 of the reporting calendar year.

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

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

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

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

Generally, each policy number represents a policy issued as a result of ordinary underwriting. If a single life policy, the base policy on a single life has the policy number and a segment number of 1. On a joint life policy, each life has separate records with the same policy number. The base policy on the first life has a segment number of 1, and the base policy on the second life has a segment number of 2. Policies that cover more than two lives are not to be submitted.
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Term/paid up riders or additional amounts of insurance purchased through dividend options on a policy issued as a result of ordinary underwriting are to be submitted. Each rider is on a separate record with the same policy number as the base policy and has a unique segment number. The details on the rider record may differ from the corresponding details on the base policy record. If underwriting in addition to the base policy underwriting is done, the coverage is given its own policy number.

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

Plans of insurance should be carefully matched with the three-digit codes in item 19, Plan. These plans of insurance are important because they will be used not only for mortality experience data collection, but also for policyholder behavior experience data collection. It is expected that most policies will be matched to three-digit codes that specify a particular policy type rather than select a code that indicates a general plan type.

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

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

ii. For policies issued on or after Jan. 1, 1990, companies must:
   a) Document the percentage that the face amount of policies excluded are relative to the face amount of submitted policies issued on or after Jan. 1, 1990; and
   b) Certify that this requirement presents a hardship due to fields not readily available in their systems/databases or legacy computer systems that continue to be used for older issued policies and differ from computer systems for newer issued policies.

F. Experience Data Reports Required by This Statistical Plan

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

2. The Experience Reporting Agent will provide to the SOA or other actuarial professional organizations an experience data report of aggregated experience that does not disclose a company’s identity, which will be used to develop industry mortality experience and valuation mortality tables.
3. As long as a company is licensed in a state, that state insurance regulator will be given access to a company’s experience data that is stored on a confidential database at the Experience Reporting Agent. Access by the state insurance regulator will be controlled by security credentials issued to the state insurance regulator by the Experience Reporting Agent.
Appendix 1: Preferred Class Structure Questionnaire

PREFERRED CLASS STRUCTURE QUESTIONNAIRE

Fill out this preferred class structure questionnaire based on companywide summaries, such as underwriting guideline manuals, compilations of issue instructions or other documentation.

The purpose of this preferred class structure questionnaire is to gather information on different preferred class structures. This questionnaire varies between nonsmoker/non-tobacco and smoker/tobacco users and provides for variations by issue year, face amount and plan. If the company has the standard Relative Risk Score (RR Score) information available, the company should map its set of preferred class structure to sets of RR Scores. Except for new preferred class structures or new sets of RR Scores applied to existing preferred class structure(s), the response to the questionnaire should remain the same from year to year.

If a company has determined sets of RR Scores for its preferred class structures, it should provide separate preferred class structure responses for each set of RR Scores applied to a preferred class structure. If a company has not determined sets of RR Scores for its preferred class structures, it should fill out this questionnaire with its preferred class structures and update the preferred class structure questionnaire at such future time that sets of RR Scores for the preferred class structures are determined. When sets of RR Scores are used, there is to be a one-to-one correspondence between a preferred class structure and a set of RR Scores.

The information given in this questionnaire will be used both to map a set of RR Scores to policy level data and as a check on the policy-level data submission. Submit this questionnaire along with the initial data submission to the Experience Reporting Agent.

Each preferred class structure must include at least two classes (e.g., one preferred class and one standard class). Make as many copies of this preferred class structure questionnaire as necessary for your individual life business and submit in addition to policy-level detail information.

<table>
<thead>
<tr>
<th>Company</th>
<th>NAIC Company Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Date</td>
</tr>
</tbody>
</table>

PREFERRED CLASS STRUCTURE – Part 1 Nonsmokers/Non-Tobacco Users

Preferred class structure must have at least one preferred and one standard class. Use multiple copies of this page if needed for nonsmokers/non-tobacco users

Number of Nonsmoker/Non-Tobacco User Risk Classes

- a) Issue Date Range Date through Date
- b) Issue Age Range Date through Date
- c) Face Amount Range Date through Date
- d) Plan Types (use three-digit codes from item 19, Plan)

Number of Nonsmoker/Non-Tobacco User Risk Classes

- a) Issue Date Range Date through Date
- b) Issue Age Range Date through Date
- c) Face Amount Range Date through Date
- d) Plan Types (use three-digit codes from item 19, Plan)
Experience Reporting Formats

Number of Nonsmoker/Non-Tobacco User Risk Classes

a) Issue Date Range \( \text{Date through Date} \)
b) Issue Age Range \( \text{Date through Date} \)
c) Face Amount Range \( \text{Date through Date} \)
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Nonsmoker/Non-Tobacco User Risk Classes

a) Issue Date Range \( \text{Date through Date} \)
b) Issue Age Range \( \text{Date through Date} \)
c) Face Amount Range \( \text{Date through Date} \)
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Nonsmoker/Non-Tobacco User Risk Classes

a) Issue Date Range \( \text{Date through Date} \)
b) Issue Age Range \( \text{Date through Date} \)
c) Face Amount Range \( \text{Date through Date} \)
d) Plan Types (use three-digit codes from item 19, Plan)

PREFERRED CLASS STRUCTURE – Part 2 Smokers/Tobacco Users

Preferred class structure must have at least one preferred and one standard class. Use multiple copies of this page if needed for smokers/tobacco users

Number of Smoker/Tobacco User Risk Classes

a) Issue Date Range \( \text{Date through Date} \)
b) Issue Age Range \( \text{Date through Date} \)
c) Face Amount Range \( \text{Date through Date} \)
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

a) Issue Date Range \( \text{Date through Date} \)
b) Issue Age Range \( \text{Date through Date} \)
c) Face Amount Range \( \text{Date through Date} \)
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

a) Issue Date Range \( \text{Date through Date} \)
b) Issue Age Range \( \text{Date through Date} \)
c) Face Amount Range \( \text{Date through Date} \)
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

a) Issue Date Range \( \text{Date through Date} \)
b) Issue Age Range \( \text{Date through Date} \)
c) Face Amount Range \( \text{Date through Date} \)
d) Plan Types (use three-digit codes from item 19, Plan)
Experience Reporting Formats

Number of Smoker/Tobacco User Risk Classes

a) Issue Date Range \textit{Date} through \textit{Date}
b) Issue Age Range \textit{Date} through \textit{Date}
c) Face Amount Range \textit{Date} through \textit{Date}
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

a) Issue Date Range \textit{Date} through \textit{Date}
b) Issue Age Range \textit{Date} through \textit{Date}
c) Face Amount Range \textit{Date} through \textit{Date}
d) Plan Types (use three-digit codes from item 19, Plan)
Appendix 2: Mortality Claims Questionnaire

MORTALITY CLAIMS QUESTIONNAIRE

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

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

<table>
<thead>
<tr>
<th>Company</th>
<th>NAIC Company Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Date</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MORTALITY CLAIMS

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

2. The death claim amounts are to be for the total face amount and on a gross basis (before reinsurance). The data is based on:
   a. Total face amount (for policies that include the cash value in addition to the face amount as a death benefit, use only the face amount) as specified OR Other (describe):
      If not as specified, indicate time period for which this occurred ___________ - _______
   b. Gross basis (before reinsurance) as specified OR Other (describe):
      If not as specified, indicate time period for which this occurred: ___________ - _______
      Is this the same basis used for face amounts included in the study data? Yes No

3. The date that the termination is reported is to be used for the termination reported date. The date that the termination actually occurred is to be used for the actual termination date. What dates are used for death claims in the study data with respect to?
   a) Termination reported date
      If not reported date, indicate basis for dates provided
      Reported date Other (describe):
   b) Actual termination date for death claims:
      Date of death Other (describe):
      If not date of death, indicate basis for dates provided

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

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

If no indicate time period for which this occurred: __________________

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

   Yes  No

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

6. For death claims on policies issued before 1990:

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

   If no, indicate approach used:

7. Please briefly describe any other unique aspects of the death claims data that are not covered above.
Appendix 3: Additional Plan Code Form

If you need an additional plan code(s) for a product(s) in addition to those plan codes in Item 19, Plan, of the statistical plan for life insurance mortality, fill in this form using plan codes in the range 300 to 999. Your data submission should reflect the plan codes in this form. Make as many copies as necessary for your individual life business and submit in addition to policy-level information. When this form is used, it must be sent to the Experience Reporting Agent at the time that data is submitted.

Completed by: ______________________ Title: _______________________________
Company:__________________________ NAIC Company Code: ________________ Date: ______
Phone Number: _____________________ Email:_______________________________

Add comments or attachments where necessary.

Enter unique three-digit plan codes for each product.

<table>
<thead>
<tr>
<th>Plan Code For Product I</th>
<th>Plan Code for Product II</th>
<th>Plan Code for Product III</th>
</tr>
</thead>
</table>

Enter specific plan names for each product.

A. General Product Information

<table>
<thead>
<tr>
<th>1. In what year was each product introduced?</th>
<th>Product I</th>
<th>Product II</th>
<th>Product III</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Briefly describe the product.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Enter three-digit plan code in the range 300 to 999.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
For the products listed, please fit each product into one of the categories below.

<table>
<thead>
<tr>
<th>Categories for Product I</th>
<th>Categories for Product II</th>
<th>Categories for Product III</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Traditional Whole Life Plans</td>
<td>1 Traditional Whole Life Plans</td>
<td>1 Traditional Whole Life Plans</td>
</tr>
<tr>
<td>2 Term Insurance Plans</td>
<td>2 Term Insurance Plans</td>
<td>2 Term Insurance Plans</td>
</tr>
<tr>
<td>5 Variable Life Plans (without Secondary Guarantees)</td>
<td>5 Variable Life Plans (without Secondary Guarantees)</td>
<td>5 Variable Life Plans (without Secondary Guarantees)</td>
</tr>
<tr>
<td>6 Variable Life Plans with Secondary Guarantees</td>
<td>6 Variable Life Plans with Secondary Guarantees</td>
<td>6 Variable Life Plans with Secondary Guarantees</td>
</tr>
<tr>
<td>7 Nonforfeiture</td>
<td>7 Nonforfeiture</td>
<td>7 Nonforfeiture</td>
</tr>
<tr>
<td>8 Other</td>
<td>8 Other</td>
<td>8 Other</td>
</tr>
</tbody>
</table>
### Appendix 4: Mortality Data Elements and Format

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>LENGTH</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1-9</td>
<td>9</td>
<td>Submitting Company ID</td>
<td>ID number representing the company submitting this file. If the company has an NAIC Company Code, then that code must be used. If the company does not have an NAIC Company Code, the company’s Federal Employer Identification Number (FEIN) must be used. If the direct writer is the company submitting the data, items 1 and 2 must contain the same value.</td>
</tr>
<tr>
<td>2</td>
<td>10-29</td>
<td>5</td>
<td>NAIC Company Code of the Direct Writer of Business</td>
<td>The NAIC Company Code of the company that wrote the business being reported. In the case of assumption reinsurance where the assuming company is legally responsible for all benefits and claims paid, the assuming company is considered to be the direct writer. If the direct writer is the company submitting the data file, items 1 and 2 must contain the same value.</td>
</tr>
<tr>
<td>3</td>
<td>30-32</td>
<td>4</td>
<td>Observation Year</td>
<td>Enter Calendar Year of Observation</td>
</tr>
<tr>
<td>4</td>
<td>33-34</td>
<td>20</td>
<td>Policy Number</td>
<td>Enter Policy Number. For Policy Numbers with length less than 20, left justify the number, and blank fill the empty columns. Any other unique identifying number can be used instead of a Policy Number for privacy reasons.</td>
</tr>
<tr>
<td>5</td>
<td>35-37</td>
<td>3</td>
<td>Segment Number</td>
<td>If only one policy segment exists, enter segment number ‘1.’ For a single life policy, the base policy is to be put in the record with segment number ‘1.’ Subsequent policy segments are in separate records with information about that coverage and differing segment numbers. For joint life policies, the base policy of the first life is to be put in a record with segment number ‘1,’ and the base policy of the second life is to be put in a separate record with segment number ‘2.’ Joint life policies with more than two lives are not to be submitted. Subsequent policy segments are in separate records with information about that coverage and differing segment numbers. Policy segments with the same policy number are to be submitted for: a) Single life policies; b) Joint life policies; c) Term/paid up riders; or d) Additional amounts of insurance including purchase through dividend options.</td>
</tr>
<tr>
<td>6</td>
<td>38-40</td>
<td>2</td>
<td>State of Issue</td>
<td>Use standard, two-letter state abbreviation codes (e.g., NY for New York).</td>
</tr>
<tr>
<td>ITEM</td>
<td>COLUMN</td>
<td>LENGTH</td>
<td>DATA ELEMENT</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>------</td>
<td>--------</td>
<td>--------</td>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>7</td>
<td>25</td>
<td>1</td>
<td>Gender</td>
<td>0 = Unknown or unable to subdivide 1 = Male 2 = Female 3 = Unisex – Unknown or unable to identify 4 = Unisex – Male 5 = Unisex – Female</td>
</tr>
<tr>
<td>8</td>
<td>26-33</td>
<td>8</td>
<td>Date of Birth</td>
<td>Enter the numeric date of birth in YYYYMMDD format</td>
</tr>
<tr>
<td>9</td>
<td>44</td>
<td>1</td>
<td>Age Basis</td>
<td>0 = Age Nearest Birthday 1 = Age Last Birthday 2 = Age Next birthday</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Drafting Note:</strong> Professional actuarial organization will need to develop either age next birthday mortality tables or procedure to adapt existing mortality tables to age next birthday basis.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>45-47</td>
<td>3</td>
<td>Issue Age</td>
<td>Enter the insurance Issue Age</td>
</tr>
<tr>
<td>11</td>
<td>48-55</td>
<td>8</td>
<td>Issue Date</td>
<td>Enter the numeric calendar year in YYYYMMDD format.</td>
</tr>
<tr>
<td>12</td>
<td>56</td>
<td>1</td>
<td>Smoker Status (at issue)</td>
<td>Smoker status should be submitted where reliable. 0 = Unknown 1 = No tobacco usage 2 = Nonsmoker 3 = Cigarette smoker 4 = Tobacco user</td>
</tr>
<tr>
<td>13</td>
<td>57</td>
<td>1</td>
<td>Preferred Class Structure Indicator</td>
<td>0 = If no reliable information on multiple preferred and standard classes is available or if the policy segment was issued substandard or if there were no multiple preferred and standard classes available for this policy segment or if preferred information is unknown. 1 = If this policy was issued in one of the available multiple preferred and standard classes for this policy segment. Note: If Preferred Class Structure Indicator is 0, or if preferred information is unknown, leave next four items blank.</td>
</tr>
<tr>
<td>14</td>
<td>58</td>
<td>1</td>
<td>Number of Classes in Nonsmoker Preferred Class Structure</td>
<td>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 3 or 4, or if preferred information is unknown, leave blank. For nonsmoker or no tobacco usage policies that could have been issued as one of multiple preferred and standard classes, enter the number of nonsmoker preferred and standard classes available at time of issue.</td>
</tr>
<tr>
<td>ITEM</td>
<td>COLUMN</td>
<td>LENGTH</td>
<td>DATA ELEMENT</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>------</td>
<td>--------</td>
<td>--------</td>
<td>--------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| 15   | 55     | 1      | Nonsmoker Preferred Class | If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 3 or 4, or if preferred information is unknown, leave blank. For nonsmoker policy segments that could have been issued as one of multiple preferred and standard classes: 
1 = Best preferred class 
2 = Next Best preferred class after 1 
3 = Next Best preferred class after 2 
4 = Next Best preferred class after 3 
5 = Next Best preferred class after 4 
6 = Next Best preferred class after 5 
7 = Next Best preferred class after 6 
8 = Next Best preferred class after 7 
9 = Next Best preferred class after 8 
Note: The policy segment with the highest nonsmoker Preferred Class number should have that number equal to the Number of Classes in Nonsmoker Preferred Class Structure. |
| 16   | 66     | 1      | Number of Classes in Smoker Preferred Class Structure | If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 1 or 2, or if preferred information is unknown, leave blank. For smoker or tobacco user policies that could have been issued as one of multiple preferred and standard classes, enter the number of smoker preferred and standard classes available at time of issue. |
| 17   | 64     | 1      | Smoker Preferred Class | If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 1 or 2, or if preferred information is unknown, leave blank. For smoker policy segments that could have been issued as one of multiple preferred and standard classes: 
1 = Best preferred class 
2 = Next Best preferred class after 1 
3 = Next Best preferred class after 2 
4 = Next Best preferred class after 3 
5 = Next Best preferred class after 4 
6 = Next Best preferred class after 5 
7 = Next Best preferred class after 6 
8 = Next Best preferred class after 7 
9 = Next Best preferred class after 8 
Note: The policy segment with the highest Smoker Preferred Class number should have that number equal to the Number of Classes in Smoker Preferred Class Structure. |
### Experience Reporting Formats VM-51

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>LENGTH</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| 18   | 62-63  | 2      | Type of Underwriting Requirements | If underwriting requirement of ordinary business is reliably known, use code other than “99.” Ordinary business does not include separate lines of business, such as simplified issue/guaranteed issue, worksite, individually solicited group life, direct response, final expense, preneed, home service and COLI/BOLI/CHOLI.  
- 01 = Underwritten, but unknown whether fluid was collected  
- 02 = Underwritten with no fluid collection  
- 03 = Underwritten with fluid collected  
- 06 = Term Conversion  
- 07 = Group Conversion  
- 09 = Not Underwritten  
- 99 = For issues where underwriting requirement unknown or unable to subdivide |
| 19   | 64     | 1      | Substandard Indicator | 0 = Policy segment is not substandard  
1 = Policy segment is substandard  
2 = Policy segment is uninsurable  

Note:  
- a. All policy segments that are substandard need to be identified as substandard or uninsurable.  
- b. Submission of substandard policies is optional.  
- c. If feasible, identify substandard policy segments where temporary flat extra has ceased as substandard. |
| 20   | 65-67  | 3      | Plan | Exclude from contribution: spouse and children under family policies or riders. If Form for Additional Plan Codes was submitted for this policy, enter unique three-digit plan number(s) that differ from the plan numbers below:  
- 000 = If unable to distinguish among plan types listed below  
- 100 = Joint life plan unable to distinguish among joint life plan types listed below  

**Permanent Plans:**  
- 010 = Traditional fixed premium fixed benefit permanent plan  
- 011 = Permanent life (traditional) with term  
- 012 = Single premium whole life  
- 013 = Econolife (permanent life with lower premiums in the early durations)  
- 014 = Excess interest whole life  
- 015 = First to die whole life plan (submit separate records for each life)  
- 016 = Second to die whole life plan (submit separate records for each life)  
- 017 = Joint whole life plan – unknown whether 015 or 016 (submit separate records for each life) |
Experience Reporting Formats

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>018</td>
<td>Permanent products with non-level death benefits</td>
</tr>
<tr>
<td>019</td>
<td>Permanent plans 010, 011, 012, 013, 014, 015, 016, 017, 018 combined (i.e. unable to separate)</td>
</tr>
</tbody>
</table>

**Term Insurance Plans:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>020</td>
<td>Term (traditional level benefit and attained age premium)</td>
</tr>
<tr>
<td>021</td>
<td>Term (level death benefit with guaranteed level premium for five years and anticipated level term period for five years)</td>
</tr>
<tr>
<td>211</td>
<td>Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 10 years)</td>
</tr>
<tr>
<td>212</td>
<td>Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 15 years)</td>
</tr>
<tr>
<td>213</td>
<td>Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 20 years)</td>
</tr>
<tr>
<td>214</td>
<td>Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>215</td>
<td>Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>022</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 10 years)</td>
</tr>
<tr>
<td>221</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 15 years)</td>
</tr>
<tr>
<td>222</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 20 years)</td>
</tr>
<tr>
<td>223</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>224</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>023</td>
<td>Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 15 years)</td>
</tr>
<tr>
<td>231</td>
<td>Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 20 years)</td>
</tr>
<tr>
<td>232</td>
<td>Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>233</td>
<td>Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>024</td>
<td>Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 20 years)</td>
</tr>
</tbody>
</table>
## Experience Reporting Formats

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>241</td>
<td>Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>242</td>
<td>Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>025</td>
<td>Term (level death benefit with guaranteed level premium for 25 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>251</td>
<td>Term (level death benefit with guaranteed level premium for 25 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>026</td>
<td>Term (level death benefit with guaranteed level premium for 30 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>027</td>
<td>Term (level death benefit with guaranteed level premium period equal to anticipated level term period where the period is other than five, 10, 15, 20, 25 or 30 years)</td>
</tr>
<tr>
<td>271</td>
<td>Term (level death benefit with guaranteed level premium period not equal to anticipated level term period, where the periods are other than five, 10, 15, 20, 25 or 30 years)</td>
</tr>
<tr>
<td>028</td>
<td>Term (decreasing benefit)</td>
</tr>
<tr>
<td>040</td>
<td>Select ultimate term (premium depends on issue age and duration)</td>
</tr>
<tr>
<td>041</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for 15 years)</td>
</tr>
<tr>
<td>042</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for 20 years)</td>
</tr>
<tr>
<td>043</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for 25 years)</td>
</tr>
<tr>
<td>044</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for 30 years)</td>
</tr>
<tr>
<td>045</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for period other than 15, 20, 25 or 30 years)</td>
</tr>
<tr>
<td>046</td>
<td>Economatic term</td>
</tr>
<tr>
<td>059</td>
<td>Term plan, unable to classify</td>
</tr>
<tr>
<td>101</td>
<td>First to die term plan (submit separate records for each life)</td>
</tr>
<tr>
<td>102</td>
<td>Second to die term plan (submit separate records for each life)</td>
</tr>
<tr>
<td>103</td>
<td>Joint term plan – unknown whether 101 or 102 (submit separate records for each life)</td>
</tr>
</tbody>
</table>

### Universal Life Plans (Other than Variable), issued without a Secondary Guarantee:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>061</td>
<td>Single premium universal life</td>
</tr>
<tr>
<td>062</td>
<td>Universal life (decreasing risk amount)</td>
</tr>
<tr>
<td>063</td>
<td>Universal life (level risk amount)</td>
</tr>
<tr>
<td>064</td>
<td>Universal life – unknown whether code 062 or 063</td>
</tr>
<tr>
<td>065</td>
<td>First to die universal life plan (submit separate records for each life)</td>
</tr>
<tr>
<td>066</td>
<td>Second to die universal life plan (submit separate records for each life)</td>
</tr>
</tbody>
</table>
### Experience Reporting Formats

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>067</td>
<td>Joint life universal life plan – unknown whether code 065 or 066 (submit separate records for each life)</td>
</tr>
<tr>
<td>068</td>
<td>Indexed universal life</td>
</tr>
</tbody>
</table>

**Universal Life Plans (Other than Variable) with Secondary Guarantees:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>071</td>
<td>Single premium universal life with secondary guarantees</td>
</tr>
<tr>
<td>072</td>
<td>Universal life with secondary guarantees (decreasing risk amount)</td>
</tr>
<tr>
<td>073</td>
<td>Universal life with secondary guarantees (level risk amount)</td>
</tr>
<tr>
<td>074</td>
<td>Universal life with secondary guarantees – unknown whether code 072 or 073</td>
</tr>
<tr>
<td>075</td>
<td>First to die universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td>076</td>
<td>Second to die universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td>077</td>
<td>Joint life universal life plan with secondary guarantees unknown whether code 075 or 076 (submit separate records for each life)</td>
</tr>
<tr>
<td>078</td>
<td>Indexed universal life with secondary guarantees</td>
</tr>
</tbody>
</table>

**Variable Life Plans issued without a Secondary Guarantee:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>080</td>
<td>Variable life</td>
</tr>
<tr>
<td>081</td>
<td>Variable universal life (decreasing risk amount)</td>
</tr>
<tr>
<td>082</td>
<td>Variable universal life (level risk amount)</td>
</tr>
<tr>
<td>083</td>
<td>Variable universal life – unknown whether code 081 or 082</td>
</tr>
<tr>
<td>084</td>
<td>First to die variable universal life plan (submit separate records for each life)</td>
</tr>
<tr>
<td>085</td>
<td>Second to die variable universal life plan (submit separate records for each life)</td>
</tr>
<tr>
<td>086</td>
<td>Joint life variable universal life plan – unknown whether 084 or 085 (submit separate records for each life)</td>
</tr>
</tbody>
</table>

**Variable Life Plans with Secondary Guarantees:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>090</td>
<td>Variable life with secondary guarantees</td>
</tr>
<tr>
<td>091</td>
<td>Variable universal life with secondary guarantees (decreasing risk amount)</td>
</tr>
<tr>
<td>092</td>
<td>Variable universal life with secondary guarantees (level risk amount)</td>
</tr>
<tr>
<td>093</td>
<td>Variable universal life with secondary guarantees – unknown whether code 091 or 092</td>
</tr>
<tr>
<td>094</td>
<td>First to die variable universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td>095</td>
<td>Second to die variable universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td></td>
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<td>---</td>
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<tr>
<td>21</td>
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<tr>
<td>22</td>
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<tr>
<td>23</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td></td>
</tr>
</tbody>
</table>

096 = Joint life variable universal life plan with secondary guarantees – unknown whether code 094 or 095 (submit separate records for each life)

**Nonforfeiture:**
098 = Extended term
099 = Reduced paid-up
198 = Extended term for joint life (submit separate records for each life)
199 = Reduced paid-up for joint life (submit separate records for each life)
### Experience Reporting Formats VM-51

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Column 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>117–124</td>
<td>8</td>
<td>Termination Reported Date If In-force Indicator is 1, leave blank. Enter in the format YYYYMMDD the eight-digit calendar date that the termination was reported.</td>
</tr>
<tr>
<td>27</td>
<td>125–132</td>
<td>8</td>
<td>Actual Termination Date If In-force Indicator is 1, leave blank. Enter in the format YYYYMMDD the eight-digit calendar date when the termination occurred. If termination is due to death (Cause of Termination is 04), enter actual date of death. If termination is lapse due to non-payment of premium (Cause of Termination is 01 or 02 or 14), enter the last day the premium was paid to.</td>
</tr>
<tr>
<td>28</td>
<td>133–134</td>
<td>2</td>
<td>Cause of Termination If Inforce Indicator is 1, leave blank. 00 = Termination type unknown or unable to subdivide 01 = Reduced paid-up 02 = Extended term 03 = Voluntary; unable to subdivide among 01, 02, 07, 09, 10, 11 or 13 04 = Death 07 = 1035 exchange 09 = Term conversion – unknown whether attained age or original age 10 = Attained age term conversion 11 = Original age term conversion 12 = Coverage expired or contract reached end of the mortality table 13 = Surrendered for full cash value 14 = Lapse (other than to Reduced Paid Up or Extended Term) 15 = Termination via payment of a discounted face amount while still alive, pursuant to an accelerated death benefit provision</td>
</tr>
<tr>
<td>29</td>
<td>135–144</td>
<td>10</td>
<td>Annualized Premium at Issue For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, enter the annualized premium set at issue. Except for level term segments specified above, leave blank for non-base segments. For the base segments for ULSG, and Variable Life with Secondary Guarantees (VLSG) with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, enter the annualized billed premium set at issue. Round to the nearest dollar. If unknown, leave blank.</td>
</tr>
<tr>
<td>30</td>
<td>145–154</td>
<td>10</td>
<td>Annualized Premium at the Beginning of Observation Year For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, enter the annualized premium for the policy year that includes the beginning of the observation year.</td>
</tr>
</tbody>
</table>
## Experience Reporting Formats

**VM-51**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>155–164</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Annualized Premium at the End of Observation, if available. Otherwise Annualized Premium as of Year/Actual Termination Date</td>
<td>Except for level term segments specified above, leave blank for non-base segments. For the base segments for ULSG and VLSG with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, enter the annualized billed premium for the policy year that includes the beginning of the observation year. Round to the nearest dollar. For policies issued in the observation year, leave blank. If unknown, leave blank. For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, for each segment that has Item 20, with the Inforce Indicator = 1, enter the annualized premium for the policy year that includes the end of the observation year. Otherwise, enter the annualized premium that would have been paid at the end of the observation year. If end of year premium is not available, enter the annualized premium as of the Actual Termination Date (Item 26). Except for level term segments specified above, leave blank for non-base segments. For the base segments for ULSG and VLSG with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, use the annualized billed premium. For base segments that have Item 20, with the Inforce Indicator = 1, enter the annualized billed premium for the policy year that includes the end of the observation year. Otherwise, enter the annualized billed premium that would have been paid at the end of the observation year. If end of year premium is not available, enter the annualized premium as of the Actual Termination Date (Item 26). Round to the nearest dollar. If unknown, leave blank.</td>
</tr>
</tbody>
</table>

| 32 | 165–166 | 2 |
|   | Premium Mode | 01 = Annual  
02 = Semiannual  
03 = Quarterly  
04 = Monthly Bill Sent  
05 = Monthly Automatic Payment  
06 = Semi-monthly  
07 = Biweekly  
08 = Weekly  
09 = Single Premium  
10 = Other / Unknown |

<p>| 33 | 167–176 | 10 |
|   | Cumulative Premium Collected as of the Beginning of Observation Year | If not ULSG or VLSG, leave blank. For ULSG, and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: |</p>
<table>
<thead>
<tr>
<th>Column 1</th>
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<th>Column 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>34</td>
<td>177-186</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Experience Reporting Formats VM-51**

1) For non-base segments, leave blank.
2) For base segments, enter the cumulative premium collected since issue, as of the beginning of the observation year. Round to the nearest dollar.
For policies issued in the observation year, leave blank. If unknown, leave blank.

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td>187-188</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ULSG/VLSG Premium Type**

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>189-190</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Type of Secondary Guarantee**

For non-base segments, leave blank.
If not ULSG or VLSG, leave blank.
For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:
- 00 = Unknown
- 01 = Single premium
- 02 = ULSG/VLSG Whole life level premium
- 03 = Lower premium (term like)
- 04 = Other
For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:
- 00 = Unknown
- 01 = Cumulative Premium without Interest (Single Tier)
- 02 = Cumulative Premium without Interest (Multiple Tier)
- 03 = Cumulative Premium without Interest (Other)
- 04 = Cumulative Premium with Interest (Single Tier)
- 05 = Cumulative Premium with Interest (Multiple Tier)
- 06 = Cumulative Premium with Interest (Other)
- 11 = Shadow Account (Single Tier)
### Experience Reporting Formats VM-51

<table>
<thead>
<tr>
<th></th>
<th>Column Headings</th>
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</thead>
<tbody>
<tr>
<td>12</td>
<td>Shadow Account (Multiple Tier)</td>
</tr>
<tr>
<td>13</td>
<td>Shadow Account (Other)</td>
</tr>
<tr>
<td>21</td>
<td>Both Cumulative Premium without Interest and Shadow Account</td>
</tr>
<tr>
<td>22</td>
<td>Both Cumulative Premium with Interest and Shadow Account</td>
</tr>
<tr>
<td>23</td>
<td>Other, not involving either Cumulative Premium or Shadow Account</td>
</tr>
</tbody>
</table>

#### 37 101-200

**Cumulative Minimum Premium as of the Beginning of Observation Year**

- If not ULSG or VLSG, leave blank.
- For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:
  - If Item 35, Type of Secondary Guarantee is blank, 00, 11, 12, 13 or 23, leave blank.
  - If Item 35, Type of Secondary Guarantee is 01, 02, 03, 04, 05, 06, 21 or 22:
    1) Leave non-base segments, blank.
    2) For base segments:
       - Enter the cumulative minimum premiums, including applicable interest, for all policy years up to the beginning of the observation year.
  
Round to the nearest dollar.

- For policies issued in the observation year, leave blank.
- If unknown, leave blank.

#### 38 201-210

**Cumulative Minimum Premium as of the End of Observation Year/Actual Termination Date**

- If not ULSG or VLSG, leave blank.
- For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan:
  - If Item 35, Type of Secondary Guarantee is blank, 00, 11, 12, 13 or 23, leave blank.
  - If Item 35, Type of Secondary Guarantee is 01, 02, 03, 04, 05, 06, 21 or 22:
    1) For non-base segments, leave blank.
    2) For base segments in force at the end of the observation year, enter the cumulative minimum premiums, including applicable interest, up to the end of the observation year.
    3) For base segments terminated during the observation year, enter the cumulative minimum premiums, including applicable interest, up to the Actual Termination Date (Item 26)

Round to the nearest dollar.
### Experience Reporting Formats

<table>
<thead>
<tr>
<th>Experience Reporting Formats</th>
<th>VM-51</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Calculation Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>39</td>
<td>Amount at the Beginning of Observation Year</td>
<td>If not ULSG, or VLSG, leave blank. For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: If Item 35, Type of Secondary Guarantee is blank, 00, 01, 02, 03, 04, 05, 06, or 23 leave blank. If Item 35, Type of Secondary Guarantee is 11, 12, 13, 21 or 22: 1) Leave non-base segments blank. 2) For base segments: Enter total amount of the Shadow Account at the beginning of the observation year. The Shadow Account can be positive, zero or negative. Round to the nearest dollar. For policies issued in the observation year, leave blank. If unknown, leave blank.</td>
</tr>
<tr>
<td>40</td>
<td>Amount at the End of Observation Year/Actual Termination Date</td>
<td>If not ULSG, or VLSG, leave blank. For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: If Item 35, Type of Secondary Guarantee is blank, 00, 01, 02, 03, 04, 05, 06, or 23 leave blank. If Item 35, Type of Secondary Guarantee is 11, 12, 13, 21 or 22: 1) For non-base segments, leave blank. 2) For base segments in force at the end of the observation year, enter the total amount of the Shadow Account at the end of the observation year. The Shadow Account can be positive, zero or negative. 3) For base segments terminated during the observation year, enter the total amount of the Shadow Account as of the Actual Termination Date (Item 26). The Shadow Account can be positive, zero or negative. Round to the nearest dollar. If unknown, leave blank.</td>
</tr>
<tr>
<td>41</td>
<td>Account Value at the Beginning of Observation Year</td>
<td>For non-base segments, leave blank. If not ULSG or VLSG, leave blank. For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, the policy Account Value (gross of any loan) at the Beginning of the Observation Year. The policy</td>
</tr>
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</tr>
<tr>
<td>42</td>
<td>241-250</td>
<td>10</td>
</tr>
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<td></td>
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<td>43</td>
<td>251-260</td>
<td>10</td>
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<td></td>
<td></td>
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<td>44</td>
<td>261-270</td>
<td>10</td>
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### Experience Reporting Formats

#### VM-51

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Format</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>Operative Secondary Guarantee at the Beginning of Observation Year</td>
<td>271-272</td>
<td>The company defines whether a secondary guarantee is in effect for a policy with a secondary guarantee at the beginning of the Observation Year. If Item 35, Type of Secondary Guarantee is blank, leave blank. If Item 35, Type of Secondary Guarantee is 00 through 23: 1) For non-base segments, leave blank. 2) For base segments: 00 = If unknown whether the secondary guarantee is in effect 01 = If secondary guarantee is not in effect 02 = If secondary guarantee is in effect 03 = If all secondary guarantees have expired Round to the nearest dollar. If unknown, leave blank.</td>
</tr>
<tr>
<td>46</td>
<td>Operative Secondary Guarantee at the End of Observation Year/Actual Termination Date</td>
<td>273-274</td>
<td>The company defines whether a secondary guarantee is in effect for a policy with a secondary guarantee at the end of the Observation Year/Actual Termination Date. If Item 35, Type of Secondary Guarantee is blank, leave blank. If Item 35, Type of Secondary Guarantee is 00 through 23: 1) For non-base segments, leave blank. 2) For base segments in force at the end of observation year, enter the appropriate value below as of the end of observation year: 00 = If unknown whether the secondary guarantee is in effect 01 = If secondary guarantee is not in effect 02 = If secondary guarantee is in effect 03 = If all secondary guarantees have expired 3) For base segments terminated during the observation year, enter the appropriate value below as of the Actual Termination Date (Item 26): 00 = If unknown whether the secondary guarantee is in effect 01 = If secondary guarantee is not in effect 02 = If secondary guarantee is in effect 03 = If all secondary guarantees have expired</td>
</tr>
<tr>
<td>47</td>
<td>State of Domicile</td>
<td>275-276</td>
<td>Use standard, two-letter state abbreviations codes (e.g., FL for Florida) for the state of the policy owner’s domicile. If unknown or outside of the U.S., leave blank.</td>
</tr>
</tbody>
</table>
The Life Actuarial (A) Task Force met May 20, 2021. The following Task Force members participated: Doug Slape, Chair, represented by Mike Boerner, Rachel Hemphill, and Karen Jiang (TX); Judith L. French, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li and Steve Ostlund (AL); Ricardo Lara represented by Ben Bock and Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Stephen W. Robertson represented by Karl Knable (IN); Grace Arnold represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Rhonda Ahrens (NE); Marlene Caride represented by Kevin Clarkson (NJ); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Jonathan T. Pike represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. Discussed the Memorandum on Current ESG Work

Mr. Boerner discussed the memorandum (Attachment A) from the Task Force and the Life Risk-Based Capital (E) Working Group on the current economic scenario generator (ESG) work. He said the memorandum documents the Task Force and Working Group’s goal of transparency in communicating the progress on the ESG project to state insurance regulators and interested parties. He said there will be no ESG field test in 2021. He said industry subject matter experts (SMEs) will be invited to contribute to future ESG drafting group discussions. He said the Task Force will provide more frequent updates to better inform interested parties.

2. Adopted Amendment Proposal 2021-05

William Wilton (unaffiliated) discussed his comment letter (Attachment B) on amendment proposal 2021-05. He said the letter recommends making changes to only VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation, and proposes no changes be made to VM-20, Requirements for Principle-Based Reserves for Life Products, or VM-21, Requirements for Principle-Based Reserves for Variable Annuities. He said using the term “modeled company investment strategy” in VM-31 creates problems. He said he recommends replacing it with “modeled investment strategy” or “alternative investment strategy” as the appropriate terms. He further indicated that a subsequent amendment to remove the investment advisor certification requirement should be considered. David Neve (Actuarial Resources Corporation of Georgia—ARC-GA) said changes to VM-20 and VM-21 are necessary for consistency in defining the weighted average life. He said companies are misinterpreting the modeled company investment strategy referenced in VM-31 as the winning strategy. He agreed that clarification of the modeled company investment strategy is necessary.

Mr. Carmello made a motion, seconded by Mr. Robinson, to adopt amendment proposal 2021-05 (Attachment C). The motion passed unanimously.

3. Re-Exposed Amendment Proposal 2020-12

Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI comment letter (Attachment D) recognizes that a company may have valid reasons for choosing not to model a clearly defined hedging strategy (CDHS). He said amendment proposal 2020-12 seems to suggest that some CDHS strategies are not legitimate. He said the amendment proposal introduces new concepts that change the treatment of current and future hedges. He said the current version of the amendment proposal introduces additional ambiguities. He said the ACLI supports the intent of the amendment proposal but would like to see the ambiguities clarified. He noted that the ACLI comment letter provides suggested changes to address optionality within the CDHS.

Ms. Hemphill said the ACLI revisions to the amendment proposal are not acceptable because they preserve and add complexity to the current optionality. She said the optionality makes regulatory evaluation of a CDHS difficult. She said the proposal fails to address the issue of the inconsistency of the current CDHS treatment with the general principles of principle-based reserving (PBR) defined in the Guidance Note in Section 7.K.1 of VM-20. She disagreed with the ACLI notion that the amendment proposal requirement to reflect hedging suggests that certain hedging strategies are not legitimate. Ms. Jiang responded to the
ACLI general concern No. 2 related to differences in current treatment versus proposed treatment of hedges. She said the ACLI chart on Page 3 of its comment letter provides an inaccurate comparison of the proposed and current treatment. She said Section 7.K.1 of VM-20 provides requirements for future transactions for both CDHS and non-hedging derivatives. She noted that the amendment proposal does not affect any requirements for non-hedging derivatives programs. She said the amendment proposal better aligns the treatment of CDHS and non-hedging transactions.

Ms. Hemphill said the amendment proposal was revised to reflect the technical concerns posed by the ACLI, including a clarification that the principles addressed in the proposal apply to the modeling of the CDHS and not to the CDHS itself. She and Ms. Jiang disagreed with other items that the ACLI contends are potentially confusing.

Mr. Robinson shared that his comment letter (Attachment E) highlights that principle No. 2 requires all income, benefit, and expense items be included in the modeling. He said modeling a CDHS or seasoned hedging strategy (SHS) only under certain circumstances violates principle No. 2. He said the relationship of the SHS and CDHS should be clarified. Ms. Jiang said the amendment proposal incorporated most of the editorial changes Mr. Robinson proposed.

Mr. Sartain made a motion, seconded by Mr. Robinson, to re-expose amendment proposal 2020-12 (Attachment F) for a 21-day public comment period ending June 11. The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.
TO: Life Actuarial (A) Task Force
   Life Risk-Based Capital (E) Working Group
FROM: Mike Boerner (TX)
       Phil Barlow (DC)
RE: Current Work on Economic Scenario Generator
DATE: May 20, 2021

It has been brought to our attention that certain interested parties and members of the life insurance industry have concerns regarding work currently being conducted by the NAIC regulator ESG Drafting Group on the development and implementation of an Economic Scenario Generator (ESG) for life reserving and risk-based capital purposes. Specifically, there have been concerns expressed with respect to (1) the proposed timeline of conducting field testing and implementation of the ESG for use on January 1, 2022; (2) the lack of transparency of the work being conducted by the ESG Drafting Group; and (3) the lack of opportunity for specific industry input into the drafting process. We consider these to be valid concerns, and would like to address them specifically with the following statements:

1. We think it is important for everyone to know that the NAIC, Life Actuarial (A) Task Force and the Life Risk-Based Capital (E) Working Group are dedicated to producing a working ESG that meets the expectations of both the regulatory and interested party communities, and that sufficient time and effort will be devoted to this process. Therefore, we are officially extending the timeline for its completion, and advising you that there will be no field test in 2021 and the ESG will not be ready for implementation as of January 1, 2022.

2. We understand that there have been no public discussions on the ESG or work of the Drafting Group since the Spring National Meeting. The Drafting Group cannot make decisions on behalf of the Task Force, and any recommendations that may come from the Drafting Group would be openly discussed on open calls with opportunity for industry input. That being said, we will try to provide updates to interested parties on the progress of the Drafting Group on a regular basis.

3. Finally, we agree that more industry input would be helpful at this stage of the process, and we are reaching out to the American Academy of Actuaries and American Council of Life Insurers to help provide more meaningful input and expert advice to the Drafting Group at this time.

Thank you for everyone’s patience as we proceed forward with the ESG project.
May 11, 2021

Reggie Mazyck  
National Association of Insurance Commissioners  
1100 Walnut Street – Suite 1500  
Kansas City, MO  64106-2197

Re: APF 2021-05, Investment Strategy

I appreciate the opportunity to provide comments on Amendment Proposal Form 2021-05 submitted by David Neve.

Although I agree that the language needs to be cleaned-up or tightened up a little bit, I generally disagree with modifying VM-01, VM-20 or VM-21.

Investment strategy is used, based on my count, 42 times in VM-20, VM-21, and VM-31. Model Investment Strategy 10 times (6 in VM-20, 2 in VM-21, & 2 in VM-31.) Modeled Company Investment Strategy is used 5 times in VM-31. I believe clarification of the documentation requirements in VM-31 is all that is necessary. The use of “Modeled Company Investment Strategy” creates problems in VM-31 and is why I disagree that this is or should be the “preferred” term.

In my view, there is a modeled investment strategy. If we want to be more specific it is the company’s modeled investment strategy. I think it is inappropriate and confusing to refer to it as the “Modeled Company Investment Strategy” and therefore disagree with the term and its inclusion in VM-01. As is evident in VM-20, the “Company Investment Strategy” may not be modeled, rather as articulated in VM-20 Section 7.E.1.a:

“The model investment strategy may incorporate a representation of the actual investment policy that ranges from relatively complex to relatively simple. In any case, the PBR Actuarial Report shall include documentation supporting the appropriateness of the representation relative to actual investment policy.”

I personally do not find the confusion with model investment strategy and alternative investment strategy (7 instances). In fact, the first instance in VM-20 states:

“Notwithstanding the above requirements, the modeled reserve shall be the higher of that produced by the model investment strategy and that produced by substituting an alternative investment strategy…”
A similar instance is also shown in VM-21. Clearly, model investment strategy is different than alternative investment strategy. The remaining 5 instances are all in VM-31. With the exception of the VM-20 certification of the qualified actuary on investments, model investment strategy is in the same sentence as alternative investment strategy. For reference purpose, if clarification is needed, the word “company’s” should precede “model investment strategy”, not inserted in the middle of it.

It is also important to recognize that a company may have multiple investment strategies; different strategies for different products or lines of business. Therefore, the modeled investment strategy should be viewed in the context of the model. As drafting takes place for VM-22, we can continue to tighten up the language around model investment strategy because in principal, there should be no difference between VM-20, VM-21, or VM-22.

So how do we fix/clarify VM-31?

For Section 3.D.6.r., I propose we replace with:

**Modeled Investment Strategy** – Description of the company’s modeled investment strategy, including asset reinvestment and disinvestment assumptions, and document the appropriateness compared to the actual investment policy of the company.

For Section 3.D.6.s., consistent with the APF, I propose relabeling as “Alternative Investment Strategy” to be consistent with the label in Section 3.F.6.b., but modify the wording slightly.

**Alternative Investment Strategy** – Demonstration of compliance with VM-20 Section 7.E.1.g., showing that the modeled reserve is the higher of that produced using the company’s modeled investment strategy and the alternative investment strategy.

Ideally, Section 3.F.6.a. and b. should mirror the recommendation to Section 3.D.6.r. and s. above.

**Modeled Investment Strategy** – Description of the company’s modeled investment strategy, including asset reinvestment and disinvestment assumptions, and document the appropriateness compared to the actual investment policy of the company.

**Alternative Investment Strategy** – Demonstration of compliance with VM-21 Section 4.D.4.b., showing that the modeled reserve is the higher of that produced using the company’s modeled investment strategy and the alternative investment strategy.

“Modeled Company Investment Strategy” is also used in Section 3.D.14.a. (Certifications, Investment Officer on Investments). At a minimum, “Company” should be deleted. I would
further argue that the required certification should be eliminated. It is the role of the actuary to
document what is in the model and ensure that the modeled investment strategy is consistent with
the company’s investment policy. As stated in VM-20 Section 7.E.1.a.:

“... the PBR Actuarial Report shall include documentation supporting the
appropriateness of the representation relative to actual investment policy.”

I view this as a different requirement than having an individual that is not familiar with the actual
model or the dynamics of a model to “certify” that “the modeled investment strategy is
representative of and consistent with the company’s investment policy”. Actuaries have the
responsibility of the model and will have conversations with the investment area to ensure that the
assumptions in the model are appropriate given the purpose of the model. Would the domiciliary
commissioner feel comfortable providing a certification that the modeled reserve complies with
VM-20 or VM-21, whichever is applicable? If not, why are we asking the investment officer to
certify what is in the model? I believe the corporate elements of the principle-based valuation
should be handled by VM-G and not also infused into and modified by VM-31.

In addition, VM-31, Section F.16.a. should also be eliminated. The investment certification is
even more problematic because it uses “company’s current investment strategy” when it should
have stated “company’s investment policy”. It also uses modeled reinvestment strategy as opposed
to investment strategy.

I thank you for the opportunity to provide the comments on this exposure and work to provide
enhancements to the Valuation Manual to continue the process of eliminating unintended
ambiguities that may have made their way into the Valuation Manual.

Sincerely,

William H. Wilton, CFA, FSA, MAAA
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force

Amendment Proposal Form*

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

Identification: David Neve, VP and Consulting Actuary, Actuarial Resources Corporation

Title of the Issue: Clarify the definition of modeled company investment strategy and the comparison to the alternative investment strategy.

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

January 1, 2020 NAIC Valuation Manual
- VM-01 VM-21 Section 4.D

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

See attached.

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

There is an inconsistency in VM-20/VM-21 and VM-31 regarding the term “model investment strategy”. The term “model investment strategy” is used throughout VM-20 and VM-21 to describe the investment strategy used in the model as a proxy for the company’s actual investment strategy. However, VM-31 uses the term “modeled company investment strategy” in several places rather than “model investment strategy”. “Modeled company investment strategy” is the preferred term, so VM-20 and VM-21 have been modified to use “modeled company investment strategy” so that the terminology in VM-20, VM-21 and VM-31 are consistent.

Also, to address the ambiguity of whether the final investment strategy in the model is the initial investment strategy based on the company’s investment strategy or the alternative investment strategy when the alternative strategy is constraining, the term “modeled company investment strategy” has been added to the definitions in VM-01 (and a parenthetical has been added to VM-31) to clarify that the term refers to the investment strategy in the model prior to comparison to the alternative investment strategy. In addition, VM-21 has been modified to be consistent with the wording in VM-20 to clarify that the assets in the alternative investment strategy should use the same weighted average life (WAL) as the assets in the modeled company investment strategy.
VM-01 Changes:
VM-01 provides definitions for terms used in the Valuation Manual. The definitions in VM-01 do not apply to documents outside the Valuation Manual even if referenced or used by the Valuation Manual, such as the AP&P Manual. Some terms in the Valuation Manual may be defined in specific sections of the Valuation Manual instead of being defined in VM-01.

- The term “margin” means an amount included in the assumptions used to determine the modeled reserve that incorporates conservatism in the calculated value consistent with the requirements of the various sections of the Valuation Manual. It is intended to provide for estimation error and adverse deviation.

- The term “modeled company investment strategy” means the investment strategy used in the model that is intended to be a representation of the actual investment strategy of the company. It is before the comparison is made to the alternative investment strategy. It does not refer to the alternative investment strategy when the alternative investment strategy is constraining.

- The term “modeled reserve” means the deterministic reserve on the policies determined under VM-20 Section 2.A.1.a, 2.A.2.a and 2.A.3.b, plus the greater of the deterministic reserve and the stochastic reserve on the policies determined under Section 2.A.1.b, 2.A.2.b and 2.A.3.c.

VM-20 Changes:

Section 7: Cash-Flow Models
E. Reinvestment Assets and Disinvestment

1. At the valuation date and each projection interval as appropriate, model the purchase of general account reinvestment assets with available cash and net asset and liability cash flows in a manner that is representative of and consistent with the company’s investment policy for each model segment, subject to the following requirements:

   a. The modeled company investment strategy may incorporate a representation of the actual investment policy that ranges from relatively complex to relatively simple. In any case, the PBR Actuarial Report shall include documentation supporting the appropriateness of the representation relative to actual investment policy.

   b. The final maturities and cash-flow structures of assets purchased in the model, such as the patterns of gross investment income and principal repayments or a fixed or floating rate interest basis, shall be determined by the company as part of the model representation.

   c. The combination of price and structure for fixed income investments and derivative instruments associated with fixed income investments shall appropriately reflect the then-current U.S. Department of the Treasury (Treasury Department) curve along the relevant scenario and the requirements for gross asset spread assumptions stated below.

   d. For purchases of public non-callable corporate bonds, use the gross asset spreads over Treasuries prescribed in Section 9.F.8.a through Section 9.F.8.c. (For purposes of this
subsection, “public” incorporates both registered and 144a securities.) The prescribed
spreads reflect current market conditions as of the model start date and grade to long-
term conditions based on historical data at the start of projection year four.

e. For transactions of derivative instruments associated with fixed income investments,
reflect the prescribed assumptions in Section 9.F.8.d for interest rate swap spreads.

f. For purchases of other fixed income investments, if included in the modeled company
investment strategy, set assumed gross asset spreads over Treasuries in a manner that is
consistent with, and results in reasonable relationships to, the prescribed spreads for
public non-callable corporate bonds and interest rate swaps as defined in Section 9.F.8.

g. Notwithstanding the above requirements, the modeled reserve shall be the higher of that
produced by the modeled company investment strategy and that produced by
substituting an alternative investment strategy in which the fixed income reinvestment
assets have the same weighted average life (WAL) as the reinvestment assets in the
modeled company investment strategy and are all public non-callable corporate bonds
with gross asset spreads, asset default costs and investment expenses by projection year
that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and
50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of a
clearly defined hedging strategy (in compliance with Section 7.L) are not affected by
this requirement.

Guidance Note: VM-31 requires a demonstration of compliance with VM-20 Section 7.E.1.g. In many
cases, particularly if the modeled company investment strategy does not involve callable assets, it is
expected that the demonstration of compliance will not require running the reserve calculation twice.
For example, an analysis of the weighted average net reinvestment spread on new purchases by
projection year (gross spread minus prescribed default costs minus investment expenses) of the modeled
company investment strategy compared to the weighted average net reinvestment spreads by projection
year of the alternative strategy may suffice. The assumed mix of asset types, asset credit quality or the
levels of non-prescribed spreads for other fixed income investments may need to be adjusted to achieve
compliance.

VM-21 Changes:

Section 4: Determination of the Stochastic Reserve

D. Projection of Assets

4. General Account Assets

a. General account assets shall be projected, net of projected defaults, using assumed
investment returns consistent with their book value and expected to be realized in future
periods as of the date of valuation. Initial assets that mature during the projection and
positive cash flows projected for future periods shall be invested in a manner that is
representative of and consistent with the company’s investment policy, subject to the
following requirements:

i. The final maturities and cash flow structures of assets purchased in the model,
such as the patterns of gross investment income and principal repayments or a
fixed or floating rate interest basis, shall be determined by the company as part of the model representation;

ii. The combination of price and structure for fixed income investments and derivative instruments associated with fixed income investments shall appropriately reflect the projected Treasury Department curve along the relevant scenario and the requirements for gross asset spread assumptions stated below;

iii. For purchases of public non-callable corporate bonds, follow the requirements defined in VM-20 Sections 7.E, 7.F and 9.F. The prescribed spreads reflect current market conditions as of the model start date and grade to long-term conditions based on historical data at the start of projection year four;

iv. For transactions of derivative instruments associated with fixed income investments, reflect the prescribed assumptions in VM-20 Section 9.F for interest rate swap spreads;

v. For purchases of other fixed income investments, if included in the modeled company investment strategy, set assumed gross asset spreads over U.S. Treasuries in a manner that is consistent with, and results in reasonable relationships to, the prescribed spreads for public non-callable corporate bonds and interest rate swaps.

b. Notwithstanding the above requirements, the stochastic reserve shall be the higher of that produced by the modeled company investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the modeled company investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs, and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of a clearly defined hedging strategy are not affected by this requirement.

Drafting Note: This limitation is being referred to Life Actuarial (A) Task Force for review.

VM-31 Changes:

Section 3: PBR Actuarial Report Requirements

D. Life Report – This subsection establishes the Life Report requirements for individual life insurance policies valued under VM-20.

6. Assets – The following information regarding the asset assumptions used by the company in performing a principle-based valuation under VM-20:

r. Modeled Company Investment Strategy and Reinvestment Assumptions – Description of the modeled company investment strategy (before comparison to the alternative investment strategy), including asset reinvestment and disinvestment assumptions, and
documentation supporting the appropriateness of the modeled company investment strategy compared to the actual investment policy of the company.

s. **Alternative Investment Strategy** – Documentation demonstrating compliance with VM-20 Section 7.E.1.g, showing that the modeled reserve is the higher of that produced using the modeled company investment strategy and the alternative investment strategy.

F. **VA Report** – This subsection establishes the VA Report requirements for variable annuity contracts valued under VM-21.

6. **General Account Assets** – The following information regarding the general account asset assumptions used by the company in performing a principle-based valuation under VM-21:

a. **Modeled Company Investment Strategy and Reinvestment Assumptions** – Description of the modeled company investment strategy (before the comparison to the alternative investment strategy), including asset reinvestment and disinvestment assumptions, and documentation supporting the appropriateness of the modeled company investment strategy compared to the actual investment policy of the company.

b. **Alternative Investment Strategy** – Documentation demonstrating compliance with VM-21 Section 4.D.4.b showing that the stochastic reserve is the higher of that produced using the modeled company investment strategy and the alternative investment strategy, based on the limitations defined in VM-21 Section 4.D.4.b.
Dear Mr. Boerner:

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit the following comments on the re-exposure of APF 2020-12. ACLI supports the Clearly Defined Hedging Strategy (CDHS) concept and efforts to create a single set of CDHS criteria that are applicable to all chapters of the Valuation Manual. We also appreciate the spirit of the APF to address regulatory concerns around perceived optionality in the application of the CDHS concept. That said, we do not believe the APF appropriately addresses this concern, nor do we believe that the APF as currently drafted would eliminate the concern. We offer an alternative solution and outline concerns we have with the APF.

Our Suggested Alternative Path

ACLI believes work should continue to address the regulator concerns articulated in this APF. Our suggested alternative is based on a company opt-in to CDHS status and regulatory oversight/approval of changes to CDHS status to prevent toggling between CDHS and non-CDHS status. Our proposed approach is conceptually similar to the current approach for the reflection of smoothing of the C-3 charge for variable annuities.

- There would be an initial one-time initial regulatory approval for the reflection of all relevant hedging strategies and classification as either CDHS or not CDHS. Deciding whether to have a CDHS would be a company option. However, the CDHS criteria would also need to be met for CDHS treatment to apply. It would be permissible to have a strategy that satisfies the CDHS criteria but is not reflected as a CDHS.
- No ongoing regulatory approval would be needed unless: (1) there is a CDHS and the CDHS criteria are no longer met, (2) there is a CDHS and the company no longer wishes to model the strategy as a CDHS, or (3) a company wishes to change from non-CDHS treatment to CDHS treatment.
- If a change in CDHS status is either desired or warranted, regulatory involvement would be required, as follows:
  o If a strategy is a CDHS and either (a) CDHS criteria are no longer met or (b) the company no longer wishes to model the strategy as a CDHS, the company must notify the regulator in advance of reporting. The regulator has the option to require CDHS treatment.
If a strategy has not been a CDHS and the company wishes to model the strategy as a CDHS, the company must secure pre-approval from the regulator, demonstrating that the CDHS criteria are met.

The advantages of this approach are:

- It increases regulatory oversight and includes the explicit ability for regulators to constrain perceived abuse.
- It retains the fundamental decisions about hedging made during the VA reform project that have led to the reduced use of captive reinsurance.
- It avoids the incentive to deliberately “fail” CDHS status by making CDHS status an explicit choice (with the additional wrinkle that CDHS criteria must also be met for CDHS treatment to apply).
- It avoids the perverse incentive for a company to find ways (such as making a hedging strategy less “clearly defined”) if the company wishes to avoid CDHS status.
- It avoids creating unintended incentives for companies to reduce or remove certain hedging programs.
- It avoids the considerable challenges of defining boundaries for the SHS concept.

If there is interest from LATF in this concept, we would be pleased to work with regulators on an APF.

To further elaborate on why we believe this alternative is preferable to the current APF, we offer the following concerns.

**General Concerns**

1) **The APF appears to be based on a presumption that certain non-CDHS strategies are illegitimate**

The APF would create a strong deterrent for companies to employ a Seasoned Hedging Strategy (SHS) that is not a CDHS. It proposes to penalize such strategies by imposing three burdens:

- A requirement to model SHS strategies as a CDHS even if they are not classified as a CDHS;
- A requirement to report the worst of two runs, one of which treats such strategies as a CDHS and the other of which does not treat them as a CDHS; and
- A prohibition of SSAP 108 CDHS accounting treatment even if the reported reserve is based on treating them as a CDHS.

As explained later, the proposed definition of SHS has ambiguities which may create confusion or render it ineffective for addressing the stated regulatory concern. Nevertheless, the APF suggests that certain non-CDHS strategies are inappropriate. They are either CDHSs in disguise (and therefore should modeled like CDHSs), or they should not be employed at all.
The APF does not consider the possibility that a variety of reasons may exist for companies to employ non-CDHS hedging strategies. For example, complex CDHS hedge modeling may not be achievable within reporting timeframes. Companies may have also concluded that, on balance, desired financial outcomes can be better managed under programs that do not qualify as CDHS strategies.

We believe that regulators typically do not intend to create barriers for effective risk management. In ACLI’s prior comment letter on this APF, we recommended a regulator survey so that regulators could obtain information on the various reasons why companies may employ non-CDHS hedging strategies and arrive at an informed conclusion of whether the APF would impose unintended regulatory barriers. If the APF continues to be pursued, we continue to encourage such a survey.

2) **The APF materially revises the treatment of hedging within the recently adopted VM-20 and VM-21 frameworks, reversing LATF decisions made during their development**

During the development of VM-20 and during the VM-21/C3P2 VA reform project, LATF made determinations about the regulatory treatment of various types of hedging programs. The APF effectively reverses some of these decisions, as shown by the highlighted portions of the following charts:

<table>
<thead>
<tr>
<th>Current PBR Reflection of Costs and Benefits of Current and Future Hedging</th>
</tr>
</thead>
<tbody>
<tr>
<td>VM-20 (Life)</td>
</tr>
<tr>
<td>Current hedges</td>
</tr>
<tr>
<td>Include in rebalancing</td>
</tr>
<tr>
<td>Include in rebalancing</td>
</tr>
<tr>
<td>Run off</td>
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<tr>
<td>Run off</td>
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</tbody>
</table>

\(^1\) The VM-21 CDHS hedging construct requires a weighted average of “Best Efforts” and “Adjusted” runs, based on assumed hedge effectiveness. The “Best Efforts” run would be consistent with the “CDHS” treatment, while the “Adjusted” run would be consistent with the “No CDHS” treatment.

\(^2\) VM-20 Section 7.K.1 and the associated guidance note appear to differentiate between non-CDHS derivative strategies and derivative programs that are undertaken “as part of the investment strategy supporting the policies.” The guidance note suggests that future transactions of non-CDHS derivative strategies would not be reflected, while future transactions associated with derivative programs that are part of the investment strategy would be reflected, provided that such programs “are normally modeled as part of the company’s risk assessment and evaluation processes.”
Proposed PBR Reflection of Costs and Benefits of Current and Future Hedging

<table>
<thead>
<tr>
<th>CDHS, SHS</th>
<th>VM-20 (Life)</th>
<th>VM-21 (Variable Annuities)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current hedges</td>
<td>Include in rebalancing</td>
<td>Include in rebalancing</td>
</tr>
<tr>
<td>Future transactions</td>
<td>Include</td>
<td>Include</td>
</tr>
<tr>
<td>CDHS, not SHS</td>
<td>Include in rebalancing</td>
<td>Include in rebalancing</td>
</tr>
<tr>
<td>No CDHS, SHS</td>
<td>Worst of CDHS, no CDHS treatment</td>
<td>Worst of CDHS, no CDHS treatment</td>
</tr>
<tr>
<td>No CDHS, not SHS</td>
<td>Run off</td>
<td>Cash out or run off</td>
</tr>
</tbody>
</table>

The changes would appear to target following types of hedging programs:

- **Indexed product hedging.** The APF would eliminate the VM-20’s current accommodation of indexed product hedging. LATF has historically considered indexed product hedging as being distinct from the CDHS concept but has viewed the modeling of future hedging transactions as essential. Accordingly, Section 7.K.1 includes language that requires the modeling of future transactions of certain non-CDHS programs. The APF would reverse LATF’s prior decision, eliminate this accommodation, and effectively require indexed product hedging to comply with the requirements imposed by the CDHS criteria. CDHS requirements will add significant amounts of effort to the reporting process with little benefit and potentially lead to non-economic reserves from the adjusted run under VM-21.

- **Various non-CDHS hedging programs.** The impact of the APF on non-CDHS hedging strategies—primarily relevant to VAs—is unclear due to ambiguities within the language. We suspect that the APF, however, may end up targeting—perhaps unintentionally—a variety of non-CDHS strategies that are used for risk management, representing a significant policy reversal. The Valuation Manual currently views non-CDHS hedging strategies that support the relevant contracts as fundamentally legitimate. VM-21, for example, allows a company either to run off or cash out of existing hedge positions. It accommodates the reality that a hedging strategy used now, and even historically, may not be the strategy used in the future, especially over very long periods of time, as economic and other circumstances change. Many companies have spent considerable resources collapsing captive reinsurers and retooling their hedging programs to be effective and efficient within the new VA framework. The APF, however, would reverse the current VM-21 approach, viewing certain strategies as illegitimate and imposing the trio of burdens described above.

In addition, the APF would reverse the current VM-20 approach for non-hedging derivative programs that are normally modeled. The current guidance note in VM-20 suggests that future transactions would be reflected for these programs. However, the APF would exclude future transactions because these derivative programs are non-hedging programs (i.e., neither a CDHS nor a SHS).

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3 VM-20, Section 7.K.1 requires the inclusion of “appropriate costs and benefits of anticipated future derivative instrument transactions associated with non-hedging derivative programs (e.g., replication, income generation) undertaken as part of the investment strategy supporting the policies, provided they are normally modeled as part of the company’s risk assessment and evaluation processes.”
We suggest that it is premature to conclude that fundamental changes to the Valuation Manual treatment of hedging are warranted. Most carriers have just started to report year-end results under the new VM-20 and VM-21 frameworks. While we appreciate the desire to create a single PBR hedging framework, current differences exist for legitimate reasons. (That said, we do believe that some targeted changes may be merited to better accommodate indexed product hedging.)

The potential downstream impacts of making fundamental changes should not be underestimated. The forcing of indexed hedging into the CDHS realm will inevitably impose operational burdens on the industry and may create future complications with SSAP 108, for example. For VA books, the APF may promote another round of resource-intensive retooling of hedging strategies and could even encourage weakened policyholder protection.

3) The APF seems unlikely to address the stated concern

The APF seems unlikely to address the stated regulatory concern of “unintended optionality.” As shown by the above charts, the APF would make it more advantageous for companies to have a strategy that is neither an SHS nor a CDHS than to have a strategy that is an SHS but is not a CDHS. An incentive would always exist to conclude that a particular strategy is not an SHS, since nothing in the APF requires a CDHS to be an SHS.

The current drafting, in fact, makes it relatively easy to do avoid SHS status, if that is desired.

a. The definition of SHS includes the phrase “and for which future hedging transactions are normally modeled as part of the company's risk assessment and evaluation process.” For indexed products, it is difficult to conceive of a framework under which future hedging would not be reflected in some manner. On the VA side, however, many company “risk assessment and evaluation processes” do not necessarily incorporate the explicit modeling of future hedging transactions:

- Economic capital and risk management – future hedging transactions may or may not be reflected; simplified approaches would typically be used
- GAAP/IFRS – modeling of future hedging transactions is not permitted
- Pricing – future hedging transactions may or may not be reflected; simplified approaches would typically be used
- ICS – reflection of future hedging transactions is not permitted

The variety of “risk assessment and evaluation processes” within most organizations and the variety of modeling approaches used within such frameworks would often make it possible to make a case for different conclusions as to whether a particular program meets this part of the SHS definition.

b. The APF further indicates that “An SHS must meet all of the principles outlined in VM-21 Section 1.B (the most relevant of which may be Principle 5).” In other words, an SHS must affirmatively satisfy all five principles. Most of the Section 1.B principles, however, can be viewed as not applicable to most strategies (and therefore not affirmatively satisfied) because:
They are not necessarily consistent with how companies price products, report earnings, or manage risk through hedging. For instance, Principle 2 references “the greatest present value of accumulated deficiency,” which is a concept exclusive to U.S. regulatory requirements. Only hedging strategies that are based on stochastic regulatory measurements of risk would appear to clearly satisfy this principle.

Principle 5, which is highlighted in the APF, says that:

The use of assumptions, methods, models, risk management strategies (e.g., hedging), derivative instruments, structured investments, or any other risk transfer arrangements (such as reinsurance) that serve solely to reduce the calculated stochastic reserve without also reducing risk on scenarios similar to those used in the actual cash-flow modeling are inconsistent with these principles. The use of assumptions and risk management strategies should be appropriate to the business and not merely constructed to exploit ‘foreknowledge’ of the components of the required methodology.

This principle was intended to address hedging strategies designed to target a specific individual scenario (e.g., only the “pop-up” scenario of 300 bps but not a pop-up of 299 bps or 301 bps). Principle 5 does not clearly address the issue of deliberately failing CDHS criteria.

In general, the APF would move the pressure point from the CDHS criteria to the definition of SHS. While it would be possible to refine the definition of SHS, the incentives and disincentives created by the APF would tend to lead to ongoing definitional challenges around what is and is not an SHS. We suggest that regulators and industry may be better served by approaches that would avoid such challenges.

Other Areas of Potential Confusion

Beyond the above fundamental concerns, we believe the language of the proposal may create additional areas of confusion:

1. **Conflicting requirements:** The proposed edits to VM-20 seem to create conflicting requirements. VM-20 Section 7.K.4 states “If a SHS supporting the policies is not a CDHS but modeling it would result in an increase to the company’s minimum reserve, then the company shall model the SHS as if it were a CDHS when calculating reserves under VM-20.” However, this language appears to create a conflict with the Stochastic Exclusion Ratio Test (SERT) which leaves open the possibility for a group of policies with an SHS to pass the exclusion test, per VM-20 Section 6.A.1.b:

   A company may not exclude a group of policies for which there is one or more clearly defined hedging strategies from stochastic reserve requirements, except in the case where all clearly defined hedging strategies are solely associated with product features that are determined to not be material under VM-20 Section 7.B.1 due to low utilization.
The Section 6 text appears to allow a group of policies with an SHS to pass the exclusion test, however the Section 7 text requires the SHS be modeled if it raises reserves. The relationship of these provisions is not clear.

2. “Required to be modeled”: The draft of VM-21 Section 4.A.4 uses the phrase “SHS that is required to be modeled”. However, the proposed language under VM-20 (Section 7.K.4) and VM-21 (Section 9.A.6) indicates that the modeling “requirement” is not necessarily for the purpose of determining the actual reserves/TAR, but for the purpose of testing whether the hedging strategy is to be reflected within the reserves. The test involves two different reserve calculations: (1) future hedging transactions are not modeled, and (2) future hedging transactions are modeled. If the first calculation produces a greater reserve, then the SHS is effectively required to be not modeled, not required to be modeled. As such, the VM-21 Section 4.A.4 language is likely to create confusion.

3. Appropriateness of scope: The APF indicates that an SHS “may be dynamic, static, or a combination thereof.” Since a static hedging program is not rebalanced, it is not necessarily clear why static programs are part of the definition, although static hedges will eventually expire or mature.

4. Frequency of updates: The APF does not clarify how frequently a company should determine if the SHS increases reserves; it is unclear if this is a point in time calculation or must be it redetermined on an ongoing basis. Regardless of the potential frequency, the ability of the requirement to apply and not apply depending on economic conditions inherently introduces non-economic volatility, which was something the revised VM-21 framework attempted to avoid.

5. Deleted VM-20 text: The APF appears to change the requirements for VM-20 business. VM-20 Section 7.L.2 provided for an additional requirement beyond the CDHS definition: “Hedging strategies involving the offsetting of the risks associated with other products outside of the scope of these requirements is not a clearly defined hedging strategy.” While we do not necessarily oppose the deletion, we want to make sure the implications of this change are appropriately understood and we are unsure of the reason why this provision was originally included within VM-20.

We appreciate the consideration of our comments and look forward to discussing on a future call. Thank you.

Sincerely,

cc: Reggie Mazyck, NAIC
Mike,

Thank you for the opportunity to comment on this exposure.

My concerns include matters of principle and matters of use of language. The matters of principle are as follows:

1. As indicated in a Guidance Note in VM-20, the current CDHS provision is at variance with Principle 2. I presume that the reason for this is that while Principle 2 calls for “a projected total cash flow analysis by including all projected income, benefit and expense items...”, the CDHS provision only applies when the hedging strategy meets the CDHS criteria.

   It seems to me, therefore, that including a SHS that is only modeled if it would cause an increase in the reserve would also violate Principle 2. Consequently, its introduction would create two violations of Principle 2 rather than one.

2. The definition of SHS includes the statement “A SHS may or may not be a CDHS”. I have two comments:
   (a) The statement is unclear as to whether a CDHS is always an SHS. It is my understanding that this is the intent.
   (b) If it is the case that a CDHS is always an SHS, then, per VM-21 Section 9.A.5, since a new or revised CDHS only needs to be in existence for three months, the same needs to be true for an SHS.

3. The phrase “normally modeled” is somewhat open to interpretation. For example, does modeling the hedging strategy for purposes of the ORSA meet the criterion, or should it be more frequent?

4. The definitions of both CDHS and SHS include the sentence “A CDHS must meet all of the principles outlined in VM-21 Section 1.B (the most relevant of which may be Principle 5).” I think that a definition should be explicit as to the applicable criteria, and not leave it to the reader to determine what is intended. In particular, I find nothing in Principles 1-4 that can be used as a criterion for a hedging strategy. I will address this in my comments on the text below.

As to use of language and other comments, I have inserted 20 comments in the proposed text.

Thank you.

John Robinson FSA, FCA, MAAA
Director PBR – Valuation Actuary, Minnesota
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force

Amendment Proposal Form*

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

**Identification:**
Rachel Hemphill and Karen Jiang, Texas Department of Insurance

**Title of the Issue:**
Create consistency between CDHS determination in VM-20 and VM-21. Revise hedge modeling to only require CDHS if modeling future hedging reduces the reserves under VM-20 or TAR under VM-21.

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


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

See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)
Summary of 4/2/2021 Updates:

1. Revisions were made to VM-20 Section 7.K.4 (add “supporting the policies”) and VM-21 Section 9.A.6 (add “supporting the contracts”) in response to Nationwide’s comments.
2. We added a definition for “hedging transactions,” taken from the APPM but modified slightly to be consistent with Valuation Manual terminology in response to Will Wilton’s comments.
3. We have updated the list of CDHS criteria in response to Will Wilton’s comments where we agreed:
   a. Added “significant” before risks in item (c) of the CDHS definition.
   b. Combined items (f) – (h) in the CDHS definition.
   c. Change “person or persons” to “group or area, including whether internal or external,” in item (j) of the CDHS definition.
   d. We did not remove items (k) or (l) as suggested by Will Wilton, as we find this information useful to regulators. Given that these are retained, and because we were uncertain what else would be included in the new “primary risks” item suggested by Will Wilton, we have not added it. If we can be provided additional information on the risks to be reflected under this new item, an edit could be made.
4. We modified the definition of a SHS to clarify “normally modelled” in response to the ACLI comment and clarify what may be a SHS in response to Will Wilton’s comment (e.g., a single bond would not be a SHS).

We have added comment bubbles in the draft below to flag where we have made edits or chosen not to make edits and why.

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We propose having consistent requirements for a CDHS in VM-20 and VM-21, as well as any future work on VM-22, and consolidating these requirements in the VM-01 definition of a CDHS. This involves adding two criteria to VM-21’s definition of CDHS that currently exist for VM-20:

- Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
- The circumstances under which hedging strategy will not be effective in hedging the risks.

These criteria are both reasonable and apply in principle to VM-21, and to any future work on VM-22, as well as VM-20.
Further, we propose revising the requirement for hedging to be a CDHS in order for future hedging to be modeled under VM-20, VM-21, and LR027’s C-3 RBC Amount calculation to only apply when modeling such hedging reduces the life reserve level or variable annuity Total Asset Requirement (TAR) level.

The current regulatory requirements for hedging to be a CDHS in order for future hedging to be modeled under VM-20, modeled under VM-21, modeled for the C-3 RBC Amount calculation for variable annuities, and to be eligible for SSAP 108 treatment are all logical requirements when one considers whether hedging should be allowed to reduce the life reserve level or variable annuity TAR level, or whether any mismatch between movements in hedge assets and movements in the corresponding reserve levels should be allowed to be amortized over time.

However, this same requirement has led to a situation of there being unintended optionality in whether a hedging strategy that is like a CDHS is modeled or is not modeled, since a company may choose to satisfy or not satisfy certain of the criteria. This has been especially relevant for cases where modeling a company's hedging strategy would increase reserves or variable annuity TAR.

As noted in the current guidance note in VM-20 Section 7.K.1 in the 2021 Valuation Manual:

“The prohibition in these modeled reserve requirements against projecting future hedging transactions other than those associated with a clearly defined hedging strategy is intended to address initial concerns expressed by various parties that reserves could be unduly reduced by reflection of programs whose future execution and performance may have greater uncertainty. The prohibition appears, however, to be in conflict with Principle 2 listed in VM-21. Companies may actually execute and reflect in their risk assessment and evaluation processes hedging strategies similar in many ways to clearly defined hedging strategies but lack sufficient clarity in one or more of the qualification criteria. By excluding the associated derivative instruments, the investment strategy that is modeled may also not reflect the investment strategy the company actually uses. Further, because the future hedging transactions may be a net cost to the company in some scenarios and a net benefit in other scenarios, the exclusion of such transactions can result in a modeled reserve that is either lower or higher than it would have been if the transactions were not excluded. The direction of such impact on the reserves could also change from period to period as the actual and projected paths of economic conditions change. A more graded approach to recognition of non-qualifying hedging strategies may be more theoretically consistent with Principle 2. It is recommended that as greater experience is gained by actuaries and state insurance regulators with the principle-based approach and as industry hedging programs mature, the various requirements of this section be reviewed.”
We propose to continue addressing the regulatory concern that reserves could be unduly reduced by reflection of programs whose future execution and performance may have greater uncertainty, by continuing to only allowing hedging strategies that qualify as a CDHS to reduce life reserves and variable annuity TAR. However, we propose that the treatment of CDHS be made more principles-based and less subject to manipulation. To accomplish this, the proposal requires that any hedging strategy that is a part of the investment strategy supporting the policies and is normally modeled as part of the company's risk assessment and evaluation processes be modeled as if it were a CDHS if doing so results in an increase in life reserves or variable annuity TAR.

That is, CDHS becomes a requirement solely for hedging strategies that reduce life reserves or variable annuity TAR, and so becomes a more clear regulatory guardrail requiring that hedging strategies that reduce life reserves or variable annuity TAR must be clearly defined.

We continue to need the concept of a CDHS. A CDHS simply formally documents items that a company should be able to document for a robust, well-defined hedging strategy. It requires that the following be identified:

a. The specific risks being hedged (e.g., cash flow, policy interest credits, delta, rho, vega, etc.).
b. The hedge objectives.
c. The risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).
d. The financial instruments used to hedge the risks.
e. The hedge trading rules, including the permitted tolerances from hedging objectives.
f. The metrics for measuring hedging effectiveness.
g. The criteria used to measure hedging effectiveness.
h. The frequency of measuring hedging effectiveness.
i. The conditions under which hedging will not take place.
j. The person or persons responsible for implementing the hedging strategy.
k. Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
l. The circumstances under which hedging strategy will not be effective in hedging the risks.

While the last two criteria have historically applied for life but not variable annuities, these are all reasonable documentation items that for a robust, well-defined hedging strategy regardless of whether the product is life or variable annuity.

The concept of a CDHS is used for accounting in SSAP 108. SSAP 108 allows companies to set up a deferred asset or liability to amortize the mismatch between changes in the value of the liability and changes in the value of the hedging instruments attributable to the hedged risk underlying a highly effective CDHS modeled for VM-21. Allowing this treatment encourages companies to reduce risk through robust, well-defined and highly effective hedging. Without having the hedging strategy be well-defined, regulators could not rely on past effectiveness being indicative of future effectiveness, and so could not offer companies the benefit of SSAP 108 treatment.
Once we recognize the need for a concept of a well-defined hedging strategy, the only question is what criteria would need to be met to be considered well-defined – that is, what criteria should be required to be considered a CDHS. This is a distinct question from whether the concept of a CDHS is needed. We have not heard critiques of individual criteria in the CDHS definition, but consideration of the criteria is appropriate as we go forward to make the definitions in VM-20 and VM-21 consistent. Similarly, in reserve and capital calculations, we rely on the concept of historical effectiveness to determine an error factor. If modeling hedging reduces the reserve or capital amount, the error factor determines the magnitude to which this is reflected. However, this use of the historical effectiveness relies on the hedging strategy being well-documented and comparable between historical hedging and planned future hedging. So, again, a need for hedging strategies to be well-defined presents itself – a CDHS concept is needed.

Finally, edits to VM-31 are needed to reflect these updates and bring VM-20 and VM-21 reporting requirements more in line with one another where appropriate.

Note on Coordination with RBC and APPM: We have reviewed, and with these edits there are no corresponding edits necessary for LR027 for RBC but corresponding edits are necessary for SSAP 108. A referral to SAPWG is to be concurrently considered with this APF.

**VM-01**

- The term “clearly defined hedging strategy” (CDHS) means a strategy undertaken by a company to manage risks through the future purchase or sale of hedging instruments and the opening and closing of hedging positions that meet the criteria specified in the applicable reserve requirement section of the Valuation Manual. A CDHS must identify:
  
  a. The specific risks being hedged (e.g., cash flow, policy interest credits, delta, rho, vega, etc.).
  b. The hedging objectives.
  c. The significant risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).
  d. The financial instruments used to hedge the risks.
  e. The hedging strategy’s trading rules, including the permitted tolerances from hedging objectives.
  f. The metrics, criteria, and frequency for measuring hedging effectiveness.
  g. The conditions under which hedging will not take place.
  h. The group or area, including whether internal or external, responsible for implementing the hedging strategy.
  i. Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
  j. The circumstances under which hedging strategy will not be effective in hedging the risks.

**Commented [RJW1]:** “hedging objective” rather than “hedge objective”

**Commented [RH2]:** Added “significant” in response to Will Wilton’s comment. Retained item because information provided on this item by companies is helpful for regulators.

**Commented [RJW3]:** “hedging strategy”’s instead of “hedge”

**Commented [RH4]:** Edited for Will Wilton comment – combined three bullets into one.

**Commented [RH5]:** Edited for Will Wilton comment – replaced “person or persons” with “group or area, including whether internal or external,”.

**Commented [RH6]:** Three notes on Will Wilton suggestion to remove and why we chose to retain:

1. Definition needs to work for both VM-20 and VM-21, so can’t be removed based on a VM-21 requirement only.

2. VM-21 Section 9.B.4 requires that your modeling reflect this – while this item requires that your hedge documentation identifies them. That is different. This has to come before 9.B.4. You have to identify before you can reflect.

3. This also only used to exist for VM-21, and companies have suggested adding to VM-20.

**Commented [RH7]:** Did not remove as suggested by Will Wilton comment. We find the information provided by companies in response to this item helpful. This also only used to exist for VM-21, and companies have suggested adding to VM-20.
The hedging strategy must not serve solely to reduce the calculated stochastic reserve without also reducing risk (VM-21, Section 1.B, Principle 5).

The hedging strategy may be dynamic, static or a combination thereof. A strategy involving the offsetting of the risks associated with products falling under the scope of different requirements within the Valuation Manual (e.g., VM-20, VM-21, or VM-22) does not qualify as CDHS. A CDHS must meet all of the principles outlined in VM-21 Section 1.B (the most relevant of which may be Principle 5).

Guidance Note: For purposes of the above criteria, “effectiveness” need not be measured in a manner as defined in SSAP No. 86—Derivatives in the AP&P Manual.

- The term “hedging transaction” means a derivative(s) transaction which is entered into and maintained to reduce:
  a. The risk of a change in the fair value or cash flow of assets and liabilities which the company has acquired or incurred or has a firm commitment to acquire or incur or for which the company has a forecasted acquisition or incurrence; or
  b. The currency exchange rate risk or the degree of foreign currency exposure in assets and liabilities which the company has acquired or incurred or has a firm commitment to acquire or incur or for which the company has forecasted acquisition or incurrence.

- The term “Seasoned Hedging Strategy” (SHS) means a hedging strategy that is part of the company’s investment strategy and for which future hedging transactions are normally modeled as part of the company’s risk assessment and evaluation process. A SHS may or may not be a CDHS.

The hedging strategy may be dynamic, static, or a combination thereof. A strategy involving the offsetting of the risks associated with products falling under the scope of different requirements within the Valuation Manual (e.g., VM-20, VM-21, or VM-22) does not qualify as SHS. A SHS must meet all of the principles outlined in VM-21 Section 1.B (the most relevant of which may be Principle 5).

Commented [RJW(8)]: New criterion based on Principle 5.
Commented [RJW(9)]: “hedging strategy” instead of “hedge strategy”.
Commented [RJW(10)]: Delete, and replace with criterion k above.

Commented [RH11]: Added in response to Will Wilton comment about what is a SHS.

Commented [RH12]: Added “for which future hedging transactions” to address ACLI comment on ambiguity around “normally modeled”.

Also clarifies per Will Wilton comment, when combined with APPM definition of hedging transactions, since hedging transactions are derivatives transactions.

Commented [RJW(13)]: “hedging strategy” instead of “hedge strategy”.

Commented [RJW(14)]: Delete; however, since SHS is intended to be modeled only when it increases the stochastic reserve, Principle 5 cannot be used as a criterion in the same way as CDHS.
VM-20 Section 6.A.1.b

A company may not exclude a group of policies for which there is one or more clearly defined hedging strategies (CDHS) or one or more SHS required to be modeled pursuant to Section 7.K.4 from stochastic reserve requirements, except in the case where all clearly defined hedging strategies (CDHS) and all SHS required to be modeled pursuant to Section 7.K.4 are solely associated with product features that are determined to not be material under Section 7.B.1 due to low utilization.

VM-20 Section 7.E.1.g

Notwithstanding the above requirements, the modeled reserve shall be the higher of that produced by the model investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the model investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of a clearly defined hedging strategy (CDHS) or a SHS that is required to be modeled pursuant to Section 7.K.4 are not affected by this requirement.

VM-20 Section 7.K

K. Modeling of Derivative Programs

1. When determining the deterministic reserve and the stochastic reserve, the company shall include in the projections the appropriate costs and benefits of derivative instruments that are currently held by the company in support of the policies subject to these requirements. The company shall also include the appropriate costs and benefits of anticipated future derivative instrument transactions associated with the execution of a clearly defined hedging strategy (CDHS) or a SHS that is required to be modeled pursuant to Section 7.K.4, as well as the appropriate costs and benefits of anticipated future derivative instrument transactions associated with non-hedging derivative programs (e.g., replication, income generation) undertaken as part of the investment strategy supporting the policies, provided they are normally modeled as part of the company’s risk assessment and evaluation processes.

Guidance Note: The requirements stated here for handling hedging strategies are essentially consistent with those included in the CTE methodology of VM-21 and the five principles spelled out there. The prohibition in these modeled reserve requirements against projecting future hedging transactions other than those associated with a clearly defined hedging strategy is intended to address initial concerns expressed...
by various parties that reserves could be unduly reduced by reflection of programs whose future execution and performance may have greater uncertainty. The prohibition appears, however, to be in conflict with Principle 2 listed in VM-21. Companies may actually execute and reflect in their risk assessment and evaluation processes hedging strategies similar in many ways to clearly defined hedging strategies but lack sufficient clarity in one or more of the qualification criteria. By excluding the associated derivative instruments, the investment strategy that is modeled may also not reflect the investment strategy the company actually uses. Further, because the future hedging transactions may be a net cost to the company in some scenarios and a net benefit in other scenarios, the exclusion of such transactions can result in a modeled reserve that is either lower or higher than it would have been if the transactions were not excluded. The direction of such impact on the reserves could also change from period to period as the actual and projected paths of economic conditions change. A more graded approach to recognition of non-qualifying hedging strategies may be more theoretically consistent with Principle 2. It is recommended that as greater experience is gained by actuaries and state insurance regulators with the principle-based approach and as industry hedging programs mature, the various requirements of this section be reviewed.

2. For each derivative program that is modeled, the company shall reflect the company’s established investment policy and procedures for that program; project expected program performance along each scenario; and recognize all benefits, residual risks and associated frictional costs. The residual risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, etc.). Frictional costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. For clearly defined hedging strategies CDHS or SHS required to be modeled pursuant to Section 7.K.4, the company may not assume that residual risks and frictional costs have a value of zero, unless the company demonstrates in the PBR Actuarial Report that “zero” is an appropriate expectation.

3. In circumstances where one or more material risk factors related to a derivative program are not fully captured within the cash-flow model used to calculate CTE 70, the company shall reflect such risk factors by increasing the stochastic reserve as described in Section 5.E.

4. If a SHS supporting the policies is not a CDHS but modeling it would result in an increase to the company’s minimum reserve, then the company shall model the SHS as if it were a CDHS when calculating reserves under VM-20.

VM-20 Section 7.L (Remove entire Section 7.L)

A Clearly Defined Hedging Strategy

A clearly defined hedging strategy must identify:

- The specific risks being hedged (e.g., cash flow, policy interest credits, delta, rho, vega, etc.).
- The hedge objectives.
- The risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).
- The financial instruments used to hedge the risks.
- The hedge trading rules, including the permitted tolerances from hedging objectives.
f. The metrics for measuring hedging effectiveness.
g. The criteria used to measure hedging effectiveness.
h. The frequency of measuring hedging effectiveness.
i. The conditions under which hedging will not take place.
j. The person or persons responsible for implementing the hedging strategy.
k. Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
l. The circumstances under which hedging strategy will not be effective in hedging the risks.

Hedging strategies involving the offsetting of the risks associated with other products outside of the scope of these requirements is not a clearly defined hedging strategy.

**Guidance Note:** For purposes of the above criteria, “effectiveness” need not be measured in a manner as defined in SSAP No. 86 – Derivatives in the AP&P Manual.
The term “clearly defined hedging strategy” (CDHS) is defined in VM-01. In order to be designated as a CDHS, the strategy must meet the principles outlined in Section 1.B (particularly Principle 5) and shall, at a minimum, identify:

a. The specific risks being hedged (e.g., delta, rho, vega, etc.).
b. The hedge objectives.
c. The risks not being hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).
d. The financial instruments that will be used to hedge the risks.
e. The hedge trading rules, including the permitted tolerances from hedging objectives.
f. The criteria that will be used to measure hedging effectiveness.
g. The metric(s) for measuring hedging effectiveness.
h. The frequency of measuring hedging effectiveness.
i. The conditions under which hedging will not take place.
j. The person or persons responsible for implementing the hedging strategy.

Guidance Note: It is important to note that strategies involving the offsetting of the risks associated with VA guarantees with other products outside of the scope of these requirements (e.g., equity-indexed annuities) do not currently qualify as a clearly defined hedging strategy under these requirements.

VM-21 Section 4.A.4

Modeling of Hedges

a. For a company that does not have a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6:

i. The company shall not consider the cash flows from any future hedge purchases or any rebalancing of existing hedge assets in its modeling.

ii. Existing hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the starting assets. The hedge assets may then be considered in one of two ways:

a) Include the asset cash flows from any contractual payments and maturity values in the projection model; or
b) No hedge positions – in which case the hedge positions held on the valuation date are replaced with cash and/or other general account assets in an amount equal to the aggregate market value of these hedge positions.

**Guidance Note:** If the hedge positions held on the valuation date are replaced with cash, then as with any other cash, such amounts may then be invested following the company’s investment strategy.

A company may switch from method a) to method b) at any time, but it may only change from b) to a) with the approval of the domiciliary commissioner.

b. **For a company with a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6,** the detailed requirements for the modeling of hedges are defined in Section 9. The following paragraphs are a high-level summary and do not supersede the detailed requirements.

i. The appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the projections used in the determination of the stochastic reserve.

ii. The projections shall take into account the appropriate costs and benefits of hedge positions expected to be held in the future through the execution of the CDHS or the SHS that is required to be modeled pursuant to Section 9.A.6. Because models do not always accurately portray the results of hedge programs, the company shall, through back-testing and other means, assess the accuracy of the hedge modeling. The company shall determine a stochastic reserve as the weighted average of two CTE values; first, a CTE70 (“best efforts”) representing the company’s projection of all of the hedge cash flows, including future hedge purchases, and a second CTE70 (“adjusted”) which shall use only hedge assets held by the company on the valuation date and no future hedge purchases. These are discussed in greater detail in Section 9. The stochastic reserve shall be the weighted average of the two CTE70 values, where the weights reflect the error factor (E) determined following the guidance of Section 9.C.4.

iii. The company is responsible for verifying compliance with CDHS requirements or SHS requirements if required to be modeled pursuant to Section 9.A.6, and any other requirements in Section 9 for all hedging instruments included in the projections.

iv. The use of products not falling under the scope of these requirements (e.g., equity-indexed annuities) as a hedge shall not be recognized in the determination of accumulated deficiencies.

**VM-21 Section 4.D.4.b**

Notwithstanding the above requirements, the model investment strategy and any non-prescribed asset spreads shall be adjusted as necessary so that the aggregate reserve is not less than that which would be obtained by substituting an alternative investment strategy in which all fixed income reinvestment assets are public non-callable corporate bonds with gross asset spreads, asset default costs, and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).
Policy loans, equities and derivative instruments associated with the execution of a clearly defined hedging strategy (CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6) are not affected by this requirement.

**VM-21 Section 6.B.3.a.ii – Footnote (Footnote at Bottom of Page 21-22)**

Throughout this Section 6, references to CTE70 (adjusted) shall also mean the Stochastic Reserve for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6 as discussed in Section 4.A.4.a.

**VM-21 Section 6.B.3.b.ii**

Calculate the Prescribed Projections Amount as the CTE70 (adjusted) using the same method as that outlined in Section 9.C (which is the same as the stochastic reserves following Section 4.A.4.a for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6) but substituting the assumptions prescribed by Section 6.C. The calculation of this Prescribed Projections Amount also requires that the scenario reserve for any given scenario be equal to or in excess of the cash surrender value in aggregate on the valuation date for the group of contracts modeled in the projection.

**VM-21 Section 6.B.5**

Cash flows associated with hedging shall be projected in the same manner as that used in the calculation of the CTE70 (adjusted) as discussed in Section 9.C or Section 4.A.4.a for a company without a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6.
VM-21 Section 9

Section 9: Modeling of Hedges under a CDHS

A. Initial Considerations

1. Subject to Section 9.C.2, the appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the calculation of the stochastic reserve, determined in accordance with Section 3.D and Section 4.D.

2. If the company is following a CDHS, in accordance with an investment policy adopted by the board of directors, or a committee of board members, the company shall take into account the costs and benefits of hedge positions expected to be held by the company in the future along each scenario based on the execution of the hedging strategy, and it is eligible to reduce the amount of the stochastic reserve using projections otherwise calculated. The investment policy must clearly articulate the company’s hedging objectives, including the metrics that drive rebalancing/trading. This specification could include maximum tolerable values for investment losses, earnings, volatility, exposure, etc. in either absolute or relative terms over one or more investment horizons vis-à-vis the chance of occurrence. Company management is responsible for developing, documenting, executing and evaluating the investment strategy, including the hedging strategy, used to implement the investment policy.

3. For this purpose, the investment assets refer to all the assets, including derivatives supporting covered products and guarantees. This also is referred to as the investment portfolio. The investment strategy is the set of all asset holdings at all points in time in all scenarios. The hedging portfolio, which also is referred to as the hedging assets, is a subset of the investment assets. The hedging strategy is the hedging asset holdings at all points in time in all scenarios. There is no attempt to distinguish what is the hedging portfolio and what is the investment portfolio in this section. Nor is the distinction between investment strategy and hedging strategy formally made here. Where necessary to give effect to the intent of this section, the requirements applicable to the hedging portfolio or the hedging strategy are to apply to the overall investment portfolio and investment strategy.

4. This particularly applies to restrictions on the reasonableness or acceptability of the models that make up the stochastic cash-flow model used to perform the projections, since these restrictions are inherently restrictions on the joint modeling of the hedging and non-hedging portfolio. To give effect to these requirements, they must apply to the overall investment strategy and investment portfolio.

5. Before either a new or revised hedging strategy can be used to reduce the amount of the stochastic reserve otherwise calculated, the hedging strategy should be in place (i.e., effectively implemented by the company) for at least three months. The company may meet the time requirement by having evaluated the effective implementation of the hedging strategy for at least three months without actually having executed the trades indicated by the hedging strategy (e.g., mock testing or by having effectively implemented the strategy with similar annuity products for at least three months).

6. If a SHS supporting the contracts is not a CDHS but modeling it as if it were a CDHS would result in an increase in the company’s TAR, then the company shall model the SHS as if it were a CDHS when calculating reserves under AG43 and/or VM-21 and when calculating the C-3 RBC Amount under LR027. The company shall not treat the SHS as a CDHS for purposes of SSAP 108.

Commented [RJW(20): Here, the company is required to follow a CDHS. The documentation requirements alone do not prove that the company is following its CDHS.

Commented [RH21]: Added “supporting the contracts” in response to Nationwide comments.
B. Modeling Approaches

1. The analysis of the impact of the hedging strategy on cash flows is typically performed using either one of two types of methods as described below. Although a hedging strategy normally would be expected to reduce risk provisions, the nature of the hedging strategy and the costs to implement the strategy may result in an increase in the amount of the stochastic reserve otherwise calculated.

2. The fundamental characteristic of the first type of method, referred to as the “explicit method,” is that hedging positions and their resulting cash flows are included in the stochastic cash-flow model used to determine the scenario reserve, as discussed in Section 3.D, for each scenario.

3. The fundamental characteristic of the second type of method, referred to as the “implicit method,” is that the effectiveness of the current hedging strategy on future cash flows is evaluated, in part or in whole, outside of the stochastic cash-flow model. There are multiple ways that this type of modeling can be implemented. In this case, the reduction to the stochastic reserve otherwise calculated should be commensurate with the degree of effectiveness of the hedging strategy in reducing accumulated deficiencies otherwise calculated.

4. Regardless of the methodology used by the company, the ultimate effect of the current hedging strategy (including currently held hedge positions) on the stochastic reserve needs to recognize all risks, associated costs, imperfections in the hedges and hedging mismatch tolerances associated with the hedging strategy. The risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, annuitization, etc.). Costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. In addition, the reduction to the stochastic reserve attributable to the hedging strategy may need to be limited due to the uncertainty associated with the company’s ability to implement the hedging strategy in a timely and effective manner. The level of operational uncertainty varies indirectly with the amount of time that the new or revised strategy has been in effect or mock tested.

Guidance Note: No hedging strategy is perfect. A given hedging strategy may eliminate or reduce some but not all risks, transform some risks into others, introduce new risks, or have other imperfections. For example, a delta-only hedging strategy does not adequately hedge the risks measured by the “Greeks” other than delta. Another example is that financial indices underlying typical hedging instruments typically do not perform exactly like the separate account funds, and hence the use of hedging instruments has the potential for introducing basis risk.

5. A safe harbor approach is permitted for CDHS reflection for those companies whose modeled hedge assets comprise only linear instruments not sensitive to implied volatility. For companies with option-based hedge strategies, electing this approach would require representing the option-based portion of the strategy as a delta-rho two-Greek hedge program. The normally modeled option portfolio would be replaced with a set of linear instruments that have the same first-order Greeks as the original option portfolio.
C. Calculation of Stochastic Reserve (Reported)

1. The company shall calculate CTE70 (best efforts)—the results obtained when the CTE70 is based on incorporating the CDHS (including both currently held and future hedge positions) into the stochastic cash-flow model on a best efforts basis, including all of the factors and assumptions needed to execute the CDHS (e.g., stochastic implied volatility). The determination of CTE70 (best efforts) may utilize either explicit or implicit modeling techniques.

2. The company shall calculate a CTE70 (adjusted) by recalculating the CTE70 assuming the company has no CDHS, therefore following the requirements of Section 4.A.4.a.

3. Because most models will include at least some approximations or idealistic assumptions, CTE70 (best efforts) may overstate the impact of the hedging strategy. To compensate for potential overstatement of the impact of the hedging strategy, the value for the stochastic reserve is given by:

   \[
   \text{Stochastic reserve} = \text{CTE70 (best efforts)} + E \times \max[0, \text{CTE70 (adjusted)} - \text{CTE70 (best efforts)}]
   \]

4. The company shall specify a value for \(E\) (the “error factor”) in the range from 5% to 100% to reflect the company’s view of the potential error resulting from the level of sophistication of the stochastic cash-flow model and its ability to properly reflect the parameters of the hedging strategy (i.e., the Greeks being covered by the strategy), as well as the associated costs, risks and benefits. The greater the ability of the stochastic model to capture all risks and uncertainties, the lower the value of \(E\). The value of \(E\) may be as low as 5% only if the model used to determine the CTE70 (best efforts) effectively reflects all of the parameters used in the hedging strategy. If certain economic risks are not hedged, yet the model does not generate scenarios that sufficiently capture those risks, \(E\) must be in the higher end of the range, reflecting the greater likelihood of error. Likewise, simplistic hedge cash-flow models shall assume a higher likelihood of error.

5. The company shall conduct a formal back-test, based on an analysis of at least the most recent 12 months, to assess how well the model is able to replicate the hedging strategy in a way that supports the determination of the value used for \(E\).

6. Such a back-test shall involve one of the following analyses:
   a. For companies that model hedge cash flows directly (“explicit method”), replace the stochastic scenarios used in calculating the CTE70 (best efforts) with a single scenario that represents the market path that actually manifested over the selected back-testing period and compare the projected hedge asset gains and losses against the actual hedge asset gains and losses – both realized and unrealized – observed over the same time period. For this calculation, the model assumptions may be replaced with parameters that reflect actual experience during the back-testing period. In order to isolate the comparison between the modeled hedge strategy and actual hedge results for this calculation, the projected liabilities should accurately reflect the actual liabilities throughout the back-testing period; therefore, adjustments that facilitate this accuracy (e.g. reflecting actual experience instead of model assumptions, including new business, etc.) are permissible.

   To support the choice of a low value of \(E\), the company should ascertain that the projected hedge asset gains and losses are within close range of 100% (e.g., 80–125%) of the actual hedge asset
gains and losses. The company may also support the choice of a low value of \( E \) by achieving a high R-squared (e.g., 0.80 or higher) when using a regression analysis technique.

b. For companies that model hedge cash flows implicitly by quantifying the cost and benefit of hedging using the fair value of the hedged item (an "implicit method" or "cost of reinsurance method"), calculate the delta, rho and vega coverage ratios in each month over the selected back-testing period in the following manner:

i. Determine the hedge asset gains and losses—both realized and unrealized—incurred over the month attributable to equity, interest rate, and implied volatility movements.

ii. Determine the change in the fair value of the hedged item over the month attributable to equity, interest rate, and implied volatility movements. The hedged item should be defined in a manner that reflects the proportion of risks hedged (e.g., if a company elects to hedge 50% of a contract’s market risks, it should quantify the fair value of the hedged item as 50% of the fair value of the contract).

iii. Calculate the delta coverage ratio as the ratio between (i) and (ii) attributable to equity movements.

iv. Calculate the rho coverage ratio as the ratio between (i) and (ii) attributable to interest rate movements.

v. Calculate the vega coverage ratio as the ratio between (i) and (ii) attributable to implied volatility movements.

vi. To support the company’s choice of a low value of \( E \), the company should be able to demonstrate that the delta and rho coverage ratios are both within close range of 100 % (e.g., 80–125%) consistently across the back-testing period.

vii. In addition, the company should be able to demonstrate that the vega coverage ratio is within close range of 100 % in order to use the prevailing implied volatility levels as of the valuation date in quantifying the fair value of the hedged item for the purpose of calculating CTE70 (best efforts). Otherwise, the company shall quantify the fair value of the hedged item for the purpose of calculating CTE70 (best efforts) in a manner consistent with the realized volatility of the scenarios captured in the CTE (best efforts).

c. Companies that do not model hedge cash flows explicitly, but that also do not use the implicit method as outlined in Section 9.C.6.b above, shall conduct the formal back-test in a manner that allows the company to clearly illustrate the appropriateness of the selected method for reflecting the cost and benefit of hedging, as well as the value used for \( E \).

7. A company that does not have 12 months of experience to date shall set \( E \) to a value that reflects the amount of experience available, and the degree and nature of any change to the hedge program. For a material change in strategy, with no history, \( E \) should be at least 0.50. However, \( E \) may be lower than 0.50 if some reliable experience is available and/or if the change in strategy is a refinement rather than a substantial change in strategy.

**Guidance Note:** The following examples are provided as guidance for determining the \( E \) factor when there has been a change to the hedge program:
The error factor should be temporarily large (e.g., \( \geq 50\% \)) for substantial changes in hedge methodology (e.g., moving from a fair-value based strategy to a stop-loss strategy) where the company has not been able to provide a meaningful simulation of hedge performance based on the new strategy.

A temporary moderate increase (e.g., 15–30\%) in error factor should be used for substantial modifications to hedge programs or CDHS modeling where meaningful simulation has not been created (e.g., adding second-order hedging, such as gamma or rate convexity).

No increase in the error factor may be used for incremental modifications to the hedge strategy (e.g., adding death benefits to a program that previously covered only living benefits, or moving from swaps to Treasury Department futures).

D. Additional Considerations for CTE70 (best efforts)

If the company is following a CDHS, the fair value of the portfolio of contracts falling within the scope of these requirements shall be computed and compared to the CTE70 (best efforts) and CTE70 (adjusted). If the CTE70 (best efforts) is below both the fair value and CTE70 (adjusted), the company should be prepared to explain why that result is reasonable.

For the purposes of this analysis, the stochastic reserve and fair value calculations shall be done without requiring the scenario reserve for any given scenario to be equal to or in excess of the cash surrender value in aggregate for the group of contracts modeled in the projection.

E. Specific Considerations and Requirements

1. As part of the process of choosing a methodology and assumptions for estimating the future effectiveness of the current hedging strategy (including currently held hedge positions) for purposes of reducing the stochastic reserve, the company should review actual historical hedging effectiveness. The company shall evaluate the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, the mix of business and other items that are likely to result in materially adverse results. This includes an analysis of model assumptions that, when combined with the reliance on the hedging strategy, are likely to result in adverse results relative to those modeled. The parameters and assumptions shall be adjusted (based on testing contingent on the strategy used and other assumptions) to levels that fully reflect the risk based on historical ranges and foreseeable future ranges of the assumptions and parameters. If this is not possible by parameter adjustment, the model shall be modified to reflect them at either anticipated experience or adverse estimates of the parameters.

2. A discontinuous hedging strategy is a hedging strategy where the relationships between the sensitivities to equity markets and interest rates (commonly referred to as the Greeks) associated with the guaranteed contract holder options embedded in the variable annuities and other in-scope products and these same sensitivities associated with the hedging assets are subject to material discontinuities. This includes, but is not limited to, a hedging strategy where material hedging assets will be obtained when the variable annuity account balances reach a predetermined level in relationship to the guarantees. Any hedging strategy, including a delta hedging strategy, can be a discontinuous hedging strategy if implementation of the strategy permits material discontinuities between the sensitivities to equity markets and interest rates associated with the
guaranteed contract holder options embedded in the variable annuities and other in-scope products and these same sensitivities associated with the hedging assets. There may be scenarios that are particularly costly to discontinuous hedging strategies, especially where those result in large discontinuous changes in sensitivities (Greeks) associated with the hedging assets. Where discontinuous hedging strategies contribute materially to a reduction in the stochastic reserve, the company must evaluate the interaction of future trigger definitions and the discontinuous hedging strategy, in addition to the items mentioned in the previous paragraph. This includes an analysis of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.

3. A strategy that has a strong dependence on acquiring hedging assets at specific times that depend on specific values of an index or other market indicators may not be implemented as precisely as planned.

4. The combination of elements of the stochastic cash-flow model—including the initial actual market asset prices, prices for trading at future dates, transaction costs and other assumptions—should be analyzed by the company as to whether the stochastic cash-flow model permits hedging strategies that make money in some scenarios without losing a reasonable amount in some other scenarios. This includes, but is not limited to:
   a. Hedging strategies with no initial investment that never lose money in any scenario and in some scenarios make money.
   b. Hedging strategies that, with a given amount of initial money, never make less than accumulation at the one-period risk-free rates in any scenario but make more than this in one or more scenarios.

5. If the stochastic cash-flow model allows for such situations, the company should be satisfied that the results do not materially rely directly or indirectly on the use of such strategies. If the results do materially rely directly or indirectly on the use of such strategies, the strategies may not be used to reduce the stochastic reserve otherwise calculated.

6. In addition to the above, the method used to determine prices of financial instruments for trading in scenarios should be compared to actual initial market prices. In addition to comparisons to initial market prices, there should be testing of the pricing models that are used to determine subsequent prices when scenarios involve trading financial instruments. This testing should consider historical relationships. For example, if a method is used where recent volatility in the scenario is one of the determinants of prices for trading in that scenario, then that model should approximate actual historic prices in similar circumstances in history.

**VM-31 Section 3.C.5**

**Assets and Risk Management** – A brief description of the asset portfolio, and the approach used to model risk management strategies, such as hedging, and other derivative programs, including a description of any clearly defined hedging strategies. CDHS and any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4.
VM-31 Section 3.D.6.f

Risk Management – Detailed description of model risk management strategies, such as hedging and other derivative programs, including any clearly defined hedging strategies, specific to the groups of policies covered in this sub-report and not discussed in the Life Summary Section 3.C.5. This should include documentation for any hedging strategy that meets the requirements to be a CDHS. It should also include, for any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4, documentation of any CDHS criteria met, listing of CDHS criteria not met, and documentation of the reserve level with and without the SHS being modeled as if it were a CDHS.


a. Investment Officer on Investments – A certification from a duly authorized investment officer that the modeled company investment strategy, including any CDHS and any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4, is representative of and consistent with the company’s investment policy.

b. Qualified Actuary on Investments – A certification by a qualified actuary, not necessarily the same qualified actuary that has been assigned responsibility for the PBR Actuarial Report or this sub-report, that the modeling of any clearly defined hedging strategies CDHS and any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4 was performed in accordance with VM-20 and in compliance with all applicable ASOPs, and the alternative investment strategy as defined in VM-20 Section 7.E.1.g reflects the prescribed mix of assets with the same WAL as the reinvestment assets in the company investment strategy.

VM-31 Section 3.E.5

Assets and Risk Management – A brief description of the general account asset portfolio, and the approach used to model risk management strategies, such as hedging and other derivative programs, including a description of any CDHS or any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6 clearly defined hedging strategies, and any material changes to the hedging strategy from the prior year.
VM-31 Section 3.F.8

Hedging and Risk Management – The following information regarding the hedging and risk management assumptions used by the company in performing a principle-based valuation under VM-21:

a. Strategies – Detailed description of risk management strategies, such as hedging and other derivative programs, including any CDHS or any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, specific to the groups of contracts covered in this sub-report.
   i. Descriptions of basis risk, gap risk, price risk and assumption risk.
   ii. Methods and criteria for estimating the a priori effectiveness of the strategy.
   iii. Results of any reviews of actual historical hedging effectiveness.

b. CDHS – Documentation for any hedging strategy that meets the requirements to be a CDHS.

c. Other Modeled Hedging Strategies – Documentation for any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, including documentation of any CDHS criteria met, listing of CDHS criteria not met, and documentation of the TAR level with and without the SHS being modeled as if it were a CDHS.

c-d. Strategy Changes – Discussion of any changes to the hedging strategy during the past 12 months, including identification of the change, reasons for the change, and the implementation date of the change.

c-e. Hedge Modeling – Description of how the hedge strategy was incorporated into modeling, including:
   i. Differences in timing between model and actual strategy implementation.
   ii. For a company that does not have a CDHS or a SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, disclosure of the method used to consider hedge assets included in the starting assets, either (1) including the asset cash flows in the projection model; or (2) replacing the hedge positions with cash and/or other general account assets in an amount equal to the market value of the hedge positions, as discussed in VM-21 Section 4.A.4.a.
   iii. Evaluations of the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, and other items that are likely to result in materially adverse results.
   iv. If residual risks and frictional costs are assumed to have a value of zero, a demonstration that a value of zero is an appropriate expectation.
   v. Any discontinuous hedging strategies modeled, and where such discontinuous hedging strategies contribute materially to a reduction in the stochastic reserve, any evaluations of the interaction of future trigger definitions and the discontinuous hedging strategy, including any analyses of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.
   vi. Disclosure of any situations where the modeled hedging strategies make money in some scenarios without losing a reasonable amount in some other scenarios, and an explanation of why the situations are not material for determining the CTE 70 (best efforts).
   vii. Results of any testing of the method used to determine prices of financial instruments for trading in scenarios against actual initial market prices, including how the testing considered historical relationships. If there are substantial discrepancies, disclosure of the substantial discrepancies and documentation as to why the model-based prices are appropriate for determining the stochastic reserve.
viii. Any model adjustments made when calculating CTE 70 (adjusted), in particular, any liquidation or substitution of assets for currently held hedges.

c. Error Factor (\( E \)) and Back-Testing – Description of \( E \), the error factor, and formal back-tests performed, including:
   i. The value of \( E \), and the approach and rationale for the value of \( E \) used in the reserve calculation.
   ii. For companies that model hedge cash flows using the explicit method, as described in VM-21 Section 9.C.6.a, and have 12 months of experience, an analysis of at least the most recent 12 months of experience and the results of a back-test showing that the model is able to replicate the hedging results experienced in a way that justifies the value used for \( E \). Include at least a ratio of the actual change in market value of the hedges to the modeled change in market value of the hedges at least quarterly.
   iii. For companies that model hedge cash flows using the implicit method, and have 12 months of experience, as described in VM-21 Section 9.C.6.b, the results of a back-test in which (a) actual hedge asset gains and losses are compared against (b) proportional fair value movements in hedged liability, including:
      a) Delta, rho and vega coverage ratios in each month over the back-testing period, which may be presented in a chart or graph.
      b) The implied volatility level used to quantify the fair value of the hedged item, as well as the methodology undertaken to determine the appropriate level used.
   iv. For companies that do not model hedge cash flows using either the explicit method or the implicit method, as described in VM-21 Section 9.C.6.c, and have 12 months of experience, the results of the formal back-test conducted to validate the appropriateness of the selected method and value used for \( E \).
   v. For companies that do not have 12 months of experience, the basis for the value of \( E \) is chosen based on the guidance provided in VM-21 Section 9.C.7, considering the actual history available and the degree and nature of any changes made to the hedge strategy.

f. Safe Harbor for CDHS – If electing the safe harbor approach for CDHS, as discussed in VM-21 Section 9.C.8, a description of the linear instruments used to model the option portfolio.

g. Hedge Model Results – Disclosure of whether the calculated CTE 70 (best efforts) is below both the fair value and CTE 70 (adjusted), and if so, justification for why that result is reasonable, as discussed in VM-21 Section 9.D.

**VM-31 Section 3.F.12.c**

CTEPA – If using the CTEPA method, a summary including:
   i. Disclosure (in tabular form) of the scenario reserves using the same method and assumptions as those used by the company to calculate CTE 70 (adjusted) as outlined in VM-21 Section 9.C (or the stochastic reserves following VM-21 Section 4.A.4.a for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to VM-21 Section 9.A.6), as well as the corresponding scenarios reserves substituting the assumptions prescribed by VM-21 Section 6.C.
ii. Summary of results from a cumulative decrement projection along the scenario whose reserve value is closest to the CTE 70 (adjusted), as outlined in VM-21 Section 9.C (or the stochastic reserves following VM-21 Section 4.A.4.a for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to VM-21 Section 9.A.6), under the assumptions outlined in VM-21 Section 6.C. Such a cumulative decrement projection shall include, at the end of each projection year, the projected proportion (expressed as a percent of the total projected account value) of persisting contracts as well as the allocation of projected decrements across death, full surrender, account value depletion, elective annuitization, and other benefit election.

iii. Summary of results from a cumulative decrement projection, identical to (ii) above, but replacing all assumptions outlined in VM-21 Section 6.C with the corresponding assumptions used in calculating the stochastic reserve.

**VM-31 Section 3.F.16.a and Section 3.F.16.b**

a. **Investment Officer on Investments** – A certification from a duly authorized investment officer that the modeled asset investment strategy, including any CDHS and any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, is consistent with the company’s current investment strategy except where the modeled reinvestment strategy may have been substituted with the alternative investment strategy, and also any CDHS meets the requirements of a CDHS.

b. **Qualified Actuary on Investments** – A certification by a qualified actuary, not necessarily the same qualified actuary that has been assigned responsibility for the PBR Actuarial Report or this sub-report, that the modeling of any clearly defined hedging strategies CDHS and any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6 was performed in accordance with VM-21 and in compliance with all applicable ASOPs.
Life Actuarial (A) Task Force/Health Actuarial (B) Task Force
Amendment Proposal Form*

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

**Identification:**
Rachel Hemphill and Karen Jiang, Texas Department of Insurance

**Title of the Issue:**
Create consistency between CDHS determination in VM-20 and VM-21. Revise hedge modeling to only require CDHS if modeling future hedging reduces the reserves under VM-20 or TAR under VM-21.

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


January 1, 2021 NAIC Valuation Manual

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

See attached.

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

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**Summary of 5/17/2021 Editorial Changes and Clarifications:**

1. Editorial changes were made in response to the comment by John Robinson of MN:
   a. Replace “hedge” with “hedging” when used as an adjective.
   b. Clarify that the Principles apply to the modeling of a CDHS or SHS.
   c. Add references to “one or more” CDHS or SHS, to reflect that a company may have multiple CDHS or SHS.
   d. Add reference to a CDHS that the company is following.

2. Clarifying edits were made in response to the comment ACLI:
   a. Clarify that PBR reflecting a company’s investment policy and risk management strategies supporting the policies or contracts does not target, deem illegitimate, or otherwise reflect a negative view on the company’s investment policy and risk management strategies supporting the policies or contracts. In fact, the opposite is true. Note that this is consistent with VM-20 Section 7.K.1’s treatment of non-hedging derivative use.
   b. Clarify even further that the CDHS requirements are documentation requirements (i.e., documentation clearly defining the hedging strategy) and may always be satisfied at the company’s option.
Summary of 4/2/2021 Updates:

1. Revisions were made to VM-20 Section 7.K.4 (add “supporting the policies”) and VM-21 Section 9.A.6 (add “supporting the contracts”) in response to Nationwide’s comments.
2. We added a definition for “hedging transactions,” taken from the APPM but modified slightly to be consistent with Valuation Manual terminology in response to Will Wilton’s comments.
3. We have updated the list of CDHS criteria in response to Will Wilton’s comments where we agreed:
   a. Added "significant" before risks in item (c) of the CDHS definition.
   b. Combined items (f) – (h) in the CDHS definition.
   c. Change "person or persons" to "group or area, including whether internal or external," in item (j) of the CDHS definition.
   d. We did not remove items (k) or (l) as suggested by Will Wilton, as we find this information useful to regulators. Given that these are retained, and because we were uncertain what else would be included in the new “primary risks” item suggested by Will Wilton, we have not added it. If we can be provided additional information on the risks to be reflected under this new item, an edit could be made.
4. We modified the definition of a SHS to clarify “normally modelled” in response to the ACLI comment and clarify what may be a SHS in response to Will Wilton’s comment (e.g., a single bond would not be a SHS).

We have added comment bubbles in the draft below to flag where we have made edits or chosen not to make edits and why.

We propose having consistent requirements for a CDHS in VM-20 and VM-21, as well as any future work on VM-22, and consolidating these requirements in the VM-01 definition of a CDHS. This involves adding two criteria to VM-21’s definition of CDHS that currently exist for VM-20:

- Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
- The circumstances under which hedging strategy will not be effective in hedging the risks.

These criteria are both reasonable and apply in principle to VM-21, and to any future work on VM-22, as well as VM-20.

Further, we propose revising the requirement for hedging to be a CDHS in order for future hedging to be modeled under VM-20, modeled under VM-21, and LR027’s C-3 RBC Amount calculation to only apply when modeling such hedging reduces the life reserve level or variable annuity Total Asset Requirement (TAR) level.

The current regulatory requirements for hedging to be a CDHS in order for future hedging to be modeled under VM-20, modeled under VM-21, modeled for the C-3 RBC Amount calculation for variable annuities, and to be eligible for SSAP 108 treatment are all logical requirements when one considers whether hedging should be allowed to reduce the life reserve level or variable annuity TAR level, or whether any mismatch between movements in hedge assets and movements in the corresponding reserve levels should be allowed to be amortized over time.
However, this same requirement has led to a situation of there being unintended optionality in whether a hedging strategy that is like a CDHS is modeled or is not modeled, since a company may choose to satisfy or not satisfy certain of the criteria. This has been especially relevant for cases where modeling a company’s hedging strategy would increase reserves or variable annuity TAR.

As noted in the current guidance note in VM-20 Section 7.K.1 in the 2021 Valuation Manual:

“The prohibition in these modeled reserve requirements against projecting future hedging transactions other than those associated with a clearly defined hedging strategy is intended to address initial concerns expressed by various parties that reserves could be unduly reduced by reflection of programs whose future execution and performance may have greater uncertainty. The prohibition appears, however, to be in conflict with Principle 2 listed in VM-21. Companies may actually execute and reflect in their risk assessment and evaluation processes hedging strategies similar in many ways to clearly defined hedging strategies but lack sufficient clarity in one or more of the qualification criteria. By excluding the associated derivative instruments, the investment strategy that is modeled may also not reflect the investment strategy the company actually uses. Further, because the future hedging transactions may be a net cost to the company in some scenarios and a net benefit in other scenarios, the exclusion of such transactions can result in a modeled reserve that is either lower or higher than it would have been if the transactions were not excluded. The direction of such impact on the reserves could also change from period to period as the actual and projected paths of economic conditions change. A more graded approach to recognition of non-qualifying hedging strategies may be more theoretically consistent with Principle 2. It is recommended that as greater experience is gained by actuaries and state insurance regulators with the principle-based approach and as industry hedging programs mature, the various requirements of this section be reviewed.”

We propose to continue addressing the regulatory concern that reserves could be unduly reduced by reflection of programs whose future execution and performance may have greater uncertainty, by continuing to only allowing hedging strategies that qualify as a CDHS to reduce life reserves and variable annuity TAR. However, we propose that the treatment of CDHS be made more principles-based and less subject to manipulation. To accomplish this, the proposal requires that any hedging strategy that is a part of the investment strategy supporting the policies and is normally modeled as part of the company’s risk assessment and evaluation processes be modeled as if it were a CDHS if doing so results in an increase in life reserves or variable annuity TAR.

That is, CDHS becomes a requirement solely for hedging strategies that reduce life reserves or variable annuity TAR, and so becomes a more clear regulatory guardrail requiring that hedging strategies that reduce life reserves or variable annuity TAR must be clearly defined.

We continue to need the concept of a CDHS. A CDHS simply formally documents items that a company should be able to document for a robust, well-defined hedging strategy. It requires that the following be identified:

a. The specific risks being hedged (e.g., cash flow, policy interest credits, delta, rho, vega, etc.).

b. The hedge objectives.

c. The risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).

d. The financial instruments used to hedge the risks.

e. The hedge trading rules, including the permitted tolerances from hedging objectives.

f. The metrics for measuring hedging effectiveness.

g. The criteria used to measure hedging effectiveness.

h. The frequency of measuring hedging effectiveness.
i. The conditions under which hedging will not take place.

j. The person or persons responsible for implementing the hedging strategy.

k. Areas where basis, gap or assumption risk related to the hedging strategy have been identified.

l. The circumstances under which hedging strategy will not be effective in hedging the risks.

While the last two criteria have historically applied for life but not variable annuities, these are all reasonable documentation items that for a robust, well-defined hedging strategy regardless of whether the product is life or variable annuity.

The concept of a CDHS is used for accounting in SSAP 108. SSAP 108 allows companies to set up a deferred asset or liability to amortize the mismatch between changes in the value of the liability and changes in the value of the hedging instruments attributable to the hedged risk underlying a highly effective CDHS modeled for VM-21. Allowing this treatment encourages companies to reduce risk through robust, well-defined and highly effective hedging. Without having the hedging strategy be well-defined, regulators could not rely on past effectiveness being indicative of future effectiveness, and so could not offer companies the benefit of SSAP 108 treatment. Once we recognize the need for a concept of a well-defined hedging strategy, the only question is what criteria would need to be met to be considered well-defined—that is, what criteria should be required to be considered a CDHS. This is a distinct question from whether the concept of a CDHS is needed. We have not heard critiques of individual criteria in the CDHS definition, but consideration of the criteria is appropriate as we go forward to make the definitions in VM-20 and VM-21 consistent. Similarly, in reserve and capital calculations, we rely on the concept of historical effectiveness to determine an error factor. If modeling hedging reduces the reserve or capital amount, the error factor determines the magnitude to which this is reflected. However, this use of the historical effectiveness relies on the hedging strategy being well-documented and comparable between historical hedging and planned future hedging. So, again, a need for hedging strategies to be well-defined presents itself—a CDHS concept is needed.

Finally, edits to VM-31 are needed to reflect these updates and bring VM-20 and VM-21 reporting requirements more in line with one another where appropriate.

**Note on Coordination with RBC and APPM:** We have reviewed, and with these edits there are no corresponding edits necessary for LR027 for RBC but corresponding edits are necessary for SSAP 108. A referral to SAPWG is to be concurrently considered with this APF.
The term “clearly defined hedging strategy” (CDHS) means a strategy undertaken by a company to manage risks through the future purchase or sale of hedging instruments and the opening and closing of hedging positions. A CDHS must identify:

- a. The specific risks being hedged (e.g., cash flow, policy interest credits, delta, rho, vega, etc.).
- b. The hedging objectives.
- c. The significant risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).
- d. The financial instruments used to hedge the risks.
- e. The hedging strategy’s trading rules, including the permitted tolerances from hedging objectives.
- f. The metrics, criteria, and frequency for measuring hedging effectiveness.
- g. The conditions under which hedging will not take place.
- h. The group or area, including whether internal or external, responsible for implementing the hedging strategy.
- i. Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
- j. The circumstances under which hedging strategy will not be effective in hedging the risks.

The hedging strategy may be dynamic, static or a combination thereof. A strategy involving the offsetting of the risks associated with products falling under the scope of different requirements within the Valuation Manual (e.g., VM-20, VM-21, or VM-22) does not qualify as CDHS.

Guidance Note: All of the principles outlined in VM-21 Section 1.B (particularly Principle 5) apply to the modeling of a CDHS.

The term “hedging transaction” means a derivative(s) transaction which is entered into and maintained to reduce:

- a. The risk of a change in the fair value or cash flow of assets and liabilities which the company has acquired or incurred or has a firm commitment to acquire or incur or for which the company has a forecasted acquisition or incurrence; or
- b. The currency exchange rate risk or the degree of foreign currency exposure in assets and liabilities which the company has acquired or incurred or has a firm commitment to acquire or incur or for which the company has forecasted acquisition or incurrence.

The term “Seasoned Hedging Strategy” (SHS) means a hedging strategy that is part of the company’s investment strategy and for which future hedging transactions are normally modeled as part of any of the company’s risk assessment and evaluation processes. A SHS may or may not be a CDHS.

Guidance Note: All of the principles outlined in VM-21 Section 1.B (particularly Principle 5) apply to the modeling of a SHS.
VM-20 Section 6.A.1.b

A company may not exclude a group of policies for which there is one or more CDHS or one or more SHS required to be modeled pursuant to Section 7.K.4 from stochastic reserve requirements, except in the case where all CDHS and all SHS required to be modeled pursuant to Section 7.K.4 are solely associated with product features that are determined to not be material under Section 7.B.1 due to low utilization.

VM-20 Section 7.E.1.g

Notwithstanding the above requirements, the modeled reserve shall be the higher of that produced by the model investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the model investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of a CDHS (in compliance with the definition of CDHS in VM-01) or a SHS that is required to be modeled pursuant to Section 7.K.4 are not affected by this requirement.

VM-20 Section 7.K

K. Modeling of Derivative Programs

1. When determining the deterministic reserve and the stochastic reserve, the company shall include in the projections the appropriate costs and benefits of derivative instruments that are currently held by the company in support of the policies subject to these requirements. The company shall also include the appropriate costs and benefits of anticipated future derivative instrument transactions associated with the execution of a CDHS or a SHS that is required to be modeled pursuant to Section 7.K.4, as well as the appropriate costs and benefits of anticipated future derivative instrument transactions associated with non-hedging derivative programs (e.g., replication, income generation) undertaken as part of the investment strategy supporting the policies, provided they are normally modeled as part of the company’s risk assessment and evaluation processes.

2. For each derivative program that is modeled, the company shall reflect the company’s established investment policy and procedures for that program; project expected program performance along each scenario; and recognize all benefits, residual risks and associated frictional costs. The residual risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, etc.). Frictional costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. For CDHS or SHS required to be modeled pursuant to Section 7.K.4, the company may not assume that residual risks and frictional costs have a value of zero, unless the company demonstrates in the PBR Actuarial Report that “zero” is an appropriate expectation.

3. In circumstances where one or more material risk factors related to a derivative program are not fully captured within the cash-flow model used to calculate CTE 70, the company shall reflect such risk factors by increasing the stochastic reserve as described in Section 8.E.
4. If a SHS supporting the policies is not a CDHS but modeling it would result in a material increase to the company’s minimum reserve, then the company shall model the SHS as if it were a CDHS when calculating reserves under VM-20. In addition, if modeling the SHS as if it were a CDHS would result in a decrease in the company’s minimum reserve, the company may provide the documentation required for the SHS to be a CDHS as defined in VM-01 and then model the SHS as a CDHS.

**Guidance Note:** The intent of reflecting SHS is not to penalize any hedging strategies, but rather to reflect the company’s investment strategy and risk management strategies, including all material established hedging strategies supporting the policies, while requiring CDHS documentation for any such hedging strategies that reduce the minimum reserve.

**VM-20 Section 7.L (Remove entire Section 7.L)**

**Deleted:**

- L. Clearly Defined Hedging Strategy
  - A clearly defined hedging strategy must identify:
    - The specific risks being hedged (e.g., cash flow, policy interest credits, delta, rho, vega, etc.).
    - The hedge objectives.
    - The risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).
    - The financial instruments used to hedge the risks.
    - The hedge trading rules, including the permitted tolerances from hedging objectives.
    - The metrics for measuring hedging effectiveness.
    - The criteria used to measure hedging effectiveness.
    - The frequency of measuring hedging effectiveness.
    - The person or persons responsible for implementing the hedging strategy.
    - Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
    - The circumstances under which hedging strategy will not be effective in hedging the risks.
  - Hedging strategies involving the offsetting of the risks associated with other products outside of the scope of these requirements is not a clearly defined hedging strategy.

**Guidance Note:** For purposes of the above criteria, “effectiveness” need not be measured in a manner as defined in SSAP No. 86— Derivatives in the AP&P Manual.
VM-21 Section 1.D.2 (Delete entire definition and renumber subsequent sections VM-21 Section 1.D.3 and VM-21 Section 1.D.4)

VM-21 Section 4.A.4

Modeling of Hedges

a. For a company that does not have a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6:

i. The company shall not consider the cash flows from any future hedge purchases or any rebalancing of existing hedge assets in its modeling.

ii. Existing hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the starting assets. The hedge assets may then be considered in one of two ways:

a) Include the asset cash flows from any contractual payments and maturity values in the projection model; or

b) No hedge positions – in which case the hedge positions held on the valuation date are replaced with cash and/or other general account assets in an amount equal to the aggregate market value of these hedge positions.

Guidance Note: If the hedge positions held on the valuation date are replaced with cash, then as with any other cash, such amounts may then be invested following the company’s investment strategy.

A company may switch from method a) to method b) at any time, but it may only change from b) to a) with the approval of the domiciliary commissioner.

b. For a company following one or more CDHS or one or more SHS that are required to be modeled pursuant to Section 9.A.6, the detailed requirements for the modeling of hedges are defined in Section 9. The following paragraphs are a high-level summary and do not supersede the detailed requirements.

i. The appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the projections used in the determination of the stochastic reserve.

ii. The projections shall take into account the appropriate costs and benefits of hedge positions expected to be held in the future through the execution of a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6. Because models do not always accurately portray the results of hedge programs, the company shall, through back-testing and other means, assess the accuracy of the hedge modeling. The company shall determine a stochastic reserve as the weighted average of two CTE values; first, a CTE70 (“best efforts”) representing the company’s projection of all of the hedge cash flows, including future hedge purchases, and a second CTE70 (“adjusted”) which shall use only hedge assets held by the company on the valuation date and no future hedge purchases. These are discussed in greater detail in Section 9. The stochastic reserve shall be the weighted average of the two CTE70 values, where the weights reflect the error factor (E) determined following the guidance of Section 9.C.4.
iii. The company is responsible for verifying compliance with CDHS requirements or SHS requirements if required to be modeled pursuant to Section 9.A.6 and any other requirements in Section 9 for all hedging instruments included in the projections.

iv. The use of products not falling under the scope of these requirements (e.g., equity-indexed annuities) as a hedge shall not be recognized in the determination of accumulated deficiencies.

**VM-21 Section 4.D.4.b**

Notwithstanding the above requirements, the model investment strategy and any non-prescribed asset spreads shall be adjusted as necessary so that the aggregate reserve is not less than that which would be obtained by substituting an alternative investment strategy in which all fixed income reinvestment assets are public non-callable corporate bonds with gross asset spreads, asset default costs, and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of a CDHS (in compliance with the definition of CDHS in VM-01) or a SHS that is required to be modeled pursuant to Section 9.A.6 are not affected by this requirement.

**VM-21 Section 6.B.3.a.ii – Footnote (Footnote at Bottom of Page 21-22)**

Throughout this Section 6, references to CTE70 (adjusted) shall also mean the Stochastic Reserve for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6 as discussed in Section 4.A.4.a.

**VM-21 Section 6.B.3.b.ii**

Calculate the Prescribed Projections Amount as the CTE70 (adjusted) using the same method as that outlined in Section 9.C (which is the same as the stochastic reserves following Section 4.A.4.a for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6) but substituting the assumptions prescribed by Section 6.C. The calculation of this Prescribed Projections Amount also requires that the scenario reserve for any given scenario be equal to or in excess of the cash surrender value in aggregate on the valuation date for the group of contracts modeled in the projection.

**VM-21 Section 6.B.5**

Cash flows associated with hedging shall be projected in the same manner as that used in the calculation of the CTE70 (adjusted) as discussed in Section 9.C or Section 4.A.4.a for a company without a CDHS or a SHS that is required to be modeled pursuant to Section 9.A.6.
VM-21 Section 9

Section 9: Modeling of Hedges under a CDHS

A. Initial Considerations

1. Subject to Section 9.C.2, the appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the calculation of the stochastic reserve, determined in accordance with Section 3.D and Section 4.D.

2. If the company is following one or more CDHS, in accordance with an investment policy adopted by the board of directors, or a committee of board members, the company shall take into account the costs and benefits of hedge positions expected to be held by the company in the future along each scenario based on the execution of the hedging strategy, and it is eligible to reduce the amount of the stochastic reserve using projections otherwise calculated. The investment policy must clearly articulate the company’s hedging objectives, including the metrics that drive rebalancing/trading. This specification could include maximum tolerable values for investment losses, earnings, volatility, exposure, etc. in either absolute or relative terms over one or more investment horizons vis-à-vis the chance of occurrence. Company management is responsible for developing, documenting, executing and evaluating the investment strategy, including the hedging strategy, used to implement the investment policy.

3. For this purpose, the investment assets refer to all the assets, including derivatives supporting covered products and guarantees. This also is referred to as the investment portfolio. The investment strategy is the set of all asset holdings at all points in time in all scenarios. The hedging portfolio, which also is referred to as the hedging assets, is a subset of the investment assets. The hedging strategy is the hedging asset holdings at all points in time in all scenarios. There is no attempt to distinguish what is the hedging portfolio and what is the investment portfolio in this section. Nor is the distinction between investment strategy and hedging strategy formally made here. Where necessary to give effect to the intent of this section, the requirements applicable to the hedging portfolio or the hedging strategy are to apply to the overall investment portfolio and investment strategy.

4. This particularly applies to restrictions on the reasonableness or acceptability of the models that make up the stochastic cash-flow model used to perform the projections, since these restrictions are inherently restrictions on the joint modeling of the hedging and non-hedging portfolio. To give effect to these requirements, they must apply to the overall investment strategy and investment portfolio.

5. Before either a new or revised hedging strategy can be used to reduce the amount of the stochastic reserve otherwise calculated, the hedging strategy should be in place (i.e., effectively implemented by the company) for at least three months. The company may meet the time requirement by having evaluated the effective implementation of the hedging strategy for at least three months without actually having executed the trades indicated by the hedging strategy (e.g., mock testing or by having effectively implemented the strategy with similar annuity products for at least three months).

6. If a SHS supporting the contracts is not a CDHS but modeling it as if it were a CDHS would result in a material increase in the company’s TAR, then the company shall model the SHS as a CDHS. In addition, if modeling the SHS as a CDHS would result in a decrease in the company’s TAR, the company may provide the documentation required for the SHS to be a CDHS as defined in VM-01 and then model the SHS as a CDHS when calculating reserves under AG43 and/or VM-21 when calculating the C-3 RBC Amount under LR027. The company shall not treat a SHS as a CDHS for purposes of SSAP 108 without providing the documentation required for the SHS to be a CDHS as defined in VM-01.

Guidance Note: The intent of reflecting SHS is not to penalize any hedging strategies, but rather to reflect the company’s investment strategy and risk management strategies, including all material established.
hedging strategies supporting the contracts, while requiring CDHS documentation for any such hedging strategies that reduce TAR.

B. Modeling Approaches

1. The analysis of the impact of the hedging strategy on cash flows is typically performed using either one of two types of methods as described below. Although a hedging strategy normally would be expected to reduce risk provisions, the nature of the hedging strategy and the costs to implement the strategy may result in an increase in the amount of the stochastic reserve otherwise calculated.

2. The fundamental characteristic of the first type of method, referred to as the “explicit method,” is that hedging positions and their resulting cash flows are included in the stochastic cash-flow model used to determine the scenario reserve, as discussed in Section 3.D, for each scenario.

3. The fundamental characteristic of the second type of method, referred to as the “implicit method,” is that the effectiveness of the current hedging strategy on future cash flows is evaluated, in part or in whole, outside of the stochastic cash-flow model. There are multiple ways that this type of modeling can be implemented. In this case, the reduction to the stochastic reserve otherwise calculated should be commensurate with the degree of effectiveness of the hedging strategy in reducing accumulated deficiencies otherwise calculated.

4. Regardless of the methodology used by the company, the ultimate effect of the current hedging strategy (including currently held hedge positions) on the stochastic reserve needs to recognize all risks, associated costs, imperfections in the hedges and hedging mismatch tolerances associated with the hedging strategy. The risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, annuitization, etc.). Costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. In addition, the reduction to the stochastic reserve attributable to the hedging strategy may need to be limited due to the uncertainty associated with the company’s ability to implement the hedging strategy in a timely and effective manner. The level of operational uncertainty varies indirectly with the amount of time that the new or revised strategy has been in effect or mock tested.

Guidance Note: No hedging strategy is perfect. A given hedging strategy may eliminate or reduce some but not all risks, transform some risks into others, introduce new risks, or have other imperfections. For example, a delta-only hedging strategy does not adequately hedge the risks measured by the “Greeks” other than delta. Another example is that financial indices underlying typical hedging instruments typically do not perform exactly like the separate account funds, and hence the use of hedging instruments has the potential for introducing basis risk.

5. A safe harbor approach is permitted for CDHS reflection for those companies whose modeled hedge assets comprise only linear instruments not sensitive to implied volatility. For companies with option-based hedge strategies, electing this approach would require representing the option-based portion of the strategy as a delta-rho two-Greek hedge program. The normally modeled option portfolio would be replaced with a set of linear instruments that have the same first-order Greeks as the original option portfolio.

C. Calculation of Stochastic Reserve (Reported)

1. The company shall calculate CTE70 (best efforts)—the results obtained when the CTE70 is based on incorporating the CDHS (including both currently held and future hedge positions) into the stochastic cash-flow model on a best efforts basis, including all of the factors and assumptions needed to execute the CDHS
(e.g., stochastic implied volatility). The determination of CTE70 (best efforts) may utilize either explicit or implicit modeling techniques.

2. The company shall calculate a CTE70 (adjusted) by recalculating the CTE70 assuming the company has no CDHS, therefore following the requirements of Section 4.A.4.a.

3. Because most models will include at least some approximations or idealistic assumptions, CTE70 (best efforts) may overstate the impact of the hedging strategy. To compensate for potential overstatement of the impact of the hedging strategy, the value for the stochastic reserve is given by:

\[
\text{Stochastic reserve} = \text{CTE70 (best efforts)} + E \times \max[0, \text{CTE70 (adjusted)} - \text{CTE70 (best efforts)}]
\]

4. The company shall specify a value for \( E \) (the “error factor”) in the range from 5% to 100% to reflect the company’s view of the potential error resulting from the level of sophistication of the stochastic cash-flow model and its ability to properly reflect the parameters of the hedging strategy (i.e., the Greeks being covered by the strategy), as well as the associated costs, risks and benefits. The greater the ability of the stochastic model to capture all risks and uncertainties, the lower the value of \( E \). The value of \( E \) may be as low as 5% only if the model used to determine the CTE70 (best efforts) effectively reflects all of the parameters used in the hedging strategy. If certain economic risks are not hedged, yet the model does not generate scenarios that sufficiently capture those risks, \( E \) must be in the higher end of the range, reflecting the greater likelihood of error. Likewise, simplistic hedge cash-flow models shall assume a higher likelihood of error.

5. The company shall conduct a formal back-test, based on an analysis of at least the most recent 12 months, to assess how well the model is able to replicate the hedging strategy in a way that supports the determination of the value used for \( E \).

6. Such a back-test shall involve one of the following analyses:
   a. For companies that model hedge cash flows directly (“explicit method”), replace the stochastic scenarios used in calculating the CTE70 (best efforts) with a single scenario that represents the market path that actually manifested over the selected back-testing period and compare the projected hedge asset gains and losses against the actual hedge asset gains and losses – both realized and unrealized – observed over the same time period. For this calculation, the model assumptions may be replaced with parameters that reflect actual experience during the back-testing period. In order to isolate the comparison between the modeled hedge strategy and actual hedge results for this calculation, the projected liabilities should accurately reflect the actual liabilities throughout the back-testing period; therefore, adjustments that facilitate this accuracy (e.g. reflecting actual experience instead of model assumptions, including new business, etc.) are permissible.

   To support the choice of a low value of \( E \), the company should ascertain that the projected hedge asset gains and losses are within close range of 100% (e.g., 80–125%) of the actual hedge asset gains and losses. The company may also support the choice of a low value of \( E \) by achieving a high R-squared (e.g., 0.80 or higher) when using a regression analysis technique.

   b. For companies that model hedge cash flows implicitly by quantifying the cost and benefit of hedging using the fair value of the hedged item (an “implicit method” or “cost of reinsurance method”), calculate the delta, rho and vega coverage ratios in each month over the selected back-testing period in the following manner:

   i. Determine the hedge asset gains and losses—both realized and unrealized—incurred over the month attributable to equity, interest rate, and implied volatility movements.
ii. Determine the change in the fair value of the hedged item over the month attributable to equity, interest rate, and implied volatility movements. The hedged item should be defined in a manner that reflects the proportion of risks hedged (e.g., if a company elects to hedge 50% of a contract’s market risks, it should quantify the fair value of the hedged item as 50% of the fair value of the contract).

iii. Calculate the delta coverage ratio as the ratio between (i) and (ii) attributable to equity movements.

iv. Calculate the rho coverage ratio as the ratio between (i) and (ii) attributable to interest rate movements.

v. Calculate the vega coverage ratio as the ratio between (i) and (ii) attributable to implied volatility movements.

vi. To support the company’s choice of a low value of E, the company should be able to demonstrate that the delta and rho coverage ratios are both within close range of 100% (e.g., 80–125%) consistently across the back-testing period.

vii. In addition, the company should be able to demonstrate that the vega coverage ratio is within close range of 100% in order to use the prevailing implied volatility levels as of the valuation date in quantifying the fair value of the hedged item for the purpose of calculating CTE70 (best efforts) in a manner consistent with the realized volatility of the scenarios captured in the CTE (best efforts).

c. Companies that do not model hedge cash flows explicitly, but that also do not use the implicit method as outlined in Section 9.C.6.b above, shall conduct the formal back-test in a manner that allows the company to clearly illustrate the appropriateness of the selected method for reflecting the cost and benefit of hedging, as well as the value used for E.

7. A company that does not have 12 months of experience to date shall set E to a value that reflects the amount of experience available, and the degree and nature of any change to the hedge program. For a material change in strategy, with no history, E should be at least 0.50. However, E may be lower than 0.50 if some reliable experience is available and/or if the change in strategy is a refinement rather than a substantial change in strategy.

Guidance Note: The following examples are provided as guidance for determining the E factor when there has been a change to the hedge program:

- The error factor should be temporarily large (e.g., ≥ 50%) for substantial changes in hedge methodology (e.g., moving from a fair-value based strategy to a stop-loss strategy) where the company has not been able to provide a meaningful simulation of hedge performance based on the new strategy.
- A temporary moderate increase (e.g., 15–30%) in error factor should be used for substantial modifications to hedge programs or CDHS modeling where meaningful simulation has not been created (e.g., adding second-order hedging, such as gamma or rate convexity).
- No increase in the error factor may be used for incremental modifications to the hedge strategy (e.g., adding death benefits to a program that previously covered only living benefits, or moving from swaps to Treasury Department futures).

D. Additional Considerations for CTE70 (best efforts)

If the company is following a CDHS, the fair value of the portfolio of contracts falling within the scope of these requirements shall be computed and compared to the CTE70 (best efforts) and CTE70 (adjusted). If the CTE70 (best efforts) is below both the fair value and CTE70 (adjusted), the company should be prepared to explain why that result is reasonable.
For the purposes of this analysis, the stochastic reserve and fair value calculations shall be done without requiring the scenario reserve for any given scenario to be equal to or in excess of the cash surrender value in aggregate for the group of contracts modeled in the projection.

E. Specific Considerations and Requirements

1. As part of the process of choosing a methodology and assumptions for estimating the future effectiveness of the current hedging strategy (including currently held hedge positions) for purposes of reducing the stochastic reserve, the company should review actual historical hedging effectiveness. The company shall evaluate the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, the mix of business and other items that are likely to result in materially adverse results. This includes an analysis of model assumptions that, when combined with the reliance on the hedging strategy, are likely to result in adverse results relative to those modeled. The parameters and assumptions shall be adjusted (based on testing contingent on the strategy used and other assumptions) to levels that fully reflect the risk based on historical ranges and foreseeable future ranges of the assumptions and parameters. If this is not possible by parameter adjustment, the model shall be modified to reflect them at either anticipated experience or adverse estimates of the parameters.

2. A discontinuous hedging strategy is a hedging strategy where the relationships between the sensitivities to equity markets and interest rates (commonly referred to as the Greeks) associated with the guaranteed contract holder options embedded in the variable annuities and other in-scope products and these same sensitivities associated with the hedging assets are subject to material discontinuities. This includes, but is not limited to, a hedging strategy where material hedging assets will be obtained when the variable annuity account balances reach a predetermined level in relationship to the guarantees. Any hedging strategy, including a delta hedging strategy, can be a discontinuous hedging strategy if implementation of the strategy permits material discontinuities between the sensitivities to equity markets and interest rates associated with the guaranteed contract holder options embedded in the variable annuities and other in-scope products and these same sensitivities associated with the hedging assets. There may be scenarios that are particularly costly to discontinuous hedging strategies, especially where those result in large discontinuous changes in sensitivities (Greeks) associated with the hedging assets. Where discontinuous hedging strategies contribute materially to a reduction in the stochastic reserve, the company must evaluate the interaction of future trigger definitions and the discontinuous hedging strategy, in addition to the items mentioned in the previous paragraph. This includes an analysis of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.

3. A strategy that has a strong dependence on acquiring hedging assets at specific times that depend on specific values of an index or other market indicators may not be implemented as precisely as planned.

4. The combination of elements of the stochastic cash-flow model—including the initial actual market asset prices, prices for trading at future dates, transaction costs and other assumptions—should be analyzed by the company as to whether the stochastic cash-flow model permits hedging strategies that make money in some scenarios without losing a reasonable amount in some other scenarios. This includes, but is not limited to: a. Hedging strategies with no initial investment that never lose money in any scenario and in some scenarios make money. b. Hedging strategies that, with a given amount of initial money, never make less than accumulation at the one-period risk-free rates in any scenario but make more than this in one or more scenarios.

5. If the stochastic cash-flow model allows for such situations, the company should be satisfied that the results do not materially rely directly or indirectly on the use of such strategies. If the results do materially rely directly or indirectly on the use of such strategies, the strategies may not be used to reduce the stochastic reserve otherwise calculated.
6. In addition to the above, the method used to determine prices of financial instruments for trading in scenarios should be compared to actual initial market prices. In addition to comparisons to initial market prices, there should be testing of the pricing models that are used to determine subsequent prices when scenarios involve trading financial instruments. This testing should consider historical relationships. For example, if a method is used where recent volatility in the scenario is one of the determinants of prices for trading in that scenario, then that model should approximate actual historic prices in similar circumstances in history.

VM-31 Section 3.C.5

Assets and Risk Management – A brief description of the asset portfolio, and the approach used to model risk management strategies, such as hedging, and other derivative programs, including a description of any CDHS and any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4.

VM-31 Section 3.D.6.f

Risk Management – Detailed description of model risk management strategies, such as hedging and other derivative programs specific to the groups of policies covered in this sub-report and not discussed in the Life Summary Section 3.C.5. This should include documentation for any hedging strategy that meets the requirements to be a CDHS. It should also include, for any SHS that is not a CDHS, documentation of any CDHS criteria met, listing of CDHS criteria not met, and documentation of the impact on minimum reserves of the SHS being modeled as if it were a CDHS. In particular, such documentation should address the directional impact on minimum reserves and whether the impact is material.


a. Investment Officer on Investments – A certification from a duly authorized investment officer that the modeled company investment strategy, including any CDHS and any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4, is representative of and consistent with the company’s investment policy.

b. Qualified Actuary on Investments – A certification by a qualified actuary, not necessarily the same qualified actuary that has been assigned responsibility for the PBR Actuarial Report or this sub-report, that the modeling of any CDHS and any SHS that is required to be modeled pursuant to VM-20 Section 7.K.4, was performed in accordance with VM-20 and in compliance with all applicable ASOPs, and the alternative investment strategy as defined in VM-20 Section 7.E.1.g reflects the prescribed mix of assets with the same WAL as the reinvestment assets in the company investment strategy.

VM-31 Section 3.E.5

Assets and Risk Management – A brief description of the general account asset portfolio, and the approach used to model risk management strategies, such as hedging and other derivative programs, including a description of any CDHS or any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, and any material changes to the hedging strategy from the prior year.
VM-31 Section 3.F.8

Hedging and Risk Management – The following information regarding the hedging and risk management assumptions used by the company in performing a principle-based valuation under VM-21:

a. Strategies – Detailed description of risk management strategies, such as hedging and other derivative programs, including any CDHS or any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, specific to the groups of contracts covered in this sub-report.
   i. Descriptions of basis risk, gap risk, price risk and assumption risk.
   ii. Methods and criteria for estimating the a priori effectiveness of the strategy.
   iii. Results of any reviews of actual historical hedging effectiveness.

b. CDHS – Documentation for any hedging strategy that meets the requirements to be a CDHS.

c. Other Modeled Hedging Strategies – Documentation for any SHS that is not a CDHS, including documentation of any CDHS criteria met, listing of CDHS criteria not met, and documentation of the impact on TAR of the SHS being modeled as if it were a CDHS. In particular, such documentation should address the directional impact on TAR and whether the impact is material.

d. Strategy Changes – Discussion of any changes to the hedging strategy during the past 12 months, including identification of the change, reasons for the change, and the implementation date of the change.

e. Hedge Modeling – Description of how the hedge strategy was incorporated into modeling, including:
   i. Differences in timing between model and actual strategy implementation.
   ii. For a company that does not have a CDHS or a SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, disclosure of the method used to consider hedge assets included in the starting assets, either (1) including the asset cash flows in the projection model; or (2) replacing the hedge positions with cash and/or other general account assets in an amount equal to the market value of the hedge positions, as discussed in VM-21 Section 4.A.4.a.
   iii. Evaluations of the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, and other items that are likely to result in materially adverse results.
   iv. If residual risks and frictional costs are assumed to have a value of zero, a demonstration that a value of zero is an appropriate expectation.
   v. Any discontinuous hedging strategies modeled, and where such discontinuous hedging strategies contribute materially to a reduction in the stochastic reserve, any evaluations of the interaction of future trigger definitions and the discontinuous hedging strategy, including any analyses of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.
   vi. Disclosure of any situations where the modeled hedging strategies make money in some scenarios without losing a reasonable amount in some other scenarios, and an explanation of why the situations are not material for determining the CTE 70 (best efforts).
   vii. Results of any testing of the method used to determine prices of financial instruments for trading in scenarios against actual initial market prices, including how the testing considered historical relationships. If there are substantial discrepancies, disclosure of the substantial discrepancies and documentation as to why the model-based prices are appropriate for determining the stochastic reserve.
   viii. Any model adjustments made when calculating CTE 70 (adjusted), in particular, any liquidation or substitution of assets for currently held hedges.

e. Error Factor (E) and Back-Testing – Description of E, the error factor, and formal back-tests performed, including:
i.  The value of $E$, and the approach and rationale for the value of $E$ used in the reserve calculation.

ii. For companies that model hedge cash flows using the explicit method, as described in VM-21 Section 9.C.6.a, and have 12 months of experience, an analysis of at least the most recent 12 months of experience and the results of a back-test showing that the model is able to replicate the hedging results experienced in a way that justifies the value used for $E$. Include at least a ratio of the actual change in market value of the hedges to the modeled change in market value of the hedges at least quarterly.

iii. For companies that model hedge cash flows using the implicit method, and have 12 months of experience, as described in VM-21 Section 9.C.6.b, the results of a back-test in which (a) actual hedge asset gains and losses are compared against (b) proportional fair value movements in hedged liability, including:
   a) Delta, rho and vega coverage ratios in each month over the back-testing period, which may be presented in a chart or graph.
   b) The implied volatility level used to quantify the fair value of the hedged item, as well as the methodology undertaken to determine the appropriate level used.

iv. For companies that do not model hedge cash flows using either the explicit method or the implicit method, as described in VM-21 Section 9.C.6.c, and have 12 months of experience, the results of the formal back-test conducted to validate the appropriateness of the selected method and value used for $E$.

v. For companies that do not have 12 months of experience, the basis for the value of $E$ is chosen based on the guidance provided in VM-21 Section 9.C.7, considering the actual history available and the degree and nature of any changes made to the hedge strategy.

f. Safe Harbor for CDHS – If electing the safe harbor approach for CDHS, as discussed in VM-21 Section 9.C.8, a description of the linear instruments used to model the option portfolio.

g. Hedge Model Results – Disclosure of whether the calculated CTE 70 (best efforts) is below both the fair value and CTE 70 (adjusted), and if so, justification for why that result is reasonable, as discussed in VM-21 Section 9.D.

**VM-31 Section 3.F.12.c**

CTEPA – If using the CTEPA method, a summary including:

i. Disclosure (in tabular form) of the scenario reserves using the same method and assumptions as those used by the company to calculate CTE 70 (adjusted) as outlined in VM-21 Section 9.C (or the stochastic reserves following VM-21 Section 4.A.4.a for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to VM-21 Section 9.A.6), as well as the corresponding scenarios reserves substituting the assumptions prescribed by VM-21 Section 6.C.

ii. Summary of results from a cumulative decrement projection along the scenario whose reserve value is closest to the CTE 70 (adjusted), as outlined in VM-21 Section 9.C (or the stochastic reserves following VM-21 Section 4.A.4.a for a company that does not have a CDHS or a SHS that is required to be modeled pursuant to VM-21 Section 9.A.6), under the assumptions outlined in VM-21 Section 6.C. Such a cumulative decrement projection shall include, at the end of each projection year, the projected proportion (expressed as a percent of the total projected account value) of persisting contracts as well as the allocation of projected decrements across death, full surrender, account value depletion, elective annuitization, and other benefit election.
Summary of results from a cumulative decrement projection, identical to (ii) above, but replacing all assumptions outlined in VM-21 Section 6.C with the corresponding assumptions used in calculating the stochastic reserve.

**VM-31 Section 3.F.16.a and Section 3.F.16.b**

a. **Investment Officer on Investments** – A certification from a duly authorized investment officer that the modeled asset investment strategy, including any CDHS and any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6, is consistent with the company’s current investment strategy except where the modeled reinvestment strategy may have been substituted with the alternative investment strategy, and also any CDHS meets the requirements of a CDHS.

b. **Qualified Actuary on Investments** – A certification by a qualified actuary, not necessarily the same qualified actuary that has been assigned responsibility for the PBR Actuarial Report or this sub-report, that the modeling of any CDHS and any SHS that is required to be modeled pursuant to VM-21 Section 9.A.6 was performed in accordance with VM-21 and in compliance with all applicable ASOPs.

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**Deleted:** clearly defined hedging strategies
The Life Actuarial (A) Task Force met May 13, 2021. The following Task Force members participated: Doug Slape, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Judith L. French, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li and Steve Ostlund (AL); Ricardo Lara represented by Ben Bock and Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Rhonda Ahrens (NE); Marlene Caride represented by Kevin Clarkson (NJ); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Jonathan T. Pike represented by Tomasz Serbinowski (UT); Scott A. White represented by Craig Chupp (VA); and James A. Dodrill represented by Tim Sigman and Joylynn Fix (WV).

1. **Discussed an Upcoming ILVA Meeting**

Mr. Weber provided descriptions of annuity products in the spectrum between fixed annuities and variable annuities. He said the products are marketed under various names, including index-linked variable annuities (ILVAs) and buffer annuities. He said the products are carved out of the Standard Nonforfeiture Law for Individual Deferred Annuities (#805), but they are not within the scope of the Variable Annuity Model Regulation (#250) because they do not follow the values in a separate account. He said regulator-to-regulator meetings will be scheduled to provide education on the indexed products, where specific company filings may be discussed. Those calls will be followed by open meetings to discuss what steps can be taken to provide consumer protections related to the surrender of these products. Mr. Weber said the goal is to have requirements developed by the end of the year.

2. **Exposed Amendment Proposal 2019-34**

Mr. Robinson continued the discussion of amendment proposal 2019-34. He said two considerations for the Task Force are the challenges of trying to regulate business reinsured by offshore companies and the need to assess some business on a standalone basis. He said if the amendment proposal is exposed for comment, commenters will be asked to provide references to formal guidance that supports the notion that the company that bears the risk should be responsible for asset adequacy testing. Mr. Serbinowski discussed his comment letter (Attachment A). He said it would be difficult for the reinsurer to provide standalone asset adequacy testing to a ceding company because that business is aggregated with the business of other cedants. He said for modified coinsurance (mod-co) or funds withheld reinsurance agreements, he supports having the company holding the assets perform the asset adequacy testing. Mr. Robinson clarified that the amendment proposal is intended to address all forms of reinsurance. Mr. Sartain asked if the requirements address the responsibility of the appointed actuary for assessing credit risk. Mr. Robinson indicated that he is not aware of any such requirements. Mr. Andersen said historically, the Actuarial Standards of Practice (ASOPs) were relied upon to provide guidance on such issues. Mr. Sartain said it makes sense to have the reinsurer be responsible to perform asset adequacy testing on the business it assumes. He noted that the ceding company responsibility should increase as the credit risk grows. Ms. Fenwick said the New York State Department of Financial Services (NYSDFS) has taken the position that the ceding company retains responsibility for reinsured business and is required to do the asset adequacy testing on a gross basis without the benefit of aggregation. Leonard Mangini (American Academy of Actuaries—Academy) stressed the necessity for amendment proposal 2019-34. He said the revised ASOP 11, which will be effective for year-end 2022, requires the appointed actuary to look at all reinsurance related risks, not just credit risks.

Mr. Andersen made a motion, seconded by Mr. Yanacheak, to expose amendment proposal 2019-34 (Attachment B) for a 30-day public comment period ending June 14. The motion passed, with Mr. Sartain opposing.

3. **Exposed Amendment Proposal 2021-08**

Larry Bruning (Society of Actuaries—SOA) said the SOA Valuation Basic Table (VBT) Team Subgroup would like to reduce the time for gathering mortality experience used to determine whether the VBT should be updated. He said amendment proposal...
2021-08 shortens the lag between the reporting year and observation year for mortality experience from a two-year lag to a one-year lag and makes appropriate adjustments for the initial reporting year in which the amendment proposal is effective.

Mr. Carmello made a motion, seconded by Mr. Yanacheak, to expose amendment proposal 2021-08 (Attachment C) for a 21-day public comment period ending June 4. The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.
Thoughts from Tomasz Serbinowski on APF 2019-34

I'd like to share some thoughts on the APF. First let me say that I like the idea of clarifying responsibilities of the appointed actuaries with respect to reinsurance ceded. My interest is however more related to asset adequacy testing when the company retains the assets (ModCo and Funds Withheld treaties).

With respect to the specific proposal here are my concerns.

1. The rationale for the proposal states that "where the appointed actuary can rely on work performed by the counterparty's appointed actuary [...] this APF will require the appointed actuary to provide the results of the asset adequacy analysis, as evidence that the analysis was performed."

Given that the reinsurer is allowed to aggregate blocks assumed under numerous treaties, it may be challenging to provide results of the asset adequacy analysis with respect to a specific block.

2. The proposal appears to concentrate on reinsurance where the reserve for the ceded business is established by the reinsurer and where the assets supporting that reserve are held by the reinsurer. However, especially in situations when the reinsurer is unauthorized, captive, or an offshore company, the funds supporting the reserve may be in possession of the direct writer. Holding the assets supporting the reserve alleviates credit risk. However, it does not remedy any potential asset adequacy deficiencies.

That is, if the assets were insufficient for the liability prior to the reinsurance, they remain insufficient with the reinsurance in place. However, any insufficiency can only be detected through asset adequacy analysis.

I would welcome an amendment to the APF that would explicitly require asset adequacy testing of any reserves ceded under the arrangements where the assets supporting reserve are held by the direct writer, including ModCo and Funds Withheld treaties.

Sincerely,

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

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

John Robinson, Director PBR – Valuation Actuary, MN

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


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

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

The purposes of this APF are to
(a) Clarify the responsibilities of the appointed actuaries of both the ceding and assuming companies for all forms of reinsurance, relative to both the SAO and asset adequacy analysis.

(b) Make a minor modification to the table headings in VM-30, Section 3.A.5.

Discussion of Rationale:

1. Every appointed actuary should be held accountable for ensuring that all the reserves covered by the actuary’s SAO are subjected to asset adequacy analysis. Usually, this requires the appointed actuary to perform the analysis; however, circumstances may exist where the appointed actuary can rely on work performed by the counterparty’s appointed actuary. In any event, whether relying on another actuary or not, this APF will require the appointed actuary to provide the results of the asset adequacy analysis, as evidence that the analysis was performed.

2. VM-30 Section 3.A.7.e includes the following required statement as part of the SAO:
“The reserves and related actuarial items, when considered in light of the assets held by the company with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on the assets, and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision, according to presently accepted ASOPs, for the anticipated cash flows required by the contractual obligations and related expenses of the company.”

In a situation where part or all of the risk is reinsured, the assets held by the company may only be in respect of the portion of the risk supported by the reserves held; however, the appointed actuary’s actuarial opinion must address all the contractual obligations. It follows that, while asset adequacy analysis can only be performed on the reserves and assets held (i.e. net of reinsurance), the appointed actuary’s responsibility may extend beyond the reserves and assets held.
3. In a recent Academy survey of appointed actuaries ("A Survey of Life Appointed Actuaries, December 4, 2020", Question 66), most of them (50.38%) indicated that for the YE2019 AAT, “no special consideration for reinsurance recoverability will be added”.

This APF will provide guidance that should produce more clarity and uniformity on this issue.

4. The following excerpt is from ASOP 7, “Analysis of Life, Health, or Property/Casualty Insurer Cash Flows”:

3.8 Reinsurance—The actuary should consider whether reinsurance receivables will be collectible when due, and any terms, conditions, or other aspects that may be reasonably expected to have a material impact on the cash flow analysis.”

This APF will propose that similar guidance apply to the appointed actuary in meeting his/her responsibility beyond the reserves and assets held.

The proposed text is in the Appendix below.

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

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Notes: VM Maintenance Agenda 2019-34
APPENDIX

1. It is proposed to add the following text as VM-30, Section 4:

Section 4: Asset Adequacy Analysis For Treaties Of Reinsurance

1. Each counterparty to a reinsurance treaty has established a reserve in respect of its obligations relative to the underlying policies. Furthermore, the appointed actuary’s statement of actuarial opinion covers the reserves established for all of the company’s reinsurance treaties currently in force. Consequently, a company’s appointed actuary is required to perform adequacy analysis on the reserves which the company has established in respect of the treaties into which the company has entered and which are currently in force.

2. The results of the asset adequacy analysis shall be reported in the appointed actuary’s actuarial memorandum, as required in Section 3.B.12.b.

3. Materiality considerations may influence the decision whether to perform the asset adequacy analysis. However, the size of the reserve must not be the sole materiality criterion.

4. The appointed actuary of a direct writer must perform a review of each reinsurance counterparty to assess
   (a) whether reinsurance receivables will be collectible when due; and
   (b) any terms, conditions, or other aspects that may be reasonably expected to have a material impact on the company’s ability to meet its obligations to policyholders.

Evidence of having performed such reviews shall be provided in the actuarial memorandum.

Guidance Note:
(a) Under certain circumstances, for example, when risk is ceded under a modified coinsurance agreement, a counterparty may report a reserve of 0. This alone does not foreclose on the requirement for the asset adequacy analysis to be performed.
(b) If an appointed actuary relies on the work of another actuary, such as the appointed actuary of the reinsurance counterparty, the guidance in Section 3.A.6 and Section 3.B.2 must be followed. In relying on the work of another appointed actuary, an appointed actuary may not rely solely on the other actuary’s statement of actuarial opinion.

[Underlying principles:
1. The SAO itself
2. Each counterparty has its own perspective
3. Regulatory accountability]

Question for commenters:
In 4., should there be more specificity as to what evidence should be provided?
If so, what should be required?
2. Revision to Section 3.A.5, Table Headings:

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<th>Statement Item</th>
<th>Formula Reserves (1)</th>
<th>Principle-Based Reserves (2)</th>
<th>Additional Reserves * (3)</th>
<th>Analysis Method b</th>
<th>Other Amount Not Tested (4)</th>
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Attachment Seven-B
Life Actuarial (A) Task Force
8/12/21

© 2021 National Association of Insurance Commissioners
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force

Amendment Proposal Form*

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

Society of Actuaries Valuation Basic Table Team – Chair Larry Bruning

Revisions to VM-51 to allow for the data experience reporting observation calendar year to be one year prior to the reporting calendar year.

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


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

Section 2: Statistical Plan for Mortality

D. Process for Submitting Experience Data Under This Statistical Plan

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

Data for this statistical plan for mortality will be compiled using a calendar year method. The reporting calendar year is the calendar year that the company submits the experience data. The observation calendar year is the calendar year of the experience data that is reported. The observation calendar year will be one year prior to the reporting calendar year. For example, if the current calendar year is 2022 and that is the reporting calendar year, the company is to report the experience data that was in-force or issued in calendar year 2021, which is the observation calendar year.

For the 2022 reporting calendar year, companies that are required to submit data for this statistical plan for mortality will be required to submit two observation calendar years of data, namely observation calendar year 2020 and observation calendar year 2021. For reporting calendar years after 2022, companies that are required to submit data for this statistical plan for mortality will be required to submit one observation calendar year of data.

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

i. Report policies in force during or issued during calendar year 20XX.
ii. Report terminations that were incurred in calendar year 20XX and reported before July 1, 20XX+1. However, exclude rescinded policies (e.g., 10-day free look exercises) from the data submission.

For any reporting calendar year, the data call will occur during July of that reporting calendar year, and data is to be submitted according to the requirements of the Valuation Manual in effect during that calendar year. For the 2022 reporting calendar year, the requirements of the 2022 Valuation Manual will be used for both the 2020 and 2021 observation years. Data submissions must be made by Sept. 30 of the reporting calendar year. Corrections of data submissions must be completed by Dec. 31 of the reporting calendar year.

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

This APF is needed for the following reasons:

1. There is a need to shorten the time period between data observation and data collection to facilitate more timely analysis and reporting of mortality experience.
2. Under a Principle Based Reserving methodology, valuation basic tables should reflect recent and current mortality experience.
The Life Actuarial (A) Task Force met May 6, 2021. The following Task Force members participated: Doug Slape, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Judith L. French, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li and Steve Ostlund (AL); Ricardo Lara represented by Ben Bock and Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Seversinghaus represented by Bruce Sartain and Vincent Tsang (IL); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Rhonda Ahrens (NE); Marlene Caride represented by Kevin Clarkson (NJ); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Jonathan T. Pike represented by Tomasz Serbinski (UT); Scott A. White represented by Craig Chupp (VA); and James A. Dodrill represented by Tim Sigman and Joylynn Fix (WV).

1. Re-Exposed Amendment Proposal 2019-33

Mary Bahna-Nolan (American Academy of Actuaries—Academy) continued the discussion of amendment proposal 2019-33 from the Task Force’s April 29 meeting. She noted that the amendment proposal was updated to include principle-based reserving (PBR) exemption language from the previously adopted amendment proposal 2020-11.

Mr. Weber made a motion, seconded by Mr. Andersen, to expose amendment proposal 2019-33 (Attachment A) for a 30-day public comment period ending June 7. The motion passed unanimously.

2. Adopted Amendment Proposal 2021-03

Connie Tang (Academy) said amendment proposal 2021-03 updates Section 6 of VM-21, Requirements for Principle-Based Reserves for Variable Annuities, to reflect the increase of the required minimum distribution (RMD) age from 70½ to 72. She said a guidance note was added to clarify that changes in the RMD age may require recalculation of the cohort weighting.

Mr. Weber made a motion, seconded by Mr. Knable, to adopt amendment proposal 2021-03 (Attachment B). The motion passed unanimously.

3. Exposed Amendment Proposal 2021-07

David Neve (Actuarial Resources Corporation of Georgia) said amendment proposal 2021-07 clarifies the universal life policies with secondary guarantees (ULSG) net premium reserve (NPR) calculation requirements. He said the amendment proposal reorganizes Section 3.B.5 and Section 3.B.6 of VM-20, Requirements for Principle-Based Reserves for Life Products, into a single Section 3.B.5. He stressed that no requirement changes result from the reorganization. Mr. Chupp identified several references that required updates. He agreed to work with Mr. Neve to make the changes prior to exposure.

Mr. Chupp made a motion, seconded by Mr. Weber, to expose amendment proposal 2021-07 (Attachment C), including the changes identified by Mr. Chupp, for a 40-day public comment period ending June 14. The motion passed unanimously.

4. Discussed Amendment Proposal 2019-34

Mr. Robinson said amendment proposal 2019-34 (Attachment D) initially targeted reporting for modified coinsurance (mod-co) agreements. He said the amendment proposal was expanded to address reinsurance in general. He said the amendment proposal addresses the responsibilities of the appointed actuary for reinsured business. Brian Bayerle (American Council of Life Insurers—ACLI) suggested an ACLI-provided education session for the Task Force before exposing the amendment proposal for comment.

Having no further business, the Life Actuarial (A) Task Force adjourned.
1. Identify yourself, your affiliation and a very brief description (title) of the issue.

American Academy of Actuaries, Life Reserves Work Group

Addition of language to clarify the definition of individually underwritten life insurance and the applicability of Principle-Based Reserve (PBR) requirements for group insurance contracts with individual risk selection issued under insurance certificates.

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

January 1, 2021, version of the Valuation Manual, with the revisions to APF 2020-11 (adopted by LATF on 2/11/21) shown in blue text.

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

See Appendix

All proposed changes specific to this amendment proposal are shown in red text.

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

Individual insurance certificates issued under a group contract which utilize an individual risk selection process, pricing, premium rate structures and product features are similar to individual life insurance policies. They are currently excluded from VM-20 because they are filed under a group contract, but they should be subject to VM-20 due to this similarity. See Appendix.

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Notes: APF 2019-33
Appendix

Issue

Certain contracts issued under a master group contract require individual risk selection in order to qualify for issuance of the group insurance certificate; the certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing, and risk classification; and they are managed in a similar manner as individual ordinary life insurance contracts. These individual certificates should follow the same reserve requirements as other individual life contracts of the same product type. Therefore, a change is needed within the Valuation Manual to bring these individual certificates into scope of VM-20.

Six changes are recommended:

1) Within the Reserve Requirements section (Section II), change the minimum reserve requirements to also apply to group life contracts which, other than the difference between issuing a policy and issuing a group certificate, have the same or mostly similar contract provisions, risk selection process, and underwriting as individual ordinary life contracts (Section II, subsection 1.D);

2) Within the Reserve Requirements section (Section II), add a transition period for individual group certificates issued on or before 1/1/2024 (Section II, subsections 1.F.1 and 1.F.2);

3) Within the Reserve Requirements section (Section II), add language and guidance note to subsection 1.G and the corresponding footnote to include premiums from group life contracts which have individual certificates that were issued using individual risk selection processes (Section II, subsection 1.G.1, footnote, and guidance note) and to clarify the Calculation for Exemption (Section II, subsection 1.G.2). Comment notes need to refer to NAIC Blanks (E) Working Group to update the PBR Supplement;

4) Add new paragraph, VM-20 Section 1.B (and reformat to make current paragraph Section 1.A) to clarify group life certificates issued using individual risk selection processes, including a definition and requirements to be met, are subject to the requirements of VM-20;

5) Add guidance note after first sentence in VM-20 Section 2.A.1 that group life certificates that meet the definition for individual risk selection process use the same VM-20 Reserving Categories as defined in Section 2;

6) Draft referral to the NAIC Blanks (E) Working Group to revise the VM-20 Reserves Supplement, Part 2 to report premiums for total Group Life and Group Life with certificates subjected to an individual risk selection process and which meet all of the conditions as defined in VM-20 Section 1.B separately.
II. Reserve Requirements

This section provides the minimum reserve requirements by type of product, as set forth in the seven subsections below, as follows:

1. Life Insurance Products
2. Annuity Products
3. Deposit-Type Contracts
4. Health Insurance Products
5. Credit Life and Disability Products
6. Riders and Supplemental Benefits
7. Claim Reserves

All reserve requirements provided by this section relate to business issued on or after the operative date of the Valuation Manual. All reserves must be developed in a manner consistent with the requirements and concepts stated in the Overview of Reserve Concepts in Section I of the Valuation Manual.

**Guidance Note:** The terms “policies” and “contracts” are used interchangeably.

Subsection 1: Life Insurance Products

A. This subsection establishes reserve requirements for all contracts issued on and after the operative date of the Valuation Manual that are classified as life contracts as defined in SSAP No. 50 in the AP&P Manual, with the exception of annuity contracts and credit life contracts. Minimum reserve requirements for annuity contracts and credit life contracts are provided below in subsection 2 and subsection 5, respectively.

B. Minimum reserve requirements for variable and nonvariable individual life contracts—excluding guaranteed issue life contracts, preneed life contracts, industrial life contracts, and policies of companies exempt pursuant to the life PBR exemption in paragraph D below—subsection 1.G are provided by VM-20, Requirements for Principle-Based Reserves for Life Products, except for election of the transition period in paragraph C below subsection 1.F.2 below. For this purpose, joint life policies are considered individual life.

C. Minimum reserve requirements of VM-20 are considered principle-based valuation requirements for purposes of the Valuation Manual.

D. Minimum reserve requirements for individual certificates under group life contracts which meet all the requirements in VM-20 Section 1.B are provided by VM-20, except for election of the transition period in subsection 1.F.1 below.

E. Minimum reserve requirements for life contracts not subject to VM-20 are those pursuant to applicable requirements in VM-A and VM-C. For guaranteed issue life contracts issued after Dec. 31, 2018, mortality tables are defined in VM Appendix M, Mortality Tables (VM-M), and the same table shall be used for reserve requirements as is used for minimum nonforfeiture requirements as defined in VM-02, Minimum Nonforfeiture Mortality and Interest.
F. A company may elect to establish minimum reserves pursuant to applicable requirements in VM-A and VM-C for:

1. Business described in subsection 1.D above and issued on or after the operative date of the Valuation Manual and prior to 1/1/2024.

2. Business not described subsection 1.D otherwise subject to VM-20 requirements and issued during the first three years following the operative date of the Valuation Manual.

A company electing to establish reserves using the requirements of VM-A and VM-C may elect to use the 2017 Commissioners’ Standard Ordinary (CSO) Tables as the mortality standard following the conditions outlined in VM-20 Section 3. If a company during the three years elects to apply VM-20 to a block of such business, then a company must continue to apply the requirements of VM-20 for future issues of this business.

G. Life PBR Exemption

1. A company meeting the at least one of the conditions in Dsubsection 1.G.2 below may file a statement of exemption for individual ordinary life insurance policies and certificates, except for policies in Dsubsection 1.G.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. If a company has no business issued directly or assumed during the current calendar year that would otherwise be subject to VM-20, a statement of exemption is not required. For a filed statement of exemption, the statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that at least one of the two conditions in Dsubsection 1.G.2 was met and the statement of exemption must also be included with the NAIC filing for the second quarter of that year.

The domiciliary commissioner may reject such statement prior to September 1 and require the company to follow the requirements of VM-20 for the ordinary life policies covered by the statement.

If a filed statement of exemption is not rejected by the domiciliary commissioner, the filing of subsequent statements of exemption is not required as long as the company continues to qualify for the exemption; rather, ongoing statements of exemption for each new calendar year will be deemed to not be rejected, unless: 1) the company does not meet either condition in Dsubsection 1.G.2 below, 2) the policies contain those in Dsubsection 1.G.3 below, or 3) the domiciliary commissioner contacts the company prior to Sept. 1 and notifies them that the statement of exemption is rejected. If any of these three events occur, then the statement of exemption for the current calendar year is rejected and a new statement of exemption must be filed and not rejected in order for the company to exempt additional policies. In the case of an ongoing statement of exemption, rather than include a statement of exemption with the NAIC filing for the second quarter of that year, the company should enter “SEE EXPLANATION” in response to the Life PBR Exemption supplemental interrogatory and provide as an explanation that the company is utilizing an ongoing statement of exemption.

2. Condition for Exemption:

a. The company has less than $300 million of ordinary life exemption premiums, and if the company is a member of an NAIC group of life insurers which includes other life insurance companies, the group has combined ordinary life exemption premiums of less than $600 million.

The only new policies that would otherwise be subject to VM-20 being issued or assumed by the company are due to election of policy benefits or features from existing policies valued under VM-A and VM-C and the company was exempted from, or otherwise not subject to, the requirements of VM-20 in the prior year.

Exemption premium is determined as follows:
a. The amount reported in the prior calendar year life/health annual statement, Exhibit 1, Part 1, Column 3 (“Ordinary Life Insurance”), line 20.1; plus

b. The portion of the amount in the prior calendar year life/health annual statement, Exhibit 1, Part 1, Column 3 (“Ordinary Life Insurance”), line 20.2 assumed from unaffiliated companies; minus

c. Amounts included in either (a) or (b) that are associated with guaranteed issue insurance policies and/or preneed life insurance policies; minus

d. Amounts included in either (a) or (b) that represent transfers of reserves in force as of the effective date of a reinsurance assumed transaction; plus

e. Amounts of premium for individual life certificates issued under a group life certificate which meet the conditions defined in VM-20, Section 1.B, and that are not included in either (a) or (b).

Guidance Note:
(i) Definitions of preneed and guaranteed issue insurance policy are in VM-01.
(ii) For statements of exemption filed for calendar year 2022 and beyond, the amount in subsection 2.e was reported in the prior calendar year life/health annual statement, VM-20 Reserve Supplement, Part 2, if applicable.

3. Policies Excluded from the Life PBR Exemption:

a. Universal life with secondary guarantee (ULSG) policies, or policies – other than ULSG – that contain a rider with a secondary guarantee, in which the secondary guarantee does not meet the VM-01 definition of a “non-material secondary guarantee.”

4. Each exemption, or lack of an exemption, outlined in D. subsection 1.G.1 – D. subsection 1.G.3 above applies only to policies issued or assumed in the current year, and it applies to all future valuation dates for those policies. However, if policies did not qualify for the Life PBR Exemption during the year of issue but would have qualified for the Life PBR Exemption if the current Valuation Manual requirements had been in effect during the year of issue, then the domiciliary commissioner may allow an exemption for such policies. The minimum reserve requirements for the ordinary life policies subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.

VM Change 4 – VM-20: Requirements for Principle-Based Reserves for Life Products

VM-20: Requirements for Principles-Based Reserves for Life Products

Section 1: Purpose

A. These requirements establish the minimum reserve valuation standard for individual life insurance policies issued on or after the operative date of the Valuation Manual and subject to a principle-based valuation with an NPR floor under Model #820. These requirements constitute the Commissioners Reserve Valuation Method (CRVM) for policies of individual life insurance.
VM Change 5 - VM-20: Requirements for Principle-Based Reserves for Life Products

Section 2: Minimum Reserve

B. Individual life certificates under a group life contract shall be subject to the requirements of VM-20 if all of the following are met. These requirements constitute the Commissioners Reserve Valuation Method (CRVM) for such certificates.

1. An individual risk selection process, defined as follows, is used to obtain group life insurance coverage;

   An individual risk selection process is one that is based on characteristics of the insured(s) beyond sex, gender, age, tobacco usage, and membership in a particular group. This may include, but is not limited to, completion of an application (beyond acknowledgement of membership to the group, sex, gender and age), questionnaire(s), online health history or tele-interview to obtain non-medical and medical or health history information, prescription history information, avocations, usage of tobacco, family history, or submission of fluids such as blood, Home Office Specimens (HOS), or oral fluid. The resulting risk classification is determined based on the characteristics of the individual insured(s) rather than the group, if any, of which it is a member (e.g., employer, affinity, etc.). The individual certificate holder is charged a premium rate based solely on the individual risk selection process and not on membership in a specific group.

   **Guidance Note:** The use of evidence of insurability does not by itself constitute an individual risk selection process. Use of information obtained from a census or question(s) regarding gender, occupation, age, income and/or tobacco usage solely for purposes of determining a rate classification does not by itself qualify a group as having used an individual risk selection process. Group insurance where the underwriting based on the characteristics of the group and census data but where some individuals are subjected to individual risk selection as a result of compensation level, age, an existing medical condition or impairment, late entry into the group, failure of the group to meet minimum participation requirements or voluntary buy-up of increased coverage does not meet the definition of an individual risk selection process.

2. The individual certificates utilize premiums or cost of insurance schedules and charges based on the individual applicant’s issue age, duration from underwriting, coverage amount and risk classification and there is a stated or implied schedule of maximum gross premiums or net cash surrender value required in order to continue coverage in force for a period in excess of one year;

3. The group master contract is designed, priced, solicited, and managed similar to individual ordinary life insurance policies rather than specific to the group as a whole;

4. The individual certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing, and risk classification to individual ordinary life insurance contracts.

5. The individual certificates are issued on or after the operative date of the Valuation Manual except election of the transition period in Section 2, subsection 1.F.1.
A. All policies subject to these requirements shall be included in one of the VM-20 Reserving Categories, as specified in Section 2.A.1, Section 2.A.2 and Section 2.A.3 below.

**Guidance Note:** Since group insurance subject to an individual risk selection process and meeting all the requirements in Section 1.B is subject to VM-20 requirements, Section 2.A shall apply—meaning that any such contracts will be included in one of the VM-20 Reserving Categories defined by Section 2.A.1, Section 2.A.2, and 2.A.3. All requirements in VM-31 which apply to a VM-20 Reserving Category shall apply to any group insurance subject to individual risk selection that has been included in that VM-20 Reserving Category.

The company may elect to exclude one or more groups of policies from the stochastic reserve calculation and/or the deterministic reserve calculation. When excluding a group of policies from a reserve calculation, the company must document that the applicable exclusion test defined in Section 6 is passed for that group of policies. The minimum reserve for each VM-20 Reserving Category is defined by Section 2.A.1, Section 2.A.2 and Section 2.A.3, and the total minimum reserve equals the sum of the Section 2.A.1, Section 2.A.2 and Section 2.A.3 results below, defined as:
VM Change 6 – VM-20 Reserves Supplement, Part 2: Life PBR Exemption

Refer to NAIC Blanks (E) Working Group, request for modification to the supplemental report for the Life PBR Exemption, to show the premiums for group life that utilized an individual risk selection process and meets all of the requirements in VM-20 Section 1.B. as these premiums are currently grouped together with other group insurance in Exhibit 1. As there are other instances where the ordinary life premiums are not included in the determination of the Life PBR Exemption (e.g., for guaranteed issue policies), it may be useful to request addition of the breakdown of premiums used to determine the exemption.

Possible insertion between questions 1 and 2 for disclosure of premiums used in the determination of eligibility for the Life PBR exemption, split by ordinary life and group subject to an individual risk selection process and meeting all of the requirements in VM-20 Section 1.B.
Life Actuarial (A) Task Force
Amendment Proposal Form 2021-03
Exposed for a 21-day public comment period ending May 3, 2021

The proposed guidance note presumes that Section 6.C.5.n refers to how cohorts and weights are unaffected by changes in interest rates at each reporting date because the discount rate for the calculations is fixed, but it indicates that periodic updates to underlying prescribed assumptions may require recalculations. LATF is requesting comments on this interpretation and its applicability to this RMD change vs. Standard Projection assumption updates more broadly.

Please submit comments to Reggie Mazyck (RMazyck@naic.org) by COB 5/3/21.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

American Academy of Actuaries, Variable Annuity Reserves & Capital Work Group

Update the reference to the required minimum distribution (RMD) age in the VM-21 Standard Projection Amount for the Setting Every Community Up for Retirement Enhancement (SECURE) Act change.

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

January 1, 2021, version of the Valuation Manual

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

In VM-21, Section 6.C.5:

i. For tax-qualified contracts, add the following to the revised GAPV^2 corresponding to an initial withdrawal age of the federal required minimum distribution (RMD) age.

\[
0.50 \times \left( \frac{0.95 - \sum_{i=\text{Issue Age}}^{\text{Initl WD Age}} \text{GAPV}_{\text{Adj, Scaled}}^2, \text{if contract is a tax-qualified GMWB}}{0.65 - \sum_{i=\text{Issue Age}}^{\text{Initl WD Age}} \text{GAPV}_{\text{Adj, Scaled}}^2, \text{if contract is a tax-qualified hybrid GMIB}} \right) \]

j. Scale the revised GAPV^2 values at all future initial withdrawal ages—i.e., all ages greater than the federal required minimum distribution (RMD) age, as identified in the preceding step—such that the sum of the revised GAPV^2 values equals 0.95 for tax-qualified GMWB contracts and 0.85 for tax-qualified hybrid GMIB contracts again.

n. The cohorts and their associated weights as determined in Section 6.C.5.a through Section 6.C.5.k are for a contract with attained age equal to its issue age. Because the discount rate used in this determination is fixed, generally these calculations only need to be performed once for a given set of contracts with a certain issue age, guaranteed benefit product, and tax status.

Guidance Note: Cohorts and their associated weights may need to be revised if prescribed assumptions are updated.
4. State the reason for the proposed amendment? (You may do this through an attachment.)

The Standard Projection’s withdrawal delay cohort method includes an adjustment at the required minimum distribution (RMD) age. The SECURE Act changed the RMD age from 70.5 to 72. This proposed amendment implements the change by directly referencing the RMD age. The direct reference will reduce Valuation Manual maintenance for any future changes.

The proposed guidance note presumes that Section 6.C.5.n refers to how cohorts and weights are unaffected by changes in interest rates at each reporting date because the discount rate for the calculations is fixed, but it indicates that periodic updates to underlying prescribed assumptions may require recalculations. LATF is requesting comments on this interpretation and its applicability to this RMD change vs. Standard Projection assumption updates more broadly.

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

NAIC Staff Comments:
Life Actuarial (A) Task Force/Health Actuarial (B) Task Force

Amendment Proposal Form*

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

Identification: David Neve, VP and Consulting Actuary, Actuarial Resources Corporation of GA
Title of the Issue: Clarify ULSG NPR calculation requirements

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

January 1, 2021 NAIC Valuation Manual, but incorporating APF 2020-03
Section 2.A.3, Section 3. B.1, 2, 5 and 6, Section 6.B.5.b

Section 3.A, Section 3.C.2 and 3

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

See attached.

As a general overview, Section 3.B.5 stayed in 3.B.5 but was renumbered, but Section 3.B.6 was moved to 3.B.5.b and c.

Below is a detailed summary of the items that were moved to a new section (and/or renumbered) but were not redlined. In some cases, the wording was redlined after it was moved (if the wording changed).

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<td>3.B.5.c.iii (with sub-bullets renumbered)</td>
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4. State the reason for the proposed amendment? (You may do this through an attachment.)

The NPR calculation requirements for ULSG products are currently contained in Section 3.B.5 and 3.B.6 of the Valuation Manual. The current wording takes the reader back and forth between Section 3.B.5 and 3.B.6 when trying to follow the reserve calculation for ULSG products, which can be confusing. And the current wording also has led some people to incorrectly interpret Section 3.B.5 to be applicable to UL products without a SG.

The APF combines the current 3.B.5 and 3.B.6 sections into a single section labeled 3.B.5 and clarifies how to determine the NPR when the policy duration at the valuation date is either prior to, or after the SG has expired. Importantly, no change has been made to the current requirements, only the formatting of the requirements to make them easier to follow. Note that the new wording has flipped the order of the old 3.B.5 and 3.B.6 when combining them in the new 3.B.5, but this movement is not shown as a tracked change (since no changes were made to the existing reserve calculation requirements in the two sections).

Section 3.A has also been revised to eliminate the confusion that can arise on whether the NPR for products in the All Other VM-20 Reserving Category is still a VM-20 reserve. The NPR requirement for products in the All Other VM-20 Reserving Category has been moved to Section 3.B.6.

Impacted references have been updated.
ATTACHMENT

Section 2: Minimum Reserve

A. All policies subject to these requirements shall be included in one of the VM-20 Reserving Categories, as specified in Section 2.A.1, Section 2.A.2 and Section 2.A.3 below.

1. Term Reserving Category
2. ULSG Reserving Category
3. All Other VM-20 Reserving Category – All policies and riders belonging to the All Other VM-20 Reserving Category are to be included in Section 2.A.3.c unless the company has elected to exclude a group of them from the stochastic reserve calculation or both the deterministic and stochastic reserve calculations and has applied the applicable exclusion test defined in Section 6, passed the test and documented the results.

Section 3: Net Premium Reserve

A. Applicability

1. The NPR for each policy must be determined on a seriatim basis pursuant to Section 3.
2. When valuing term riders pursuant to Paragraph E in “Riders and Supplemental Benefits Requirements” in Section II, the reserve requirements for term policies are applicable.

B. NPR Calculation

1. For the purposes of Section 3, the following terms apply:
   d. The “level secondary guarantee” at any time is:
      i. For a shadow account secondary guarantee, the shadow account fund value that would have existed at that time assuming payment of the level gross premium determined according to Section 3.B.5.c.i.
      ii. For a cumulative premium secondary guarantee, the amount of cumulative level gross premiums determined according to Section 3.B.5.c.i.1. accumulated with any interest or accumulation factors per the contract provisions for the secondary guarantee.

2. Section 3.B.4 and Section 3.B.5 provide the calculation of a terminal NPR under the assumption of an annual mode gross premium. In Section 3.B.4 and Section 3.B.5, the gross premium referenced is the gross premium for the policy assuming an annual premium mode.

3. For all policies and riders within the Term Reserving Category, other than those addressed in Section 3.B.8 below, the NPR on any valuation date shall be equal to the actuarial present value of future benefits less the actuarial present value of future annual valuation net premiums as follows:

4. For all policies and riders within the ULSG Reserving Category, the NPR shall be determined as follows:
   a. If the policy duration on the valuation date is prior to the point when all secondary guarantee periods have expired, the NPR shall be the greater of the reserve amount determined in Section

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b. If the policy duration on the valuation date is after the expiration of all secondary guarantee periods, the NPR shall be the reserve amount determined according to Section 3.B.5.d only, subject to the floors specified in 3.D.2.

c. A reserve amount for the policy shall be calculated assuming the secondary guarantee is in effect as described below. If the policy has multiple secondary guarantees, the NPR shall be calculated as below for the secondary guarantee that provides the greatest NPR as of the valuation date. For the purposes of this subsection, let n be the longest number of years the policy can remain in force under the provisions of the secondary guarantee. However, if a shorter period produces a materially greater NPR, then n shall be that shorter number of years.

i. As of the policy issue date:

a) Determine the level gross premium at issue, assuming payments are made each year for which premiums are permitted to be paid, such period defined as v years in this subsection, that would keep the policy in force to the end of year n, based on policy provisions, including the secondary guarantee provisions, such as mortality, interest and expenses. In no event shall v be greater than n for purposes of the NPR calculated in this subsection.

b) Using the level gross premium from Section 3.B.5.c.i.a above, determine the value of the expense allowance components for the policy at issue as $x_1$, $y_{2-5}$ and $z_t$ defined below.

$x_1$: first-year expense equal to the level gross premium at issue

$y_{2-5}$: an expense equal to 10% of the level gross premium and applied in each year from the second through fifth policy year

$z_t$: a first-year expense of $2.50 per $1,000 of insurance issued

The expense allowance shall be amortized over the span of years in the secondary guarantee period during which premiums are permitted to be paid. $E_{x+t}$, the expense allowance balance as of the end of the policy year t, shall be computed as follows:

$$E_{x+t} = VNPR\cdot a_{x+t} + \left(\frac{x_1+z_t}{\delta_{x+t}}\right) + y_{2-5}\cdot C_{x+t}$$

for $t < v$

$= 0$ for $t \geq v$

Where:

$I = 1, 2, \ldots$ (number of completed years since issue)

$VNPR = \text{Valuation Net Premium Ratio from 3B.5.c.i.c}$

$C_{x+t} = 0$ when $t = 1$

$$\cdot \sum_{i=1}^{n-1} \left(1/d_{x+i|w^t}\right)$$

when $2 \leq t < 5$

$= C_{x+5}$ when $t \geq 5$

c) Determine the annual valuation net premiums at issue as that uniform percentage (the valuation net premium ratio) of the respective gross premiums such that at issue the...
actuarial present value of future valuation net premiums over the n-year period shall equal the actuarial present value of future benefits over the n-year period. The valuation net premium ratio determined shall not change for the policy.

ii. After the policy issue date, on each future valuation date, the NPR shall be determined as follows:

a) As of the valuation date for the policy being valued, determine the actual secondary guarantee, denoted $ASG_{x+t}$, as outlined in Section 3.B.1.c and the fully funded secondary guarantee, denoted $FFSG_{x+t}$, as outlined in Section 3.B.1.b.

b) Divide $ASG_{x+t}$ by $FFSG_{x+t}$, with the resulting ratio capped at 1. The ratio is intended to measure the level of prefunding for a secondary guarantee, which is used to establish reserves. Assumptions within the numerator and denominator of the ratio, therefore, must be consistent in order to appropriately reflect the level of prefunding. As used here, "assumptions" include any factor or value, whether assumed or known, which is used to calculate the numerator or denominator of the ratio.

c) Compute the net single premium ($NSP_{x+t}$) on the valuation date for the coverage provided by the secondary guarantee for the period of time ending at attained age $x+n$, using the interest, lapse and mortality assumptions prescribed in Section 3.C below. The net single premium (NSP) shall include consideration for death benefits only.

d) The NPR for an insured age $x$ at issue at time $t$ shall be according to the formula below:

$$M_{x+t} \left( \frac{ASG_{x+t}}{FFSG_{x+t}} \cdot 1 \right) \cdot NSP_{x+t} - E_{x+t}$$

**Guidance Note:** For a non-integer value of $t$, $E_{x+t}$ is obtained by taking the present value at duration $t$ of $E_{x+T}$, where $T$ is the next higher integer; i.e., entails discounting by valuation interest, mortality, and lapse for the fractional year between the valuation date and next anniversary ($T - t$).

iii. Actuarial present values referenced in this Section 3.B.5.d are calculated using the interest, mortality and lapse assumptions prescribed in Section 3.C below.

d. A reserve amount for the policy shall be calculated assuming the secondary guarantee is not in effect. The reserve amount shall be determined by the policy features and guarantees of the policy without considering any secondary guarantee provisions as follows:

i. Determine the level gross premium at issue, assuming payments are made each year for which premiums are permitted to be paid, such period defined as “s” in this subsection, that would keep the policy in force for the entire period coverage is to be provided based on the policy guarantees of mortality, interest and expenses.

ii. Using the level gross premium from Section 3.B.5.d.i, determine the value of the expense allowance components for the policy at issue as $x_1$, $y_{2-5}$ and $z_1$ defined below.

- $x_1$ = a first-year expense equal to the level gross premium at issue
- $y_{2-5}$ = an expense equal to 10% of the level gross premium and applied in each year from the second through fifth policy year
- $z_1$ = a first-year expense of $2.50 per $1,000 of insurance issued

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The expense allowance shall be amortized over the period during which premiums are permitted to be paid. \( E_{x+t} \), the expense allowance balance, as of the end of policy year \( t \), shall be calculated as follows:

\[
E_{x+t} = VNPR \cdot \bar{d}_{x+t} \cdot \left[ \frac{1}{\bar{a}_{x+5}} \right] \quad \text{for } t < s
\]

\[
= 0 \quad \text{for } t \geq s
\]

Where:

\( t = 1, 2, \ldots \) (number of completed years since issue)

\[ VNPR = \text{Valuation Net Premium Ratio from 3.B.5.d.iii} \]

\[ C_{x+t} = 0 \quad \text{when } t = 1 \]

\[ = \sum_{w=1}^{t-1} \frac{1}{\bar{a}_{x+t-w}} \quad \text{when } 2 \leq t \leq 5 \]

\[ = C_{x+5} \quad \text{when } t > 5 \]

iii. Determine the annual valuation net premiums as that uniform percentage (the valuation net premium ratio) of the respective gross premiums, such that at issue the actuarial present value of future valuation net premiums shall equal the actuarial present value of future benefits.

iv. For a policy issued at age \( x \), at any duration \( t \), the net premium reserve shall equal:

\[
m_{x+t} \cdot r_{x+t}
\]

Where:

a) \( m_{x+t} \) = the actuarial present value of future benefits less the actuarial present value of future valuation net premiums and less the unamortized expense allowance for the policy \( E_{x+t} \).

Guidance Note: For a non-integer value of \( t \), \( E_{x+t} \) is obtained by taking the present value at duration \( t \) of \( E_{x+T} \), where \( T \) is the next higher integer; i.e., entails discounting by valuation interest and survivorship for the fractional year between the valuation date and the next anniversary (\( T - t \)).

b) Let:

\[ e_{x+t} = \max \text{ (the actual policy fund value on the valuation date, 0)} \]

\[ f_{x+t} = \text{the policy fund value on the valuation date is that amount which, together with the payment of the future level gross premiums determined in Section 3.B.5.d.ii above, keeps the policy in force for the entire period coverage is to be provided, based on the policy guarantees of mortality, interest and expenses.} \]

Then set \( r_{x+t} \) equal to:

\[ 1, \text{ if } f_{x+t} \leq 0 \]

\[ \min[e_{x+t}/f_{x+t}], 1], \text{ otherwise} \]

v. The future benefits used in determining the value of \( m_{x+t} \) shall be based on the greater of \( e_{x+t} \) and \( f_{x+t} \), together with the future payment of the level gross premiums determined in Section 3.B.5.d.ii above, and assuming the policy guarantees of mortality, interest and expenses.
vi. The values of \( \bar{\sigma} \) are determined using the NPR interest, mortality and lapse assumptions applicable on the valuation date.

vii. Actuarial present values referenced in this Section 3.B.5.d are calculated using the interest, mortality and lapse assumptions prescribed in Section 3.C.

6. For all policies and riders within the All Other VM-20 Reserving Category, the NPR shall be determined pursuant to applicable methods in VM-A and VM-C for the basic reserve. The mortality tables to be used are those defined in Section 3.C.1 and in VM-M Section 1.H.

7. The actuarial present value of future benefits equals the present value of future benefits including, but not limited to, death, endowment (including endowments intermediate to the term of coverage) and cash surrender benefits. Future benefits are before reinsurance and before netting the repayment of any policy loans.

8. For life insurance coverage that the company has assumed on a YRT basis, the reinsurer’s net premium reserve shall be one half year’s cost of insurance for the reinsured net amount at risk.

C. Net Premium Reserve Assumptions

2. Interest Rates

b. For NPR amounts calculated according to Section 3.B.4 or Section 3.B.5.

3. Lapse Rates

c. For NPR amounts calculated according to Section 3.B.5 the lapse rate, \( L_{x+t} \), for an insured age \( x \) at issue for all durations subsequent to the valuation date shall be determined as follows:

i. Determine the ratio \( R_{x+t} \) where:

\[
R_{x+t} = \frac{[FFSG_{x+t} - ASG_{x+t}]}{[FFSG_{x+t} - LSG_{x+t}]} \quad \text{but not} \quad 1 \quad \text{and not} < 0
\]

Where:

- \( FFSG_{x+t} \) is the fully funded secondary guarantee on the valuation date for the insured age \( x \) at issue
- \( ASG_{x+t} \) is the actual secondary guarantee on the valuation date for the insured age \( x \) at issue
- \( LSG_{x+t} \) is the level secondary guarantee on the valuation date for the insured age \( x \) at issue

**Guidance Note:** The \( FFSG_{x+t} \), \( ASG_{x+t} \), and \( LSG_{x+t} \) are based on the secondary guarantee values as of the valuation date and will remain constant throughout the cash flow projection. This will result in a constant lapse assumption, calculated as of the valuation date, that does not vary by duration throughout the cash flow projection for the NPR calculation.

ii. As of the valuation date, which is \( t \) years after issue, the annual lapse rate for the policy shall be assumed to be level for all future years and denoted as \( L_{x+t} \), which shall be set equal to:

\[
L_{x+t} = R_{x+t} \times 0.01 + (1 - R_{x+t}) \times 0.005 \times r_{x+t}
\]
Where \( r_{x+t} \) is the ratio determined in Section 3.B.5.d.

**Guidance Note:** By similar logic, it follows (from ASG \( x + t \) being 0 when \( t = 0 \)) that the level annual lapse rate to be used in the calculations in Section 3.B.5.i.b and 3.B.5.i.c is 1%. On the other hand, when performing the calculations in Section 3.B.5.i.i, \( L_{x+t} \) though level, is not generally equal to what it was for the same policy on the previous valuation date.

### Section 6: Stochastic and Deterministic Exclusion Tests

**B. Deterministic Exclusion Test (DET)**

5. For purposes of determining the valuation net premiums used in the demonstration in Section 6.B.2:
   
a. If pursuant to Section 2, the NPR for the group of policies is the minimum reserve required under VM-A and VM-C, then the valuation net premiums are determined according to those minimum reserve requirements.

   b. If the NPR is determined according to Section 3.B.4 or Section 3.B.5, then the lapse rates assumed for all durations shall for the purposes of the DET be set to 0%;
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

John Robinson, Director PBR – Valuation Actuary, MN

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


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

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

The purposes of this APF are to
(a) Clarify the responsibilities of the appointed actuaries of both the ceding and assuming companies for all forms of reinsurance, relative to both the SAO and asset adequacy analysis.

(b) Make a minor modification to the table headings in VM-30, Section 3.A.5.

Discussion of Rationale:

1. Every appointed actuary should be held accountable for ensuring that all the reserves covered by the actuary’s SAO are subjected to asset adequacy analysis. Usually, this requires the appointed actuary to perform the analysis; however, circumstances may exist where the appointed actuary can rely on work performed by the counterparty’s appointed actuary. In any event, whether relying on another actuary or not, this APF will require the appointed actuary to provide the results of the asset adequacy analysis, as evidence that the analysis was performed.

2. VM-30 Section 3.A.7.e includes the following required statement as part of the SAO:
“The reserves and related actuarial items, when considered in light of the assets held by the company with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on the assets, and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision, according to presently accepted ASOPs, for the anticipated cash flows required by the contractual obligations and related expenses of the company.”

In a situation where part or all of the risk is reinsured, the assets held by the company may only be in respect of the portion of the risk supported by the reserves held; however, the appointed actuary’s actuarial opinion must address all the contractual obligations. It follows that, while asset adequacy analysis can only be performed on the reserves and assets held (i.e. net of reinsurance), the appointed actuary’s responsibility may extend beyond the reserves and assets held.
3. In a recent Academy survey of appointed actuaries ("A Survey of Life Appointed Actuaries, December 4, 2020", Question 66), most of them (50.38%) indicated that for the YE2019 AAT, “no special consideration for reinsurance recoverability will be added”.

This APF will provide guidance that should produce more clarity and uniformity on this issue.

4. The following excerpt is from ASOP 7, “Analysis of Life, Health, or Property/Casualty Insurer Cash Flows”:

3.8 Reinsurance—The actuary should consider whether reinsurance receivables will be collectible when due, and any terms, conditions, or other aspects that may be reasonably expected to have a material impact on the cash flow analysis.”

This APF will propose that similar guidance apply to the appointed actuary in meeting his/her responsibility beyond the reserves and assets held.

The proposed text is in the Appendix below.

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

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Notes: VM Maintenance Agenda 2019-34
1. It is proposed to add the following text as VM-30, Section 4:

Section 4: Asset Adequacy Analysis For Treaties Of Reinsurance

1. Each counterparty to a reinsurance treaty has established a reserve in respect of its obligations relative to the underlying policies. Furthermore, the appointed actuary’s statement of actuarial opinion covers the reserves established for all of the company’s reinsurance treaties currently in force. Consequently, a company’s appointed actuary is required to perform adequacy analysis on the reserves which the company has established in respect of the treaties into which the company has entered and which are currently in force.

2. The results of the asset adequacy analysis shall be reported in the appointed actuary’s actuarial memorandum, as required in Section 3.B.12.b.

3. Materiality considerations may influence the decision whether to perform the asset adequacy analysis. However, the size of the reserve must not be the sole materiality criterion.

4. The appointed actuary of a direct writer must perform a review of each reinsurance counterparty to assess
   (a) whether reinsurance receivables will be collectible when due; and
   (b) any terms, conditions, or other aspects that may be reasonably expected to have a material impact on the company’s ability to meet its obligations to policyholders.

   Evidence of having performed such reviews shall be provided in the actuarial memorandum.

Guidance Note:
   (a) Under certain circumstances, for example, when risk is ceded under a modified coinsurance agreement, a counterparty may report a reserve of 0. This alone does not foreclose on the requirement for the asset adequacy analysis to be performed.
   (b) If an appointed actuary relies on the work of another actuary, such as the appointed actuary of the reinsurance counterparty, the guidance in Section 3.A.6 and Section 3.B.2 must be followed. In relying on the work of another appointed actuary, an appointed actuary may not rely solely on the other actuary’s statement of actuarial opinion.

[Underlying principles:
   1. The SAO itself
   2. Each counterparty has its own perspective
   3. Regulatory accountability]

Question for commenters:
In 4., should there be more specificity as to what evidence should be provided?
If so, what should be required?
2. Revision to Section 3.A.5, Table Headings:

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<th>Principle-Based Reserves (2)</th>
<th>Additional Reserves ^ (3)</th>
<th>Analysis Method b</th>
<th>Other Amount Not Tested (4)</th>
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</table>

© 2021 National Association of Insurance Commissioners
The Life Actuarial (A) Task Force met April 29, 2021. The following Task Force members participated: Doug Slape, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Judith L. French, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li and Steve Ostlund (AL); Ricardo Lara represented by Ben Bock, Perry Kupferman and Thomas Reedy (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Rhonda Ahrens (NE); Marlene Caride represented by Kevin Clarkson (NJ); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Jonathan T. Pike represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. **Adopted Amendment Proposal 2021-04**

   Brian Bayerle (American Council of Life Insurers—ACLI) said amendment proposal 2021-04 clarifies the references to Internal Revenue Code (IRC) Section 7702 in VM-02, Minimum Nonforfeiture Mortality and Interest.

   Mr. Leung made a motion, seconded by Mr. Weber, to adopt amendment proposal 2021-04 (Attachment A). The motion passed unanimously.

2. **Discussed Amendment Proposal 2021-01**

   Mr. Robinson said amendment proposal 2021-01 attempts to reduce the work required for determining the pre-reinsurance ceded reserve by eliminating the requirements for pre-reinsurance ceded exclusion tests. He said previous discussions have revealed that in certain situations, the amendment proposal could increase the work required. He said the intent of the amendment proposal is to revise the reserve requirements to reflect the qualitative nature of the pre-reinsurance ceded reserve in a manner that allows for a reduction in the work required to meet the requirements.

   Mr. Chupp expressed concerns about the intent of the amendment proposal. He said the amendment proposal will not significantly reduce the work required. He added that the proposed requirement is not consistent with the *Term and Universal Life Insurance Reserve Financing Model Regulation* (#787).

   Mr. Robinson acknowledged the inconsistency, but he noted that Model #787 is not reserve guidance.

   Ms. Hemphill said she is concerned that the work reduction may allow a company to forgo the pre-reinsurance stochastic reserve calculation in situations where it is greater than the pre-reinsurance deterministic and net premium reserves.

   Ms. Fenwick said ceding business to a reinsurer should not create an opportunity to avoid the exclusion testing.

   Ms. Ahrens, Ms. Fenwick, Mr. Bock and Mr. Serbinowski opposed exposing the amendment proposal. Mr. Sartain said while he is sympathetic to the issue, he would vote against exposing the amendment proposal unless industry voiced their support for it.

   After his motion to expose amendment proposal 2021-01 (Attachment B) was not seconded, Mr. Robinson withdrew the amendment proposal.

3. **Discussed Amendment Proposal 2019-33**

   Mary Bahna-Nolan (Academy Life Reserves Work Group—LRWG) said the comments received for the previous exposure of amendment proposal 2019-33 (Attachment C) were focused on correcting referencing and formatting issues. She briefly
discussed the revisions made to the amendment proposal in response to the comment letters received after the previous exposure. Discussion of the amendment proposal will continue May 6.

Having no further business, the Life Actuarial (A) Task Force adjourned.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

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

Brian Bayerle, ACLI – edits adopted changes to VM-02 for improved clarity and to remove potential circularity.

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

Valuation Manual (January 1, 2021 edition), VM-02 Section 3.A

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

See attached.

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

Subsequent the adopted changes to the federal tax code (IRC S. 7702), this proposed change would clarify the language in the previously adopted edits to VM-02 to avoid any potential circularity.
Valuation Manual VM-02

Section 3: Interest

A. The nonforfeiture interest rate for any life insurance policy issued in a particular calendar year beginning on and after the operative date of the Valuation Manual shall be equal to 125% of the calendar year statutory valuation interest rate defined for the NPR in the Valuation Manual for a life insurance policy with nonforfeiture values, whether or not such sections apply to such policy for valuation purposes, rounded to the nearer one-quarter of 1%, provided, however, that the nonforfeiture interest rate shall not be less than the Applicable Accumulation Test Minimum Rate in the Cash Value Accumulation Test under Section 7702 (Life Insurance Contract Defined) of the U.S. Internal Revenue Code.

Guidance Note: For flexible premium universal life insurance policies as defined in Section 3.D of the Universal Life Insurance Model Regulation (#585), this is not intended to prevent an interest rate guarantee less than the nonforfeiture interest rate.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

   John Robinson, Director PBR – Valuation Actuary, MN

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


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   See APPENDIX below.

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

   In circumstances where the ceding company computes separate pre-reinsurance and post-reinsurance reserves,

   (a) The post-reinsurance reserve is supported by assets held by the company.

   (b) The pre-reinsurance reserve is not supported by assets held by the company. According to ASOP 52 (PBR), Section 3.5.2, “...the calculation of a pre-reinsurance ceded stochastic reserve or deterministic reserve requires the construction of a hypothetical portfolio of starting assets and a corresponding model investment strategy. Possible methods for constructing the hypothetical portfolio include, but are not limited to, the following: ...”

   (c) When calculating the pre-reinsurance reserve, the company may be able to select sufficient starting assets for the calculation by “borrowing” assets not otherwise assigned to PBR calculations.

   (d) When calculating the pre-reinsurance reserve, the company may not be able to select sufficient starting assets for the calculation by “borrowing” assets not otherwise assigned to the PBR calculations. In this case, the qualified actuary might be required to use “notional assets”.

   (e) The pre-reinsurance reserve is not equivalent to the sum of the reserves held by the respective counterparties.
(f) SERT performed on a pre-reinsurance basis would similarly require 16 hypothetical asset portfolios, and this should be considered in assessing its value.

It follows from these observations that the pre-reinsurance reserve should not be subject to the same level of scrutiny as the post-reinsurance reserve and need not require the same degree of rigor.

The purpose of this APF is, under these circumstances, to eliminate the requirements to

1. perform separate exclusion tests for pre-reinsurance and post-reinsurance reserves; and
2. apply asset collar considerations for the pre-reinsurance reserve.

Implication for the reserve credit:

The following demonstrates that by eliminating pre-reinsurance exclusion tests and following the post-reinsurance exclusion test results, the resulting reserve credit may sometimes be higher and other times lower than when separate tests are performed.

Scenario 1: pre-reserve and post-reserve tested separately

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<thead>
<tr>
<th>Post-reserve</th>
<th>Pre-reserve</th>
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<tbody>
<tr>
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<td>Fail</td>
</tr>
<tr>
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</table>

Scenario 2: only post-reserve tested, pre-reserve uses same results

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<th>Post-reserve</th>
<th>Pre-reserve</th>
<th>Comments</th>
</tr>
</thead>
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<td>SET</td>
</tr>
<tr>
<td>Fail</td>
<td>Fail</td>
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</table>
APPENDIX

VM-20, Section 8.D: Determination of a Pre-Reinsurance Minimum Reserve

2. The pre-reinsurance-ceded minimum reserve shall be calculated pursuant to the requirements of VM-20, using methods and assumptions consistent with those used in calculating the minimum reserve, but excluding the effect of ceded reinsurance. The remainder of this Section 8.D.2 assumes that the pre-reinsurance-ceded minimum reserve and post-reinsurance-ceded minimum reserve for a group of policies are being calculated separately.

a. If, on a pre-reinsurance-ceded basis, a group of policies has not passed one or both of the exclusion tests pursuant to Section 6, then the required deterministic or stochastic reserves shall be calculated in determining the pre-reinsurance-ceded minimum reserve, even if not required for the minimum reserve.

b. The company shall use assumptions that represent company experience in the absence of reinsurance—for example, assuming that the business was managed in a manner consistent with the manner that retained business is managed—when computing the such pre-reinsurance-ceded minimum exclusion tests and reserves.

c. The requirement in Section 7.D.3 regarding the 98% to 102% collar does not apply when determining the amount of starting assets excluding the effect of ceded reinsurance for calculating the pre-reinsurance-ceded minimum reserve.

Commented [RJW(1)]: Clarify when this guidance applies.
Commented [RJW(2)]: Only post-reins exclusion testing required.
Commented [RJW(3)]: The issue is not whether it is able to pass, it is whether it has passed.
Commented [RJW(4)]: Using post-reins exclusion test result. Delete.
Commented [RJW(5)]: Consistent wording.
Commented [RJW(6)]: Consistent terminology; delete pre-reins exclusion test.
Commented [RJW(7)]: Consistent terminology.
Life Actuarial (A) Task Force/Health Actuarial (B) Task Force
Amendment Proposal Form*

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

American Academy of Actuaries, Life Reserves Work Group

Addition of language to clarify the definition of individually underwritten life insurance and the applicability of Principle-Based Reserve (PBR) requirements for group insurance contracts with individual risk selection issued under insurance certificates.

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

January 1, 2021, version of the Valuation Manual used.

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

See Appendix

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

Individual insurance certificates issued under a group contract which utilize an individual risk selection process, pricing, premium rate structures and product features are similar to individual life insurance policies. They are currently excluded from VM-20 because they are filed under a group contract, but they should be subject to VM-20 due to this similarity. See Appendix.

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Notes: APF 2019-33
Appendix

Issue

Certain contracts issued under a master group contract require individual risk selection in order to qualify for issuance of the group insurance certificate; the certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing, and risk classification; and they are managed in a similar manner as individual ordinary life insurance contracts. These individual certificates should follow the same reserve requirements as other individual life contracts of the same product type. Therefore, a change is needed within the Valuation Manual to bring these individual certificates into scope of VM-20.

Six changes are recommended:

1) Within the Reserve Requirements section (Section II), change the minimum reserve requirements to also apply to group life contracts which, other than the difference between issuing a policy and issuing a group certificate, have the same or mostly similar contract provisions, risk selection process, and underwriting as individual ordinary life contracts (Section II, subsection 1.D);

2) Within the Reserve Requirements section (Section II), add a transition period for individual group certificates issued on or before 1/1/2024 (Section II, subsections 1.F.1 and 1.F.2);

3) Within the Reserve Requirements section (Section II), add language and guidance note to subsection 1.G and the corresponding footnote to include premiums from group life contracts which have individual certificates that were issued using individual risk selection processes (Section II, subsection 1.G.1, footnote, and guidance note) and to clarify the Calculation for Exemption (Section II, subsection 1.G.2). Comment notes need to refer to NAIC Blanks (E) Working Group to update the PBR Supplement;

4) Add new paragraph, VM-20 Section 1.B (and reformat to make current paragraph Section 1.A) to clarify group life certificates issued using individual risk selection processes, including a definition and requirements to be met, are subject to the requirements of VM-20;

5) Add guidance note after first sentence in VM-20 Section 2.A.1 that group life certificates that meet the definition for individual risk selection process use the same VM-20 Reserving Categories as defined in Section 2;

6) Draft referral to the NAIC Blanks (E) Working Group to revise the VM-20 Reserves Supplement, Part 2 to report premiums for total Group Life and Group Life with certificates subjected to an individual risk selection process and which meet all of the conditions as defined in VM-20 Section 1.B separately.
II. Reserve Requirements

This section provides the minimum reserve requirements by type of product, as set forth in the seven subsections below, as follows:

1. Life Insurance Products
2. Annuity Products
3. Deposit-Type Contracts
4. Health Insurance Products
5. Credit Life and Disability Products
6. Riders and Supplemental Benefits
7. Claim Reserves

All reserve requirements provided by this section relate to business issued on or after the operative date of the Valuation Manual. All reserves must be developed in a manner consistent with the requirements and concepts stated in the Overview of Reserve Concepts in Section I of the Valuation Manual.

Guidance Note: The terms “policies” and “contracts” are used interchangeably.

Subsection 1: Life Insurance Products

A. This subsection establishes reserve requirements for all contracts issued on and after the operative date of the Valuation Manual that are classified as life contracts as defined in SSAP No. 50 in the AP&P Manual, with the exception of annuity contracts and credit life contracts. Minimum reserve requirements for annuity contracts and credit life contracts are provided below in subsection 2 and subsection 5, respectively.

B. Minimum reserve requirements for variable and nonvariable individual life contracts—excluding guaranteed issue life contracts, preneed life contracts, industrial life contracts, and policies of companies exempt pursuant to the life PBR exemption in paragraph D below—subsection 1.G are provided by VM-20, Requirements for Principle-Based Reserves for Life Products, except for election of the transition period in paragraph C below subsection 1.F.1 below. For this purpose, joint life policies are considered individual life.

C. Minimum reserve requirements of VM-20 are considered principle-based valuation requirements for purposes of the Valuation Manual.

D. Minimum reserve requirements for individual certificates under group life contracts which meet all the requirements in VM-20 Section 1.B are provided by VM-20, except for election of the transition period in subsection 1.F.1 below.

E. Minimum reserve requirements for life contracts not subject to VM-20 are those pursuant to applicable requirements in VM-A and VM-C. For guaranteed issue life contracts issued after Dec. 31, 2018, mortality tables are defined in VM Appendix M, Mortality Tables (VM-M), and the same table shall be used for reserve requirements as is used for minimum nonforfeiture requirements as defined in VM-02, Minimum Nonforfeiture Mortality and Interest.
F. A company may elect to establish minimum reserves pursuant to applicable requirements in VM-A and VM-C for:

1. Business described in subsection 1.D above and issued on or after the operative date of the Valuation Manual and prior to 1/1/2024.

2. Business not described subsection 1.D otherwise subject to VM-20 requirements and issued during the first three years following the operative date of the Valuation Manual.

A company electing to establish reserves using the requirements of VM-A and VM-C may elect to use the 2017 Commissioners’ Standard Ordinary (CSO) Tables as the mortality standard following the conditions outlined in VM-20 Section 3. If a company during the three years elects to apply VM-20 to a block of such business, then a company must continue to apply the requirements of VM-20 for future issues of this business.

G. Life PBR Exemption

1. A company meeting the condition in subsection 1.G.2 below may file a statement of exemption for individual ordinary life insurance policies and certificates, except for policies in subsection 1.G.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. Such a statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that the condition of subsection 1.G.2 was met based on premiums from the prior calendar year annual statement. The statement of exemption must also be included with the NAIC filing for the second quarter of that year.

The domiciliary commissioner may reject such statement prior to September 1 and require the company to follow the requirements of VM-20 for the ordinary life policies covered by the statement.

2. Condition for Exemption:
   
a. The company has less than $300 million of exemption premium, and if the company is a member of an NAIC group of life insurers which includes other life insurance companies, the group has combined exemption premium of less than $600 million. Exemption premium is determined as follows:
   
a. The amount reported in the prior calendar year life/health annual statement, Exhibit 1, Part 1, Column 3 (“Ordinary Life Insurance”), line 20.1; plus
   
b. The portion of the amount in the prior calendar year life/health annual statement, Exhibit 1, Part 1, Column 3 (“Ordinary Life Insurance”), line 20.2 assumed from unaffiliated companies; minus
   
c. Amounts included in either (a) or (b) that are associated with guaranteed issue insurance policies and/or preneed life insurance policies; minus
   
d. Amounts included in either (a) or (b) that represent transfers of reserves in force as of the effective date of a reinsurance assumed transaction; plus
   
e. Amounts of premium for individual life certificates issued under a group life certificate which meet the conditions defined in VM-20, Section 1.B, and that are not included in either (a) or (b).

Guidance Note:

(i) Definitions of preneed and guaranteed issue insurance policy are in VM-01.

(ii) For statements of exemption filed for calendar year 2022 and beyond, the amount in subsection 2.e was reported in the prior calendar year life/health annual statement, VM-20 Reserve Supplement, Part 2, if applicable.

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3. Policies Excluded from the Life PBR Exemption:
   
a. Universal life with secondary guarantee (ULSG) policies with a secondary guarantee that does not meet the VM-01, Definitions for Terms in Requirements, definition of a “non-material secondary guarantee.”

4. Each exemption, or lack of an exemption, applies only to policies issued or assumed in the current year, and it applies to all future valuation dates for those policies. The minimum reserve requirements for the ordinary life policies subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.

VM Change 4 – VM-20: Requirements for Principle-Based Reserves for Life Products

VM-20: Requirements for Principles-Based Reserves for Life Products

Section 1: Purpose

A. These requirements establish the minimum reserve valuation standard for individual life insurance policies issued on or after the operative date of the Valuation Manual and subject to a principle-based valuation with an NPR floor under Model #820. These requirements constitute the Commissioners Reserve Valuation Method (CRVM) for policies of individual life insurance.

B. Individual life certificates under a group life contract shall be subject to the requirements of VM-20 if all of the following are met. These requirements constitute the Commissioners Reserve Valuation Method (CRVM) for such certificates.

1. An individual risk selection process, defined as follows, is used to obtain group life insurance coverage;

An individual risk selection process is one that is based on characteristics of the insured(s) beyond sex, gender, age, tobacco usage, and membership in a particular group. This may include, but is not limited to, completion of an application (beyond acknowledgement of membership to the group, sex, gender and age), questionnaire(s), online health history or tele-interview to obtain non-medical and medical or health history information, prescription history information, avocations, usage of tobacco, family history, or submission of fluids such as blood, Home Office Specimens (HOS), or oral fluid. The resulting risk classification is determined based on the characteristics of the individual insured(s) rather than the group, if any, of which it is a member (e.g., employer, affinity, etc.). The individual certificate holder is charged a premium rate based solely on the individual risk selection process and not on membership in a specific group.
The individual certificates utilize premiums or cost of insurance schedules and charges based on the individual applicant’s issue age, duration from underwriting, coverage amount and risk classification and there is a stated or implied schedule of maximum gross premiums or net cash surrender value required in order to continue coverage in force for a period in excess of one year;

3. The group master contract is designed, priced, solicited, and managed similar to individual ordinary life insurance policies rather than specific to the group as a whole;

4. The individual certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing, and risk classification to individual ordinary life insurance contracts.

5. The individual certificates are issued on or after the operative date of the Valuation Manual except election of the transition period in Section 2, subsection 1.F.1.

Guidance Note: The use of evidence of insurability does not by itself constitute an individual risk selection process. Use of information obtained from a census or question(s) regarding gender, occupation, age, income and/or tobacco usage solely for purposes of determining a rate classification does not by itself qualify a group as having used an individual risk selection process. Group insurance where the underwriting based on the characteristics of the group and census data but where some individuals are subjected to individual risk selection as a result of compensation level, age, an existing medical condition or impairment, late entry into the group, failure of the group to meet minimum participation requirements or voluntary buy-up of increased coverage does not meet the definition of an individual risk selection process.

2. The individual certificates utilize premiums or cost of insurance schedules and charges based on the individual applicant’s issue age, duration from underwriting, coverage amount and risk classification and there is a stated or implied schedule of maximum gross premiums or net cash surrender value required in order to continue coverage in force for a period in excess of one year;

3. The group master contract is designed, priced, solicited, and managed similar to individual ordinary life insurance policies rather than specific to the group as a whole;

4. The individual certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing, and risk classification to individual ordinary life insurance contracts.

5. The individual certificates are issued on or after the operative date of the Valuation Manual except election of the transition period in Section 2, subsection 1.F.1.

VM Change 5 - VM-20: Requirements for Principle-Based Reserves for Life Products

Section 2: Minimum Reserve

A. All policies subject to these requirements shall be included in one of the VM-20 Reserving Categories, as specified in Section 2.A.1, Section 2.A.2 and Section 2.A.3 below.

Guidance Note: Since group insurance subject to an individual risk selection process and meeting all the requirements in Section 1.B is subject to VM-20 requirements, Section 2.A shall apply—meaning that any such contracts will be included in one of the VM-20 Reserving Categories defined by Section 2.A.1, Section 2.A.2, and 2.A.3. All requirements in VM-31 which apply to a VM-20 Reserving Category shall apply to any group insurance subject to individual risk selection that has been included in that VM-20 Reserving Category.

The company may elect to exclude one or more groups of policies from the stochastic reserve calculation and/or the deterministic reserve calculation. When excluding a group of policies from a reserve calculation, the company must document that the applicable exclusion test defined in Section 6 is passed for that group of policies. The minimum reserve for each VM-20 Reserving Category is defined by Section 2.A.1, Section 2.A.2 and Section 2.A.3, and the total minimum reserve equals the sum of the Section 2.A.1, Section 2.A.2 and Section 2.A.3 results below, defined as:
VM Change 6 – VM-20 Reserves Supplement, Part 2: Life PBR Exemption

Refer to NAIC Blanks (E) Working Group, request for modification to the supplemental report for the Life PBR Exemption, to show the premiums for group life that utilized an individual risk selection process and meets all of the requirements in VM-20 Section 1.B. as these premiums are currently grouped together with other group insurance in Exhibit 1. As there are other instances where the ordinary life premiums are not included in the determination of the Life PBR Exemption (e.g., for guaranteed issue policies), it may be useful to request addition of the breakdown of premiums used to determine the exemption.

Possible insertion between questions 1 and 2 for disclosure of premiums used in the determination of eligibility for the Life PBR exemption, split by ordinary life and group subject to an individual risk selection process and meeting all of the requirements in VM-20 Section 1.B.
The Life Actuarial (A) Task Force met April 22, 2021. The following Task Force members participated: Doug Slape, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Judith L. French, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li and Steve Ostlund (AL); Ricardo Lara represented by Ben Bock and Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheck (IA); Dana Popish Severinghaus represented by Bruce Sartin and Vincent Tsang (IL); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Rhonda Ahrens (NE); Marlene Caride represented by Kevin Clarkson (NJ); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Jonathan T. Pike represented by Tomasz Serbinowski (UT); Scott A. White represented by Craig Chupp (VA); and James A. Dodrill represented by Tim Sigman and Joylynn Fix (WV).

1. Exposed Amendment Proposal 2021-05

David Neve (Actuarial Resources Corporation of Georgia) said amendment proposal 2021-05 asserts that the term “modeled company investment strategy” is preferred to “model investment strategy,” and it seeks to use the former term consistently throughout the *Valuation Manual*. He said the proposal also clarifies that “modeled company investment strategy” refers to the investment strategy in the model prior to comparison to the alternative investment strategy. Additionally, the proposal modifies VM-21, Requirements for Principle-Based Reserves for Variable Annuities, to be consistent with the wording in VM-20, Requirements for Principle-Based Reserves for Life Products, clarifying that the assets in the alternative investment strategy should use the same weighted average life (WAL) as the assets in the modeled company investment strategy.

Mr. Leung made a motion, seconded by Mr. Kupferman, to expose amendment proposal 2021-05 (Attachment Ten-A) for a 21-day public comment period ending May 12. The motion passed unanimously.

2. Exposed Amendment Proposal 2021-06

Angela McNabb (NAIC) said amendment proposal 2021-06 revises VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, to allow reinsurers and third-party administrators (TPAs) to submit mortality experience data on behalf of the direct writing company, and it revises VM-51 to remove a column that is not valid for the Regulatory Data Collection (RDC) system from the required data format.

Mr. Leung asked if there might be reinsurers or TPAs that are foreign entities without an NAIC company code. Pat Allison (NAIC) said foreign companies should contact the NAIC for assignment of a company code.

Mr. Weber made a motion, seconded by Mr. Leung, to expose amendment proposal 2021-06 (Attachment Ten-B) for a 30-day public comment period ending May 21. The motion passed unanimously.

3. Discussed Amendment Proposal 2021-01

Mr. Robinson said amendment proposal 2021-01 attempts to reduce the work required for determining the pre-reinsurance ceded reserve by eliminating the requirements for separate pre-reinsurance ceded exclusion tests and asset collar considerations. Ms. Fenwick asked if the proposal allows companies to use reinsurance to avoid having to calculate a stochastic reserve. She indicated that she is opposed to the proposal for that reason. Discussion of amendment proposal 2021-01 (Attachment Ten-C) will continue at the Task Force’s April 29 meeting.

Having no further business, the Life Actuarial (A) Task Force adjourned.

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

Amendment Proposal Form*

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

Identification: David Neve, VP and Consulting Actuary, Actuarial Resources Corporation

Title of the Issue: Clarify the definition of modeled company investment strategy and the comparison to the alternative investment strategy.

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

   January 1, 2020 NAIC Valuation Manual
   • VM-01 VM-21 Section 4.D

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

   See attached.

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

   There is an inconsistency in VM-20/VM-21 and VM-31 regarding the term “model investment strategy”. The term “model investment strategy” is used throughout VM-20 and VM-21 to describe the investment strategy used in the model as a proxy for the company’s actual investment strategy. However, VM-31 uses the term “modeled company investment strategy” in several places rather than “model investment strategy”. “Modeled company investment strategy” is the preferred term, so VM-20 and VM-21 have been modified to use “modeled company investment strategy” so that the terminology in VM-20, VM-21 and VM-31 are consistent.

   Also, to address the ambiguity of whether the final investment strategy in the model is the initial investment strategy based on the company’s investment strategy or the alternative investment strategy when the alternative strategy is constraining, the term “modeled company investment strategy” has been added to the definitions in VM-01 (and a parenthetical has been added to VM-31) to clarify that the term refers to the investment strategy in the model prior to comparison to the alternative investment strategy. In addition, VM-21 has been modified to be consistent with the wording in VM-20 to clarify that the assets in the alternative investment strategy should use the same weighted average life (WAL) as the assets in the modeled company investment strategy.
VM-01 Changes:

VM-01 provides definitions for terms used in the Valuation Manual. The definitions in VM-01 do not apply to documents outside the Valuation Manual even if referenced or used by the Valuation Manual, such as the AP&P Manual. Some terms in the Valuation Manual may be defined in specific sections of the Valuation Manual instead of being defined in VM-01.

- The term “margin” means an amount included in the assumptions used to determine the modeled reserve that incorporates conservatism in the calculated value consistent with the requirements of the various sections of the Valuation Manual. It is intended to provide for estimation error and adverse deviation.

- The term “modeled company investment strategy” means the investment strategy used in the model that is intended to be a representation of the actual investment strategy of the company. It is before the comparison is made to the alternative investment strategy. It does not refer to the alternative investment strategy when the alternative investment strategy is constraining.

- The term “modeled reserve” means the deterministic reserve on the policies determined under VM-20 Section 2.A.1.a, 2.A.2.a and 2.A.3.b, plus the greater of the deterministic reserve and the stochastic reserve on the policies determined under Section 2.A.1.b, 2.A.2.b and 2.A.3.c.

VM-20 Changes:

Section 7: Cash-Flow Models

E. Reinvestment Assets and Disinvestment

1. At the valuation date and each projection interval as appropriate, model the purchase of general account reinvestment assets with available cash and net asset and liability cash flows in a manner that is representative of and consistent with the company’s investment policy for each model segment, subject to the following requirements:

   a. The modeled company investment strategy may incorporate a representation of the actual investment policy that ranges from relatively complex to relatively simple. In any case, the PBR Actuarial Report shall include documentation supporting the appropriateness of the representation relative to actual investment policy.

   b. The final maturities and cash-flow structures of assets purchased in the model, such as the patterns of gross investment income and principal repayments or a fixed or floating rate interest basis, shall be determined by the company as part of the model representation.

   c. The combination of price and structure for fixed income investments and derivative instruments associated with fixed income investments shall appropriately reflect the then-current U.S. Department of the Treasury (Treasury Department) curve along the relevant scenario and the requirements for gross asset spread assumptions stated below.

   d. For purchases of public non-callable corporate bonds, use the gross asset spreads over Treasuries prescribed in Section 9.F.8.a through Section 9.F.8.c. (For purposes of this
subsection, “public” incorporates both registered and 144a securities.) The prescribed spreads reflect current market conditions as of the model start date and grade to long-term conditions based on historical data at the start of projection year four.

e. For transactions of derivative instruments associated with fixed income investments, reflect the prescribed assumptions in Section 9.F.8.d for interest rate swap spreads.

f. For purchases of other fixed income investments, if included in the modeled company investment strategy, set assumed gross asset spreads over Treasuries in a manner that is consistent with, and results in reasonable relationships to, the prescribed spreads for public non-callable corporate bonds and interest rate swaps as defined in Section 9.F.8.

g. Notwithstanding the above requirements, the modeled reserve shall be the higher of that produced by the modeled company investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the modeled company investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of a clearly defined hedging strategy (in compliance with Section 7.L) are not affected by this requirement.

Guidance Note: VM-31 requires a demonstration of compliance with VM-20 Section 7.E.1.g. In many cases, particularly if the modeled company investment strategy does not involve callable assets, it is expected that the demonstration of compliance will not require running the reserve calculation twice. For example, an analysis of the weighted average net reinvestment spread on new purchases by projection year (gross spread minus prescribed default costs minus investment expenses) of the modeled company investment strategy compared to the weighted average net reinvestment spreads by projection year of the alternative strategy may suffice. The assumed mix of asset types, asset credit quality or the levels of non-prescribed spreads for other fixed income investments may need to be adjusted to achieve compliance.

VM-21 Changes:

Section 4: Determination of the Stochastic Reserve

D. Projection of Assets

4. General Account Assets

a. General account assets shall be projected, net of projected defaults, using assumed investment returns consistent with their book value and expected to be realized in future periods as of the date of valuation. Initial assets that mature during the projection and positive cash flows projected for future periods shall be invested in a manner that is representative of and consistent with the company’s investment policy, subject to the following requirements:

i. The final maturities and cash flow structures of assets purchased in the model, such as the patterns of gross investment income and principal repayments or a
fixed or floating rate interest basis, shall be determined by the company as part of the model representation;

ii. The combination of price and structure for fixed income investments and derivative instruments associated with fixed income investments shall appropriately reflect the projected Treasury Department curve along the relevant scenario and the requirements for gross asset spread assumptions stated below;

iii. For purchases of public non-callable corporate bonds, follow the requirements defined in VM-20 Sections 7.E, 7.F and 9.F. The prescribed spreads reflect current market conditions as of the model start date and grade to long-term conditions based on historical data at the start of projection year four;

iv. For transactions of derivative instruments associated with fixed income investments, reflect the prescribed assumptions in VM-20 Section 9.F for interest rate swap spreads;

v. For purchases of other fixed income investments, if included in the modeled company investment strategy, set assumed gross asset spreads over U.S. Treasuries in a manner that is consistent with, and results in reasonable relationships to, the prescribed spreads for public non-callable corporate bonds and interest rate swaps.

b. Notwithstanding the above requirements, the stochastic reserve shall be the higher of that produced by the modeled company investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the modeled company investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs, and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of a clearly defined hedging strategy are not affected by this requirement.

Drafting Note: This limitation is being referred to Life Actuarial (A) Task Force for review.

VM-31 Changes:

Section 3: PBR Actuarial Report Requirements

D. Life Report – This subsection establishes the Life Report requirements for individual life insurance policies valued under VM-20.

6. Assets – The following information regarding the asset assumptions used by the company in performing a principle-based valuation under VM-20:
   
r. Modeled Company Investment Strategy and Reinvestment Assumptions – Description of the modeled company investment strategy (before comparison to the alternative investment strategy), including asset reinvestment and disinvestment assumptions, and
documentation supporting the appropriateness of the modeled company investment strategy compared to the actual investment policy of the company.

s. Alternative Investment Strategy – Documentation demonstrating compliance with VM-20 Section 7.E.1.g, showing that the modeled reserve is the higher of that produced using the modeled company investment strategy and the alternative investment strategy.

F. VA Report – This subsection establishes the VA Report requirements for variable annuity contracts valued under VM-21.

6. General Account Assets – The following information regarding the general account asset assumptions used by the company in performing a principle-based valuation under VM-21:

a. Modeled Company Investment Strategy and Reinvestment Assumptions – Description of the modeled company investment strategy (before the comparison to the alternative investment strategy), including asset reinvestment and disinvestment assumptions, and documentation supporting the appropriateness of the modeled company investment strategy compared to the actual investment policy of the company.

b. Alternative Investment Strategy – Documentation demonstrating compliance with VM-21 Section 4.D.4.b showing that the stochastic reserve is the higher of that produced using the modeled company investment strategy and the alternative investment strategy, based on the limitations defined in VM-21 Section 4.D.4.b.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force

Amendment Proposal Form*

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

Angela McNabb & Pat Allison – NAIC staff support

Revisions to VM-50 and VM-51 to allow for data experience reporting to be performed by a reinsurer or third-party administrator and a correction to VM-51 Appendix 4.

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


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

See attached redline document.

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

This APF is needed for the following reasons:

1. VM-51 Appendix 4 includes a column indicating the position within the data file for each field. This is not valid as the NAIC’s RDC system was designed to accept comma delimited files. This APF will remove that column.

2. The VM-51 Section 2.B states that companies must submit data for all their direct written business prior to reinsurance ceded. The only exception is in the case of assumption reinsurance where policies have been legally novated. The NAIC has received feedback from a number of companies indicating that they have business that is reinsured and fully administered by the reinsurer. Since the ceding companies do not have the data, it represents a hardship for them to submit this business.

3. Currently, VM-51 Appendix 4 only allows one company code. In order to allow a reinsurer or third-party administrator to submit data on behalf of the direct writer, the NAIC must be able to identify both the submitting company and the direct writer of the block of business. This APF adds an additional field to accomplish this. By having the submitting company’s code, any questions the NAIC has regarding the data can be directed to the submitting company without fear of breaching confidentiality.

4. Having separate identifiers for the submitting company and direct writer will allow the NAIC to validate the reconciliations required by VM-50 Section 4.B.3.

Below are examples showing how the reconciliations would work according to the amended language in VM-50 Section 4.B.3.

Example 1: This example illustrates the scenario described in redlined language in VM-50 Section 4.B.3.c. Company A is a direct writer selected for VM-51 reporting.

- The company has retained and administers 35,000 policies (out of a total of 100,000).
- Company B (a reinsurer not selected to submit their own business) administers 50,000 policies for Company A.
Experience Reporting Requirements VM-50
- Company C (a reinsurer selected to submit their own direct business) administers 15,000 policies for Company A.

<table>
<thead>
<tr>
<th>RECONCILIATION FOR COMPANY A (Direct Writer)</th>
<th>Policy Count</th>
<th>Insurance Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Business as Reported in Company A's Annual Statement</td>
<td>100,000</td>
<td>2,500,000,000</td>
</tr>
<tr>
<td>Business being reported by Company B</td>
<td>(50,000)</td>
<td>(1,250,000,000)</td>
</tr>
<tr>
<td>Business being reported by Company C</td>
<td>(15,000)</td>
<td>(50,000,000)</td>
</tr>
<tr>
<td>Totals included in Company A’s data submissions</td>
<td>35,000</td>
<td>1,200,000,000</td>
</tr>
</tbody>
</table>

Example 2: This example illustrates the scenario described in the redlined language in VM-50 Section 4.B.3.a. Company D is another direct writing company selected for VM-51 reporting. Company B has been asked by Companies A and D to submit data Company B has assumed and administers.
- Company B administers 50,000 policies for Company A.
- Company B administers 100,000 policies for Company D.
- Company B is not required to reconcile to their Annual Statement since they were not selected to submit their direct business.
- In this example, Company B is a reinsurer. However, Company B could also be a third-party administrator that is not an insurance company.

<table>
<thead>
<tr>
<th>RECONCILIATION FOR COMPANY B</th>
<th>Policy Count</th>
<th>Insurance Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business being reported on behalf of Company A</td>
<td>50,000</td>
<td>1,250,000,000</td>
</tr>
<tr>
<td>Business being reported on behalf of Company D</td>
<td>100,000</td>
<td>1,500,000,000</td>
</tr>
<tr>
<td>Totals included in Company B’s data submission</td>
<td>150,000</td>
<td>2,750,000,000</td>
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</table>

Example 3: This example illustrates the scenario described in redlined language in VM-50 Section 4.B.3.b. Company C has also been asked by company A to submit data Company C has assumed and administers.
- Company C has 1,500,000 policies reported in their Annual Statement.
- Company C has 250,000 of reinsurance assumed policies which should not be included in their submission. Reinsurance assumed should only be included when the ceding company requests that the reinsurer report it on their behalf.
- Company C has 1,250,000 policies of direct written business that they must report.
- In addition to Company C’s direct written business, they will also be reporting 15,000 policies that they administer on behalf of Company A (per Company A’s request).

<table>
<thead>
<tr>
<th>RECONCILIATION FOR COMPANY C</th>
<th>Policy Count</th>
<th>Insurance Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Business as Reported in Company C’s Annual Statement</td>
<td>1,500,000</td>
<td>180,000,000,000</td>
</tr>
<tr>
<td>Assumed Reinsurance Total</td>
<td>(250,000)</td>
<td>(6,000,000,000)</td>
</tr>
<tr>
<td>Subtotal - Direct Written Business for Company C</td>
<td>1,250,000</td>
<td>174,000,000,000</td>
</tr>
<tr>
<td>Business being reported on behalf of Company A</td>
<td>15,000</td>
<td>50,000,000</td>
</tr>
<tr>
<td>Totals included in Company C’s data submissions</td>
<td>1,265,000</td>
<td>174,050,000,000</td>
</tr>
<tr>
<td>Dates</td>
<td>Reviewed by Staff</td>
<td>Distributed</td>
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<td>-------</td>
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<td>4/19/21</td>
<td>RM</td>
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Notes: APF 2021-06
Section 1: Overview

A. Purpose of the Experience Reporting Requirements

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

B. PBR and the Need for Experience Data

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

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

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

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

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

5. The collection of experience data will provide a basis for establishing and updating the
assumptions and margins prescribed by regulators in the Valuation Manual.

6. The reliability of assumptions based on company experience is founded on reliable
historical data from comparable characteristics of insurance policies including, but not
limited to, underwriting standards and insurance policy benefits and provisions. As with
Experience Reporting Requirements

VM-50

all forms of experience data analysis, larger and more consistent statistical samples have a
greater probability of producing reliable analyses of historic experience than smaller or
inconsistent samples. To improve statistical credibility, it is necessary that experience data
from multiple companies be combined and aggregated.

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

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

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

Section 2: Statutory Authority and Experience Reporting Agent

A. Statutory Authority

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

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

3. Section 4A(5) of Model #820 defines the data to be collected to be confidential.

B. Experience Reporting Agent

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

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

Section 3: Experience Reporting Requirements

A. Statistical Plans

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

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

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

B. Role and Responsibilities of the Experience Reporting Agent

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

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

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

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

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

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

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

6. The Experience Reporting Agent will obtain and undergo at least annual external audits to validate that controls with respect to data security and related topics are consistent with industry standards and best practices. The Experience Reporting Agent will provide a copy of any report prepared in connection with such an audit, upon a company’s request. In the event of a material deficiency identified in the external audit or in the event of an identified security breach affecting the Experience Reporting Data, the Experience Reporting Agent shall notify the NAIC, and the states that have directed the Experience Reporting Agent to collect this information, of the nature and extent of such an issue. In the event of an identified security breach affecting Experience Reporting Data, the Experience Reporting Agent shall also notify any insurer whose data was affected. Upon good cause shown, the Experience Reporting Agent will take reasonable actions to protect the data under its control, including that the data submission process may be suspended until the security issue has been remediated. If data submission is suspended under this section, the Experience Reporting Agent will work with the states that have directed collection to issue appropriate guidance modifying the requirements of VM 51, Section 2.D. The term “good cause” shall mean that there is the chance of irreparable harm upon continuing the transmission of the data to the Experience Reporting Agent. Once the security issue has been remediated, the Experience Reporting Agent shall notify the NAIC and the states that have directed the Experience Reporting Agent to collect this information. The Experience Reporting Agent shall work in conjunction with the NAIC and the states that have directed the Experience Reporting Agent to collect this information to develop a revised data submission schedule for any deferred submissions. The revised schedule shall provide for reasonable timing for companies to provide such data.

C. Role of Other Organizations

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

1. Consult with the NAIC (as appropriate) in the design and implementation of the experience retrieval process;
2. Assist with the data validation process for data intended to be forwarded to the SOA or other actuarial professional organizations to develop industry experience tables;
3. Analyze data, including any summarized or aggregated data, produced by the Experience Reporting Agent;
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4. Create initial experience tables and any revised tables;

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

6. Create statutory valuation tables as appropriate and necessary;

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

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

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

Section 4: Data Quality and Ownership

A. General Requirements

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

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

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

B. Specific Requirements

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

2. Each submission of data filed by an insurance company with the Experience Reporting Agent shall be balanced against a set of control totals provided by the company with the data submission. At a minimum, these control totals shall include applicable record counts, claim counts, amounts insured and claim amounts. Any submission that does not balance to the control totals shall be referred to the company for review and resolution.

3. Each company submitting experience data and each company on whose behalf data is being submitted as required in VM-51 will perform a reconciliation between its submitted experience data with its statistical and financial data, and provide an explanation of differences, to the Experience Reporting Agent. The reconciliation must include policy count and insurance amount.

a. If a third-party administrator that is not an insurance company or an insurance company not required to submit their direct data is submitting data on behalf of an insurance company, the reconciliation will consist of separate lines identifying each insurance company for whom this entity is submitting data.

b. If the third-party administrator is an insurance company that is required to submit their direct data, the reconciliation must include separate lines identifying each additional company whose data is being submitted.

c. The reconciliation to company statistical and financial data for both the direct writer and the reinsurer or third-party administrator must include lines indicating the amount of business that is being reported by the reinsurer or third-party administrator. The NAIC will use this information to confirm that all in-scope business is reported and there is no double counting of policies.

4. Validity checks are designed to identify:

a. Improper syntax or incomplete coding (e.g., a numeric field that is not numeric, missing elements of a date field);

b. Data elements containing codes that are not contained within the set of possible valid codes;

c. Data elements containing codes that are contained within the set of possible valid codes but are not valid in conjunction with another data element code;

d. Required data elements that are not populated.

5. Where quality would not appear to be significantly compromised, the Experience Reporting Agent may use records with missing or invalid data if such invalid or missing data do not involve a field that is relevant or would affect the credibility of the report. For companies with a body of data for a state, line of business, product type or observation period that fails to meet these standards, the Experience Reporting Agent will use its discretion, with regulatory disclosure of key decisions made, regarding the omission of the entire body of data or only including records with valid data. Completeness of reports is desirable, but not at the risk of including a body of data that appears to have an unreasonably high chance of significant errors.
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6. Errors of a consistent nature are referred to as “systematic.” Incorrect coding instructions can introduce errors of a consistent nature. Programming errors within the data processing system of insurer company can also produce systematic miscoding as the system converts data to the required formats for experience reporting. Most systematic errors will produce data that, when reviewed using tests designed to reveal various types of systematic errors, will appear unreasonable and likely to be in error. In addition, some individual coding errors may produce erroneous results that show up when exposures and losses are compared in a systematic fashion. Such checking often cannot, however, provide a conclusive indication that data with unusual patterns is incorrect. The Experience Reporting Agent will perform tests and look at trends using previously reported data to determine if systematic errors or unusual patterns are occurring.

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

8. At a minimum, reasonability checks by the Experience Reporting Agent will include:
   a. An unusually large percentage of company data reported under a single or very limited number of categories;
   b. Unusual or unlikely reporting patterns in a company’s data;
   c. Claim amounts that appear unusually high or low for the corresponding exposures;
   d. Reported claims without corresponding policy values and exposures;
   e. Unreasonable loss frequencies or amounts in comparison to ranges of expectation that recognize statistical fluctuation;
   f. Unusual shifts in the distribution of business from one reporting period to the next.

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

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

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

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

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

C. Ownership of Data

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

2. The Experience Reporting Agent will be responsible for maintaining data, error reports, logs and other intermediate work products, and reports for use in processing, documentation, production and reproduction of reports provided to state insurance regulators in accordance with the Valuation Manual. The Experience Reporting Agent will be responsible for demonstrating such reproducibility at the request of state insurance regulators or an auditor designated by state insurance regulators.

Section 5: Experience Data

A. Introduction

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

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

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

B. Design of Reports Linked to Purpose

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

C. Basic Report Designs

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

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

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

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

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

D. Supplemental Reports

1. For specific lines of business and types of experience data, state insurance regulators may request additional reports from the Experience Reporting Agent. State insurance regulators also may request custom reports, which may contain specific data or experience not regularly produced in other reports.
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2. The regulator and the Experience Reporting Agent must negotiate time schedules for producing supplemental reports. The information in these reports is limited by the amount of data actually available and the manner in which it has been reported.

E. Reports to State Insurance Departments

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

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

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

Section 6: Confidentiality of Data

A. Confidentiality of Experience Data

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

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

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

B. Treatment of Confidential Information

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

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

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

   a. State, federal or international regulatory agencies;

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

   c. The NAIC, and its affiliates and subsidiaries;

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

   e. Other individuals or entities, including contractors or subcontractors of the Experience Reporting Agent, otherwise assisting the Experience Reporting Agent or state insurance regulators in fulfilling the purposes of VM-50. These other individuals or entities may provide services related to a variety of areas of expertise, such as assisting with performing industry experience studies, developing valuation mortality tables, data editing and data quality review. These other individuals and entities shall be subject to the same standards as the Experience Reporting Agent with respect to the maintenance of confidential information.
VM-51: Experience Reporting Formats

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Section 1: Introduction

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

B. Each statistical plan shall contain the following information:

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

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

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

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

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

6. The experience data reports to be produced.
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Section 2: Statistical Plan for Mortality

A. Type of Experience Collected Under This Statistical Plan

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

B. Scope of Business Collected Under This Statistical Plan

1. The data for this statistical plan is the individual ordinary life line of business. Such business is to include direct written business issued in the U.S., all values should be prior to any reinsurance ceded except for the situation defined in VM-51 Section 2.B.2. Therefore, reinsurance assumed from a ceding company shall be excluded from data collection to avoid double-counting of experience submitted by an issuer and by its reinsurers; however, Assumption reinsurance of an individual ordinary life line of business, where the assuming company is legally responsible for all benefits and claims paid, shall be included within the scope of this statistical plan. The ordinary life line of business does not include separate lines of business, such as SI/GI, worksite, individually solicited group life, direct response, paid-up annuity, home service, credit life, and corporate-owned life insurance (COLI)/bank-owned life insurance (BOLI)/charity-owned life insurance (CHOLI).

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

   a. As defined in VM-50 Section 4.B.3, the reconciliation to company statistical and financial data for both the direct writing company and all reinsurers and/or third-party administrators must include lines indicating the amount of business that is being reported by the reinsurers and/or third-party administrators. The Experience Reporting Agent will compare the reconciliations for all business submitted by the direct writer and any reinsurers and/or third-party administrators to ensure that all business is included and there is no double counting of policies.

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

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

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

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

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

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

Data for this statistical plan for mortality will be compiled using a calendar year method. The reporting calendar year is the calendar year that the company submits the experience data. The observation calendar year is the calendar year of the experience data that is reported. The observation calendar year will be two years prior to the reporting calendar year. For example, if the current calendar year is 2018 and that is the reporting calendar year, the company is to report the experience data that was in-force or issued in calendar year 2016, which is the observation calendar year.

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

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

ii. Report terminations that were incurred in calendar year 20XX and reported before July 1, 20XX+1. However, exclude rescinded policies (e.g., 10-day free look exercises) from the data submission.

For any reporting calendar year, the data call will occur during the second quarter, and data is to be submitted according to the requirements of the Valuation Manual in effect during that calendar year. Data submissions must be made by Sept. 30 of the reporting calendar year. Corrections of data submissions must be completed by Dec. 31 of the reporting calendar year.

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

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

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

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

Generally, each policy number represents a policy issued as a result of ordinary underwriting. If a single life policy, the base policy on a single life has the policy number and a segment number of 1. On a joint life policy, each life has separate records with the same policy number. The base policy on the first life has a segment number of 1, and the base policy on the second life has a segment number of 2. Policies that cover more than two lives are not to be submitted.
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Term/paid up riders or additional amounts of insurance purchased through dividend options on a policy issued as a result of ordinary underwriting are to be submitted. Each rider is on a separate record with the same policy number as the base policy and has a unique segment number. The details on the rider record may differ from the corresponding details on the base policy record. If underwriting in addition to the base policy underwriting is done, the coverage is given its own policy number.

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

Plans of insurance should be carefully matched with the three-digit codes in item 19, Plan. These plans of insurance are important because they will be used not only for mortality experience data collection, but also for policyholder behavior experience data collection. It is expected that most policies will be matched to three-digit codes that specify a particular policy type rather than select a code that indicates a general plan type.

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

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

ii. For policies issued on or after Jan. 1, 1990, companies must:
   a) Document the percentage that the face amount of policies excluded are relative to the face amount of submitted policies issued on or after Jan. 1, 1990; and
   b) Certify that this requirement presents a hardship due to fields not readily available in their systems/databases or legacy computer systems that continue to be used for older issued policies and differ from computer systems for newer issued policies.

F. Experience Data Reports Required by This Statistical Plan

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

2. The Experience Reporting Agent will provide to the SOA or other actuarial professional organizations an experience data report of aggregated experience that does not disclose a company’s identity, which will be used to develop industry mortality experience and valuation mortality tables.
Experience Reporting Formats VM-51

3. As long as a company is licensed in a state, that state insurance regulator will be given access to a company’s experience data that is stored on a confidential database at the Experience Reporting Agent. Access by the state insurance regulator will be controlled by security credentials issued to the state insurance regulator by the Experience Reporting Agent.
Appendix 1: Preferred Class Structure Questionnaire

PREFERRED CLASS STRUCTURE QUESTIONNAIRE

Fill out this preferred class structure questionnaire based on companywide summaries, such as underwriting guideline manuals, compilations of issue instructions or other documentation.

The purpose of this preferred class structure questionnaire is to gather information on different preferred class structures. This questionnaire varies between nonsmoker/non-tobacco and smoker/tobacco users and provides for variations by issue year, face amount and plan. If the company has the standard Relative Risk Score (RR Score) information available, the company should map its set of preferred class structure to sets of RR Scores. **Except for new preferred class structures or new sets of RR Scores applied to existing preferred class structure(s), the response to the questionnaire should remain the same from year to year.**

If a company has determined sets of RR Scores for its preferred class structures, it should provide separate preferred class structure responses for each set of RR Scores applied to a preferred class structure. If a company has not determined sets of RR Scores for its preferred class structures, it should fill out this questionnaire with its preferred class structures and update the preferred class structure questionnaire at such future time that sets of RR Scores for the preferred class structures are determined. When sets of RR Scores are used, there is to be a one-to-one correspondence between a preferred class structure and a set of RR Scores.

The information given in this questionnaire will be used both to map a set of RR Scores to policy level data and as a check on the policy-level data submission. Submit this questionnaire along with the initial data submission to the Experience Reporting Agent.

Each preferred class structure must include at least two classes (e.g., one preferred class and one standard class). Make as many copies of this preferred class structure questionnaire as necessary for your individual life business and submit in addition to policy-level detail information.

<table>
<thead>
<tr>
<th>Company</th>
<th>NAIC Company Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Date</td>
</tr>
</tbody>
</table>

PREFERRED CLASS STRUCTURE – Part 1 Nonsmokers/Non-Tobacco Users

Preferred class structure must have at least one preferred and one standard class. Use multiple copies of this page if needed for nonsmokers/non-tobacco users

Number of Nonsmoker/Non-Tobacco User Risk Classes

a) Issue Date Range Date through Date
b) Issue Age Range Date through Date
c) Face Amount Range Date through Date
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Nonsmoker/Non-Tobacco User Risk Classes

a) Issue Date Range Date through Date
b) Issue Age Range Date through Date
c) Face Amount Range Date through Date
d) Plan Types (use three-digit codes from item 19, Plan)
Experience Reporting Formats

Number of Nonsmoker/Non-Tobacco User Risk Classes

a) Issue Date Range Date through Date
b) Issue Age Range Date through Date
c) Face Amount Range Date through Date
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Nonsmoker/Non-Tobacco User Risk Classes

a) Issue Date Range Date through Date
b) Issue Age Range Date through Date
c) Face Amount Range Date through Date
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Nonsmoker/Non-Tobacco User Risk Classes

a) Issue Date Range Date through Date
b) Issue Age Range Date through Date
c) Face Amount Range Date through Date
d) Plan Types (use three-digit codes from item 19, Plan)

**PREFERRED CLASS STRUCTURE – Part 2 Smokers/Tobacco Users**

Preferred class structure must have at least one preferred and one standard class. Use multiple copies of this page if needed for smokers/tobacco users

Number of Smoker/Tobacco User Risk Classes

a) Issue Date Range Date through Date
b) Issue Age Range Date through Date
c) Face Amount Range Date through Date
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

a) Issue Date Range Date through Date
b) Issue Age Range Date through Date
c) Face Amount Range Date through Date
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

a) Issue Date Range Date through Date
b) Issue Age Range Date through Date
c) Face Amount Range Date through Date
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

a) Issue Date Range Date through Date
b) Issue Age Range Date through Date
c) Face Amount Range Date through Date
d) Plan Types (use three-digit codes from item 19, Plan)
Experience Reporting Formats

<table>
<thead>
<tr>
<th>VM-51</th>
</tr>
</thead>
</table>

Number of Smoker/Tobacco User Risk Classes

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Issue Date Range ( Date ) through ( Date )</td>
</tr>
<tr>
<td>b)</td>
<td>Issue Age Range ( Date ) through ( Date )</td>
</tr>
<tr>
<td>c)</td>
<td>Face Amount Range ( Date ) through ( Date )</td>
</tr>
<tr>
<td>d)</td>
<td>Plan Types (use three-digit codes from item 19, Plan)</td>
</tr>
</tbody>
</table>

Number of Smoker/Tobacco User Risk Classes

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Issue Date Range ( Date ) through ( Date )</td>
</tr>
<tr>
<td>b)</td>
<td>Issue Age Range ( Date ) through ( Date )</td>
</tr>
<tr>
<td>c)</td>
<td>Face Amount Range ( Date ) through ( Date )</td>
</tr>
<tr>
<td>d)</td>
<td>Plan Types (use three-digit codes from item 19, Plan)</td>
</tr>
</tbody>
</table>
Experience Reporting Formats

Appendix 2: Mortality Claims Questionnaire

MORTALITY CLAIMS QUESTIONNAIRE

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

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

<table>
<thead>
<tr>
<th>Company</th>
<th>NAIC Company Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name

Date

MORTALITY CLAIMS

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

2. The death claim amounts are to be for the total face amount and on a gross basis (before reinsurance). The data is based on:
   a. Total face amount (for policies that include the cash value in addition to the face amount as a death benefit, use only the face amount) as specified OR Other (describe):
      If not as specified, indicate time period for which this occurred: __________ - _______
   b. Gross basis (before reinsurance) as specified OR Other (describe):
      If not as specified, indicate time period for which this occurred: __________ - _______
      Is this the same basis used for face amounts included in the study data? Yes No

3. The date that the termination is reported is to be used for the termination reported date. The date that the termination actually occurred is to be used for the actual termination date. What dates are used for death claims in the study data with respect to?
   a) Termination reported date
      If not reported date, indicate basis for dates provided Reported date Other (describe):
   b) Actual termination date for death claims:
      Date of death Other (describe):
      If not date of death, indicate basis for dates provided
4. Death claims pending at the end of the observation period but paid during the subsequent six months following the observation year are to be included in the data submission. Claims that are still pending at the end of the six month run out are to be included.

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

If no indicate time period for which this occurred: __________________

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

Yes No

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

6. For death claims on policies issued before 1990:

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

If no, indicate approach used:

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

Appendix 3: Additional Plan Code Form

If you need an additional plan code(s) for a product(s) in addition to those plan codes in Item 19, Plan, of the statistical plan for life insurance mortality, fill in this form using plan codes in the range 300 to 999. Your data submission should reflect the plan codes in this form. Make as many copies as necessary for your individual life business and submit in addition to policy-level information. When this form is used, it must be sent to the Experience Reporting Agent at the time that data is submitted.

Completed by: ______________________  Title: _______________________________
Company: _________________________  NAIC Company Code: ________________  Date: ______
Phone Number: _____________________  Email: ____________________________

Add comments or attachments where necessary.

Enter unique three-digit plan codes for each product.

<table>
<thead>
<tr>
<th>Plan Code For Product I</th>
<th>Plan Code for Product II</th>
<th>Plan Code for Product III</th>
</tr>
</thead>
</table>

Enter specific plan names for each product.

A. General Product Information

<table>
<thead>
<tr>
<th>1. In what year was each product introduced?</th>
<th>Product I</th>
<th>Product II</th>
<th>Product III</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Briefly describe the product.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Enter three-digit plan code in the range 300 to 999.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
B. For the products listed, please fit each product into one of the categories below.

<table>
<thead>
<tr>
<th>Categories for Product I</th>
<th>Categories for Product II</th>
<th>Categories for Product III</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Traditional Whole Life Plans</td>
<td>1 Traditional Whole Life Plans</td>
<td>1 Traditional Whole Life Plans</td>
</tr>
<tr>
<td>2 Term Insurance Plans</td>
<td>2 Term Insurance Plans</td>
<td>2 Term Insurance Plans</td>
</tr>
<tr>
<td>5 Variable Life Plans (without Secondary Guarantees)</td>
<td>5 Variable Life Plans (without Secondary Guarantees)</td>
<td>5 Variable Life Plans (without Secondary Guarantees)</td>
</tr>
<tr>
<td>6 Variable Life Plans with Secondary Guarantees</td>
<td>6 Variable Life Plans with Secondary Guarantees</td>
<td>6 Variable Life Plans with Secondary Guarantees</td>
</tr>
<tr>
<td>7 Nonforfeiture</td>
<td>7 Nonforfeiture</td>
<td>7 Nonforfeiture</td>
</tr>
<tr>
<td>8 Other</td>
<td>8 Other</td>
<td>8 Other</td>
</tr>
</tbody>
</table>
### Appendix 4: Mortality Data Elements and Format

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>LENGTH</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9</td>
<td>Submitting Company ID</td>
<td>ID number representing the company submitting this file. If the company has an NAIC Company Code, then that code must be used. If the company does not have an NAIC Company Code, the company’s Federal Employer Identification Number (FEIN) must be used. If the direct writer is the company submitting the data, items 1 and 2 must contain the same value.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>NAIC Company Code of the Direct Writer of Business</td>
<td>The NAIC Company Code of the company that wrote the business being reported. In the case of assumption reinsurance where the assuming company is legally responsible for all benefits and claims paid, the assuming company is considered to be the direct writer. If the direct writer is the company submitting the data file, items 1 and 2 must contain the same value.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>Observation Year</td>
<td>Enter Calendar Year of Observation</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>20</td>
<td>Policy Number</td>
<td>Enter Policy Number. For Policy Numbers with length less than 20, left justify the number, and blank fill the empty columns. Any other unique identifying number can be used instead of a Policy Number for privacy reasons.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>Segment Number</td>
<td>If only one policy segment exists, enter segment number ‘1.’ For a single life policy, the base policy is to be put in the record with segment number ‘1.’ Subsequent policy segments are in separate records with information about that coverage and differing segment numbers. For joint life policies, the base policy of the first life is to be put in a record with segment number ‘1,’ and the base policy of the second life is to be put in a separate record with segment number ‘2.’ Joint life policies with more than two lives are not to be submitted. Subsequent policy segments are in separate records with information about that coverage and differing segment numbers. Policy segments with the same policy number are to be submitted for: a) Single life policies; b) Joint life policies; c) Term/paid up riders; or d) Additional amounts of insurance including purchase through dividend options.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>State of Issue</td>
<td>Use standard, two-letter state abbreviation codes (e.g., NY for New York)</td>
<td></td>
</tr>
</tbody>
</table>
### Experience Reporting Formats

**VM-51**

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMNS</th>
<th>LENGTH</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| 7    | 25      | 1      | Gender       | 0 = Unknown or unable to subdivide  
1 = Male  
2 = Female  
3 = Unisex – Unknown or unable to identify  
4 = Unisex – Male  
5 = Unisex – Female |
| 8    | 36-43   | 8      | Date of Birth | Enter the numeric date of birth in YYYYYMMDD format |
| 9    | 44      | 1      | Age Basis    | 0 = Age Nearest Birthday  
1 = Age Last Birthday  
2 = Age Next birthday |
|      |         |        | **Drafting Note:** Professional actuarial organization will need to develop either age next birthday mortality tables or procedure to adapt existing mortality tables to age next birthday basis. |
| 10   | 45-47   | 3      | Issue Age    | Enter the insurance Issue Age |
| 11   | 48-55   | 8      | Issue Date   | Enter the numeric calendar year in YYYYYMMDD format. |
| 12   | 54      | 1      | Smoker Status (at issue) | Smoker status should be submitted where reliable.  
0 = Unknown  
1 = No tobacco usage  
2 = Nonsmoker  
3 = Cigarette smoker  
4 = Tobacco user |
| 13   | 52      | 1      | Preferred Class Structure Indicator | 0 = If no reliable information on multiple preferred and standard classes is available or if the policy segment was issued substandard or if there were no multiple preferred and standard classes available for this policy segment or if preferred information is unknown.  
1 = If this policy was issued in one of the available multiple preferred and standard classes for this policy segment.  
Note: If Preferred Class Structure Indicator is 0, or if preferred information is unknown, leave next four items blank. |
| 14   | 58      | 1      | Number of Classes in Nonsmoker Preferred Class Structure | If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 3 or 4, or if preferred information is unknown, leave blank. For nonsmoker or no tobacco usage policies that could have been issued as one of multiple preferred and standard classes, enter the number of nonsmoker preferred and standard classes available at time of issue. |
### Nonsmoker Preferred Class

If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 3 or 4, or if preferred information is unknown, leave blank.

For nonsmoker policy segments that could have been issued as one of multiple preferred and standard classes:
- 1 = Best preferred class
- 2 = Next Best preferred class after 1
- 3 = Next Best preferred class after 2
- 4 = Next Best preferred class after 3
- 5 = Next Best preferred class after 4
- 6 = Next Best preferred class after 5
- 7 = Next Best preferred class after 6
- 8 = Next Best preferred class after 7
- 9 = Next Best preferred class after 8

Note: The policy segment with the highest nonsmoker Preferred Class number should have that number equal to the Number of Classes in Nonsmoker Preferred Class Structure.

### Number of Classes in Smoker Preferred Class Structure

If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 1 or 2, or if preferred information is unknown, leave blank.

For smoker or tobacco user policies that could have been issued as one of multiple preferred and standard classes, enter the number of smoker preferred and standard classes available at time of issue.

### Smoker Preferred Class

If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 1 or 2, or if preferred information is unknown, leave blank.

For smoker policy segments that could have been issued as one of multiple preferred and standard classes:
- 1 = Best preferred class
- 2 = Next Best preferred class after 1
- 3 = Next Best preferred class after 2
- 4 = Next Best preferred class after 3
- 5 = Next Best preferred class after 4
- 6 = Next Best preferred class after 5
- 7 = Next Best preferred class after 6
- 8 = Next Best preferred class after 7
- 9 = Next Best preferred class after 8

Note: The policy segment with the highest Smoker Preferred Class number should have that number equal to the Number of Classes in Smoker Preferred Class Structure.
<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>LENGTH</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>62-63</td>
<td>2</td>
<td>Type of Underwriting Requirements</td>
<td>If underwriting requirement of ordinary business is reliably known, use code other than “99.” Ordinary business does not include separate lines of business, such as simplified issue/guaranteed issue, worksite, individually solicited group life, direct response, final expense, preneed, home service and COLI/BOLI/CHOLI. 01 = Underwritten, but unknown whether fluid was collected 02 = Underwritten with no fluid collection 03 = Underwritten with fluid collected 06 = Term Conversion 07 = Group Conversion 09 = Not Underwritten 99 = For issues where underwriting requirement unknown or unable to subdivide</td>
</tr>
<tr>
<td>19</td>
<td>64</td>
<td>1</td>
<td>Substandard Indicator</td>
<td>0 = Policy segment is not substandard 1 = Policy segment is substandard 2 = Policy segment is uninsurable</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Note:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>a. All policy segments that are substandard need to be identified as substandard or uninsurable.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>b. Submission of substandard policies is optional.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>c. If feasible, identify substandard policy segments where temporary flat extra has ceased as substandard.</td>
<td></td>
</tr>
</tbody>
</table>
| 20   | 65-67  | 3      | Plan | Exclude from contribution: spouse and children under family policies or riders. If Form for Additional Plan Codes was submitted for this policy, enter unique three-digit plan number(s) that differ from the plan numbers below: 000 = If unable to distinguish among plan types listed below 100 = Joint life plan unable to distinguish among joint life plan types listed below  

**Permanent Plans:**
010 = Traditional fixed premium fixed benefit permanent plan 011 = Permanent life (traditional) with term 012 = Single premium whole life 013 = Econolife (permanent life with lower premiums in the early durations) 014 = Excess interest whole life 015 = First to die whole life plan (submit separate records for each life) 016 = Second to die whole life plan (submit separate records for each life) 017 = Joint whole life plan – unknown whether 015 or 016 (submit separate records for each life)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>018</td>
<td>Permanent products with non-level death benefits</td>
</tr>
<tr>
<td>019</td>
<td>Permanent plans 010, 011, 012, 013, 014, 015, 016, 017, 018 combined (i.e. unable to separate)</td>
</tr>
</tbody>
</table>

**Term Insurance Plans:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>020</td>
<td>Term (traditional level benefit and attained age premium)</td>
</tr>
<tr>
<td>021</td>
<td>Term (level death benefit with guaranteed level premium for five years and anticipated level term period for five years)</td>
</tr>
<tr>
<td>211</td>
<td>Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 10 years)</td>
</tr>
<tr>
<td>212</td>
<td>Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 15 years)</td>
</tr>
<tr>
<td>213</td>
<td>Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 20 years)</td>
</tr>
<tr>
<td>214</td>
<td>Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>215</td>
<td>Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>022</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 10 years)</td>
</tr>
<tr>
<td>221</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 15 years)</td>
</tr>
<tr>
<td>222</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 20 years)</td>
</tr>
<tr>
<td>223</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>224</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>023</td>
<td>Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 15 years)</td>
</tr>
<tr>
<td>231</td>
<td>Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 20 years)</td>
</tr>
<tr>
<td>232</td>
<td>Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>233</td>
<td>Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>024</td>
<td>Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 20 years)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>241</td>
<td>Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>242</td>
<td>Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 30 year)</td>
</tr>
<tr>
<td>025</td>
<td>Term (level death benefit with guaranteed level premium for 25 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>251</td>
<td>Term (level death benefit with guaranteed level premium for 25 years and anticipated level term period for 30 year)</td>
</tr>
<tr>
<td>026</td>
<td>Term (level death benefit with guaranteed level premium for 30 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>027</td>
<td>Term (level death benefit with guaranteed level premium period equal to anticipated level term period where the period is other than five, 10, 15, 20, 25 or 30 years)</td>
</tr>
<tr>
<td>271</td>
<td>Term (level death benefit with guaranteed level premium period not equal to anticipated level term period, where the periods are other than five, 10, 15, 20, 25 or 30 years)</td>
</tr>
<tr>
<td>028</td>
<td>Term (decreasing benefit)</td>
</tr>
<tr>
<td>040</td>
<td>Select ultimate term (premium depends on issue age and duration)</td>
</tr>
<tr>
<td>041</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for 15 years)</td>
</tr>
<tr>
<td>042</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for 20 years)</td>
</tr>
<tr>
<td>043</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for 25 years)</td>
</tr>
<tr>
<td>044</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for 30 years)</td>
</tr>
<tr>
<td>045</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for period other than 15, 20, 25 or 30 years)</td>
</tr>
<tr>
<td>046</td>
<td>Economatic term</td>
</tr>
<tr>
<td>059</td>
<td>Term plan, unable to classify</td>
</tr>
<tr>
<td>101</td>
<td>First to die term plan (submit separate records for each life)</td>
</tr>
<tr>
<td>102</td>
<td>Second to die term plan (submit separate records for each life)</td>
</tr>
<tr>
<td>103</td>
<td>Joint term plan – unknown whether 101 or 102 (submit separate records for each life)</td>
</tr>
</tbody>
</table>

**Universal Life Plans (Other than Variable), issued without a Secondary Guarantee:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>061</td>
<td>Single premium universal life</td>
</tr>
<tr>
<td>062</td>
<td>Universal life (decreasing risk amount)</td>
</tr>
<tr>
<td>063</td>
<td>Universal life (level risk amount)</td>
</tr>
<tr>
<td>064</td>
<td>Universal life – unknown whether code 062 or 063</td>
</tr>
<tr>
<td>065</td>
<td>First to die universal life plan (submit separate records for each life)</td>
</tr>
<tr>
<td>066</td>
<td>Second to die universal life plan (submit separate records for each life)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>067</td>
<td>Joint life universal life plan – unknown whether code 065 or 066 (submit separate records for each life)</td>
</tr>
<tr>
<td>068</td>
<td>Indexed universal life</td>
</tr>
</tbody>
</table>

**Universal Life Plans (Other than Variable) with Secondary Guarantees:**

- 071 = Single premium universal life with secondary guarantees
- 072 = Universal life with secondary guarantees (decreasing risk amount)
- 073 = Universal life with secondary guarantees (level risk amount)
- 074 = Universal life with secondary guarantees – unknown whether code 072 or 073
- 075 = First to die universal life plan with secondary guarantees (submit separate records for each life)
- 076 = Second to die universal life plan with secondary guarantees (submit separate records for each life)
- 077 = Joint life universal life plan with secondary guarantees unknown whether code 075 or 076 (submit separate records for each life)
- 078 = Indexed universal life with secondary guarantees

**Variable Life Plans issued without a Secondary Guarantee:**

- 080 = Variable life
- 081 = Variable universal life (decreasing risk amount)
- 082 = Variable universal life (level risk amount)
- 083 = Variable universal life – unknown whether code 081 or 082
- 084 = First to die variable universal life plan (submit separate records for each life)
- 085 = Second to die variable universal life plan (submit separate records for each life)
- 086 = Joint life variable universal life plan – unknown whether 084 or 085 (submit separate records for each life)

**Variable Life Plans with Secondary Guarantees:**

- 090 = Variable life with secondary guarantees
- 091 = Variable universal life with secondary guarantees (decreasing risk amount)
- 092 = Variable universal life with secondary guarantees (level risk amount)
- 093 = Variable universal life with secondary guarantees – unknown whether code 091 or 092
- 094 = First to die variable universal life plan with secondary guarantees (submit separate records for each life)
- 095 = Second to die variable universal life plan with secondary guarantees (submit separate records for each life)
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>096 = Joint life variable universal life plan with secondary guarantees – unknown whether code 094 or 095 (submit separate records for each life)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nonforfeiture:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>098 = Extended term</td>
<td></td>
<td></td>
</tr>
<tr>
<td>099 = Reduced paid-up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>198 = Extended term for joint life (submit separate records for each life)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>199 = Reduced paid-up for joint life (submit separate records for each life)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>22–24</td>
<td>12</td>
</tr>
<tr>
<td>In-force Indicator</td>
<td>Face Amount of Insurance at Issue</td>
<td>Face Amount of Insurance at the Beginning of the Observation Year</td>
</tr>
<tr>
<td>0 = If the policy segment was not in force at the end of the calendar year of observation</td>
<td>Face amount of the policy segment at its issue date rounded to nearest dollar. If policy provides payment of cash value in addition to face amount, include face amount and do not include cash value. If the policy was issued during the observation year, the Face Amount of Insurance at the Beginning of the Observation Year should be blank.</td>
<td>Face amount of the policy segment at the beginning of the calendar year of observation rounded to nearest dollar. If policy provides payment of cash value in addition to face amount, include face amount and do not include cash value. Exclude extra amounts attributable to 7702 corridors. If the policy was issued during the observation year, the Face Amount at the Beginning of the Observation Year should be blank.</td>
</tr>
<tr>
<td>25</td>
<td>26–27</td>
<td>12</td>
</tr>
<tr>
<td>Death Claim Amount</td>
<td>Face Amount of Insurance at the End of the Observation Year</td>
<td></td>
</tr>
<tr>
<td>If In-force Indicator is 1, leave blank.</td>
<td>Face amount of the policy segment at the end of the calendar year of observation rounded to nearest dollar. If policy provides payment of cash value in addition to face amount, include face amount, and do not include cash value. Exclude extra amounts attributable to 7702 corridors. If In-force Indicator is 0, enter face amount of the policy segment at the time of termination, if available; otherwise, leave blank.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Experience Reporting Formats

<table>
<thead>
<tr>
<th>Column</th>
<th>Format</th>
<th>Length</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>117–124</td>
<td>8</td>
<td>Termination Reported Date&lt;br&gt;If In-force Indicator is 1, leave blank.&lt;br&gt;Enter in the format YYYYMMDD the eight-digit calendar date that the termination was reported.</td>
</tr>
<tr>
<td>27</td>
<td>125–132</td>
<td>8</td>
<td>Actual Termination Date&lt;br&gt;If In-force Indicator is 1, leave blank.&lt;br&gt;Enter in the format YYYYMMDD the eight-digit calendar date when the termination occurred.&lt;br&gt;If termination is due to death (Cause of Termination is 04), enter actual date of death.&lt;br&gt;If termination is lapse due to non-payment of premium (Cause of Termination is 01 or 02 or 14), enter the last day the premium was paid to.</td>
</tr>
<tr>
<td>28</td>
<td>133–134</td>
<td>2</td>
<td>Cause of Termination&lt;br&gt;If Inforce Indicator is 1, leave blank.&lt;br&gt;00 = Termination type unknown or unable to subdivide&lt;br&gt;01 = Reduced paid-up&lt;br&gt;02 = Extended term&lt;br&gt;03 = Voluntary; unable to subdivide among 01, 02, 07, 09, 10, 11 or 13&lt;br&gt;04 = Death&lt;br&gt;07 = 1035 exchange&lt;br&gt;09 = Term conversion – unknown whether attained age or original age&lt;br&gt;10 = Attained age term conversion&lt;br&gt;11 = Original age term conversion&lt;br&gt;12 = Coverage expired or contract reached end of the mortality table&lt;br&gt;13 = Surrendered for full cash value&lt;br&gt;14 = Lapse (other than to Reduced Paid Up or Extended Term)&lt;br&gt;15 = Termination via payment of a discounted face amount while still alive, pursuant to an accelerated death benefit provision</td>
</tr>
<tr>
<td>29</td>
<td>135–144</td>
<td>10</td>
<td>Annualized Premium at Issue&lt;br&gt;For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, enter the annualized premium set at issue.&lt;br&gt;Except for level term segments specified above, leave blank for non-base segments.&lt;br&gt;For the base segments for ULSG, and Variable Life with Secondary Guarantees (VLSG) with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, enter the annualized billed premium set at issue.&lt;br&gt;Round to the nearest dollar.&lt;br&gt;If unknown, leave blank.</td>
</tr>
<tr>
<td>30</td>
<td>145–154</td>
<td>10</td>
<td>Annualized Premium at the Beginning of Observation Year&lt;br&gt;For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, enter the annualized premium for the policy year that includes the beginning of the observation year.</td>
</tr>
<tr>
<td>Experience Reporting Formats</td>
<td>VM-51</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>31</strong></td>
<td>155–164</td>
<td>10</td>
<td>Annualized Premium at the End of Observation, if available. Otherwise Annualized Premium as of Year/Actual Termination Date</td>
</tr>
</tbody>
</table>
| **32**                      | 165–166 | 2  | Premium Mode | 01 = Annual  
02 = Semiannual  
03 = Quarterly  
04 = Monthly Bill Sent  
05 = Monthly Automatic Payment  
06 = Semimonthly  
07 = Biweekly  
08 = Weekly  
09 = Single Premium  
10 = Other / Unknown |
| **33**                      | 167–176 | 10 | Cumulative Premium Collected as of the Beginning of Observation Year |

Except for level term segments specified above, leave blank for non-base segments.

For the base segments for ULSG and VLSG with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, enter the annualized billed premium for the policy year that includes the beginning of the observation year.

Round to the nearest dollar.

For policies issued in the observation year, leave blank.

If unknown, leave blank.

For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, for each segment that has Item 20, with the Inforce Indicator = 1, enter the annualized premium for the policy year that includes the end of the observation year. Otherwise, enter the annualized premium that would have been paid at the end of the observation year. If end of year premium is not available, enter the annualized premium as of the Actual Termination Date (Item 26).

Except for level term segments specified above, leave blank for non-base segments.

For the base segments for ULSG and VLSG with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, use the annualized billed premium. For base segments that have Item 20, with the Inforce Indicator = 1, enter the annualized billed premium for the policy year that includes the end of the observation year. Otherwise, enter the annualized billed premium that would have been paid at the end of the observation year. If end of year premium is not available, enter the annualized premium as of the Actual Termination Date (Item 26).

Round to the nearest dollar.

If unknown, leave blank.

For ULSG, and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: If not ULSG or VLSG, leave blank.
### Cumulative Premium Collected as of the End of Observation Year if available.

<table>
<thead>
<tr>
<th>Column</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>34</td>
<td>177-186</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td><strong>Cumulative Premium Collected as of the End of Observation Year if available.</strong> Otherwise Cumulative Premium Collected as of Actual Termination Date</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If not ULSG or VLSG, leave blank.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For ULSG, and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1) For non-base segments, leave blank.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2) For base segments inforce at the end of the observation year, enter the cumulative premium collected as of the end of the observation year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3) For base segments terminated during the observation year, enter the cumulative premium collected since issue, as of the Actual Termination Date (Item 26).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Round to the nearest dollar.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If unknown, leave blank.</td>
<td></td>
</tr>
</tbody>
</table>

### ULSG/VLSG Premium Type

<table>
<thead>
<tr>
<th>Column</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td>187-188</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td><strong>ULSG/VLSG Premium Type</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For non-base segments, leave blank.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If not ULSG or VLSG, leave blank.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>00 = Unknown</td>
<td></td>
</tr>
<tr>
<td></td>
<td>01 = Single premium</td>
<td></td>
</tr>
<tr>
<td></td>
<td>02 = ULSG/VLSG Whole life level premium</td>
<td></td>
</tr>
<tr>
<td></td>
<td>03 = Lower premium (term like)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>04 = Other</td>
<td></td>
</tr>
</tbody>
</table>

### Type of Secondary Guarantee

<table>
<thead>
<tr>
<th>Column</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>189-190</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td><strong>Type of Secondary Guarantee</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For non-base segments, leave blank.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If not ULSG or VLSG, leave blank.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>00 = Unknown</td>
<td></td>
</tr>
<tr>
<td></td>
<td>01 = Cumulative Premium without Interest (Single Tier)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>02 = Cumulative Premium without Interest (Multiple Tier)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>03 = Cumulative Premium without Interest (Other)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>04 = Cumulative Premium with Interest (Single Tier)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>05 = Cumulative Premium with Interest (Multiple Tier)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>06 = Cumulative Premium with Interest (Other)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11 = Shadow Account (Single Tier)</td>
<td></td>
</tr>
</tbody>
</table>
### Experience Reporting Formats

**VM-51**

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>12 = Shadow Account (Multiple Tier)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>13 = Shadow Account (Other)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>21 = Both Cumulative Premium without Interest and Shadow Account</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>22 = Both Cumulative Premium with Interest and Shadow Account</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>23 = Other, not involving either Cumulative Premium or Shadow Account</td>
</tr>
<tr>
<td>37</td>
<td>191-200</td>
<td>10</td>
<td>Cumulative Minimum Premium as of the Beginning of Observation Year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If not ULSG or VLSG, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If Item 35, Type of Secondary Guarantee is blank, 00, 11, 12, 13 or 23, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If Item 35, Type of Secondary Guarantee is 01, 02, 03, 04, 05, 06, 21 or 22:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1) Leave non-base segments, blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2) For base segments: Enter the cumulative minimum premiums, including applicable interest, for all policy years up to the beginning of the observation year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Round to the nearest dollar.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For policies issued in the observation year, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If unknown, leave blank.</td>
</tr>
<tr>
<td>38</td>
<td>201-210</td>
<td>10</td>
<td>Cumulative Minimum Premium as of the End of Observation Year/ Actual Termination Date</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If not ULSG or VLSG, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If Item 35, Type of Secondary Guarantee is blank, 00, 11, 12, 13 or 23, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If Item 35, Type of Secondary Guarantee is 01, 02, 03, 04, 05, 06, 21 or 22:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1) For non-base segments, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2) For base segments in force at the end of the observation year, enter the cumulative minimum premiums, including applicable interest, up to the end of the observation year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3) For base segments terminated during the observation year, enter the cumulative minimum premiums, including applicable interest, up to the Actual Termination Date (Item 26)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Round to the nearest dollar.</td>
</tr>
</tbody>
</table>
### Experience Reporting Formats

<table>
<thead>
<tr>
<th>Column</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>39</strong></td>
<td>211–220</td>
<td>10</td>
</tr>
<tr>
<td><strong>40</strong></td>
<td>221–240</td>
<td>10</td>
</tr>
<tr>
<td><strong>41</strong></td>
<td>221–240</td>
<td>10</td>
</tr>
<tr>
<td>Experience Reporting Formats</td>
<td>VM-51</td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td><strong>Account Value at the End of Observation Year/Actual Termination Date</strong></td>
<td>Account Value can be positive, zero or negative. Round to the nearest dollar. For policies issued in the observation year, leave blank. If unknown, leave blank.</td>
<td></td>
</tr>
<tr>
<td>42 341-350 10</td>
<td>For non-base segments, leave blank. If not ULSG or VLSG, leave blank. For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: 1) If policy is in force at the end of observation year, enter the policy Account Value (gross of any loan) at the end of the Observation Year. The policy Account Value can be positive, zero or negative. 2) If policy terminated during the observation year, enter the policy Account Value (gross of any loan) as of the Actual Termination Date (Item 26). The policy Account Value can be positive, zero or negative. Round to the nearest dollar. If unknown, leave blank.</td>
<td></td>
</tr>
<tr>
<td><strong>Amount of Surrender Charge at the Beginning of Observation Year</strong></td>
<td>For non-base segments, leave blank. If not ULSG or VLSG, leave blank. For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan: enter the dollar Amount of the Surrender Charge as of the Beginning of the Observation Year. Round to the nearest dollar. For policies issued in the observation year, leave blank. If unknown, leave blank.</td>
<td></td>
</tr>
<tr>
<td>43 351-360 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Amount of Surrender Charge at the End of Observation Year/Actual Termination Date</strong></td>
<td>For non-base segments, leave blank. If not ULSG or VLSG, leave blank. For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: 1) If policy is in force at the end of observation year, enter the dollar amount of the Surrender Charge at the end of the Observation Year. 2) If policy terminated during the observation year, enter the dollar amount of the Surrender Charge at the end of the Observation Year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>45</td>
<td>271-272</td>
<td>2</td>
</tr>
<tr>
<td>46</td>
<td>273-274</td>
<td>2</td>
</tr>
<tr>
<td>47</td>
<td>275-276</td>
<td>2</td>
</tr>
</tbody>
</table>
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

John Robinson, Director PBR – Valuation Actuary, MN

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


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

See APPENDIX below.

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

In circumstances where the ceding company computes separate pre-reinsurance and post-reinsurance reserves,

(a) The post-reinsurance reserve is supported by assets held by the company.

(b) The pre-reinsurance reserve is not supported by assets held by the company. According to ASOP 52 (PBR), Section 3.5.2, “...the calculation of a pre-reinsurance- ceded stochastic reserve or deterministic reserve requires the construction of a hypothetical portfolio of starting assets and a corresponding model investment strategy. Possible methods for constructing the hypothetical portfolio include, but are not limited to, the following:...”

(c) When calculating the pre-reinsurance reserve, the company may be able to select sufficient starting assets for the calculation by “borrowing” assets not otherwise assigned to PBR calculations.

(d) When calculating the pre-reinsurance reserve, the company may not be able to select sufficient starting assets for the calculation by “borrowing” assets not otherwise assigned to the PBR calculations. In this case, the qualified actuary might be required to use “notional assets”.

(e) The pre-reinsurance reserve is not equivalent to the sum of the reserves held by the respective counterparties.
(f) SERT performed on a pre-reinsurance basis would similarly require 16 hypothetical asset portfolios, and this should be considered in assessing its value.

It follows from these observations that the pre-reinsurance reserve should not be subject to the same level of scrutiny as the post-reinsurance reserve and need not require the same degree of rigor.

The purpose of this APF is, under these circumstances, to eliminate the requirements to
1. perform separate exclusion tests for pre-reinsurance and post-reinsurance reserves; and
2. apply asset collar considerations for the pre-reinsurance reserve.

Implication for the reserve credit:

The following demonstrates that by eliminating pre-reinsurance exclusion tests and following the post-reinsurance exclusion test results, the resulting reserve credit may sometimes be higher and other times lower than when separate tests are performed.

Scenario 1: pre-reserve and post-reserve tested separately

<table>
<thead>
<tr>
<th>Post-reserve</th>
<th>Pre-reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>DET</td>
<td>SET</td>
</tr>
<tr>
<td>Fail</td>
<td>Fail</td>
</tr>
<tr>
<td>Pass</td>
<td>Fail</td>
</tr>
<tr>
<td>Failure</td>
<td>Failure</td>
</tr>
</tbody>
</table>

Scenario 2: only post-reserve tested, pre-reserve uses same results

<table>
<thead>
<tr>
<th>Post-reserve</th>
<th>Pre-reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>DET</td>
<td>SET</td>
</tr>
<tr>
<td>Fail</td>
<td>Fail</td>
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<tr>
<td>Pass</td>
<td>Fail</td>
</tr>
<tr>
<td>Failure</td>
<td>Failure</td>
</tr>
</tbody>
</table>

Comments

For pre-reserve, DR>SR, therefore reserve credit is higher than Scenario 1(a).
For pre-reserve, SR<DR, therefore reserve credit is lower than Scenario 1(b).
APPENDIX

VM-20, Section 8.D: Determination of a Pre-Reinsurance Minimum Reserve

2. The pre-reinsurance-ceded minimum reserve shall be calculated pursuant to the requirements of VM-20, using methods and assumptions consistent with those used in calculating the minimum reserve, but excluding the effect of ceded reinsurance. The remainder of this Section 8.D.2 assumes that the pre-reinsurance-ceded minimum reserve and post-reinsurance-ceded minimum reserve for a group of policies are being calculated separately.

a. If, on a pre-reinsurance-ceded basis, a group of policies is not able to pass, it has not passed one or both of the exclusion tests pursuant to Section 6, then the required deterministic or stochastic reserves shall be calculated in determining the pre-reinsurance-ceded minimum reserve, even if not required for the minimum reserve.

b. The company shall use assumptions that represent company experience in the absence of reinsurance—for example, assuming that the business was managed in a manner consistent with the manner that retained business is managed—when computing the pre-reinsurance-ceded minimum exclusion tests and reserves.

c. The requirement in Section 7.D.3 regarding the 98% to 102% collar does not apply when determining the amount of starting assets excluding the effect of ceded reinsurance for calculating the pre-reinsurance-ceded minimum reserve.

Commented [RJW(1):] Clarify when this guidance applies.

Commented [RJW(2):] Only post-reins exclusion testing required.

Commented [RJW(3):] The issue is not whether it is able to pass, it is whether it has passed.

Commented [RJW(4):] Using post-reins exclusion test result. Delete.

Commented [RJW(5):] Consistent wording.

Commented [RJW(6):] Consistent terminology; delete pre-reins exclusion test.

Commented [RJW(7):] Consistent terminology.
August 12, 2021

From: Pete Weber, Chair
The Index-Linked Variable Annuity (A) Subgroup

To: Mike Boerner, Chair
The Life Actuarial (A) Task Force

Subject: The Report of the Index-Linked Variable Annuity (A) Subgroup to the Life Actuarial (A) Task Force

The first call of the newly formed Index-Linked Variable Annuity (A) Subgroup was held July 15th. On that call, the Subgroup discussed preparing a document listing potential options for ILVA interim value guidance, along with the pros and cons of each. The goal is then to identify the optimal approach and develop into a recommendation to LATF. Additional, periodic calls are expected to continue into the fall with the goal of presenting a recommendation to LATF at the Fall National Meeting.
The Index-Linked Variable Annuity (A) Subgroup of the Life Actuarial (A) Task Force met July 15, 2021. The following Subgroup members participated: Pete Weber, Chair (OH); Tomasz Serbinowski, Vice Chair (UT); Sarvjit Samra (CA); Rhonda Ahrens (NE); Kevin Clarkson (NJ); William Carmello and Michael Cebula (NY); Rachel Hemphill, Mengting Kim, and John Carter (TX); and Craig Chupp (VA). Also participating were: Fred Andersen (MN); and David Hippen (WA).

1. Discussed Establishing Interim Values for Index-Linked Variable Annuities

Mr. Weber said the Subgroup is charged to: “Provide recommendations and changes, as appropriate, to nonforfeiture, or interim value requirements related to index-linked variable annuities.” He said the Subgroup is to address the issue of certain non-variable products being filed as variable annuities, therefore exempting them from the Standard Nonforfeiture Law for Individual Deferred Annuities (#805). He said the Variable Annuity Model Regulation (#250) defines a variable annuity as “a policy or contract that provides for annuity benefits that vary according to the investment experience of a separate account or accounts maintained by the insurer as to the policy or contract.” He said the benefits of index-linked variable annuities (ILVAs) do not vary according to the investment experience of a separate account.

Ms. Ahrens said that there may be ILVA (also known as registered index-linked annuities [RILAs]) products where the performance attempts to mimic the index. She said the Nebraska Department of Insurance (DOI) asks companies to provide information on the funding of the separate account and the relationship of the separate account to the index. She said solely being registered with the U.S. Securities and Exchange Commission (SEC) is not a sufficient criterion for acceptance as variable product under the Nebraska insurance statutes.

Mr. Clarkson said there are existing ILVA products that are regulated as variable annuities. He said the goal should be to apply existing rules to the regulation of these products.

Mr. Serbinowski suggested developing a document that states the issue and proposes options for addressing it. He said possible options are to: 1) amend Model #805; 2) provide guidance on what constitutes a variable product; or 3) do nothing. He said the document could then be sent to the Life Actuarial (A) Task Force for consideration.

Mr. Hippen provided his perspective on the history of the SEC and NAIC tug-of-war on variable products. He said that history has led to NAIC reluctance to take a strong stand on the development of models for variable products that might conflict with SEC regulations. Mr. Serbinowski said that the states should not avoid regulation of a product merely because the product is registered with the SEC. Mr. Weber noted that consistent regulation across states is a necessity. Mr. Hippen said that states have modified their variable product regulations over the years, so there is currently very little state uniformity.

Mr. Andersen said he reviewed ILVA product filings when the product was initially developed. He listed concepts that were considered in determining how the product should be placed:

1) Does the product fit appropriately with other annuities and financial products on the risk/return spectrum?
2) Is there evidence that customers understand the downside risk associated with the product?
3) Can a state insurance regulator disapprove unreasonable products?
4) Will stricter regulations be detrimental to consumers?

Mr. Serbinowski suggested drafting a document that lays out the situation and possible outcomes so that feedback can be solicited from state insurance regulators and industry. He said the Subgroup can present the Task Force with multiple options from which to choose. He said the options might be to: 1) do nothing; 2) develop an actuarial guideline; 3) revise Model #805; or 4) revise Model #250. Mr. Clarkson said that if the Subgroup decides that doing nothing is the appropriate course of action, it should document the details leading to the decision. Mr. Serbinowski said it will be important to provide the pros and cons for all the options. Mr. Carmello suggested starting with existing regulations from a state or the Interstate Insurance Product Regulation Commission (Compact). Mr. Weber said that is a viable option. Ms. Ahrens said the Subgroup could possibly start
with an existing process that could be converted into a guideline. Mr. Weber said Subgroup members will initiate efforts to follow through on the development of potential options.

Having no further business, the Index-Linked Variable Annuity (A) Subgroup adjourned.

W:\National Meetings\2021\Summer\TF\LA\ILVA\7_15 ILVA Minutes.docx
August 12, 2021

From: Rhonda Ahrens, Chair  
Longevity Risk (E/A) Subgroup

To: Mike Boerner, Chair  
The Life Actuarial (A) Task Force

Subject: The Report of Longevity Risk (E/A) Subgroup to the Life Actuarial (A) Task Force

The Longevity Risk (E/A) Subgroup has not met since the Spring National Meeting. A Drafting Group has been formed to contemplate reserve requirements related to pension risk transfer (PRT) and longevity reinsurance (LR) transactions that are more specific to the PRT reserves and are not solely related to the longevity component. The Subgroup will reconsider C-2 RBC for PRT products or LR transactions after reviewing the Drafting Group’s recommendations for resolution of identified issues. The Subgroup Chair has had communication with the Academy of Actuaries Longevity Risk Task Force to ensure that the Task Force is aware of Subgroup needs and able to provide guidance as requested for the upcoming recommendations from the Drafting Group and VM-22 (A) Subgroup.
August 12, 2021

From: Rhonda Ahrens, Chair
       Guaranteed Issue (GI) Life Valuation (A) Subgroup

To: Mike Boerner, Chair
    The Life Actuarial (A) Task Force

Subject: The Report of Guaranteed Issue (GI) Life Valuation (A) Subgroup to the Life Actuarial (A) Task Force

The Guaranteed Issue (GI) Life Valuation (A) Subgroup has not met since the Spring National Meeting and may meet prior to the Winter National Meeting depending on availability of subgroup members or their concerns. Otherwise, it is in a dormant/monitoring mode given that there have been no new known studies of GI Life mortality that could prove useful in formulating a new prescriptive requirement for the reserves for GI Life products. One direction the subgroup could go is to continue consideration of how to adopt the GI Life table but require companies with credible experience to use a credibility weighted mortality whether their experience is lower or higher than the table.
August 12, 2021

From: Fred Andersen, Chair
The Experience Reporting (A) Subgroup

To: Mike Boerner, Chair
The Life Actuarial (A) Task Force

Subject: The Report of the Experience Reporting (A) Subgroup to the Life Actuarial (A) Task Force

The Experience Reporting (A) Subgroup has not met since the Spring National Meeting. Upcoming projects include monitoring the plans for collecting life insurance mortality and policyholder behavior data using the NAIC as the statistical agent, starting to develop mandatory reporting of variable annuity data, and continuing to work on evaluating actuarial aspects of accelerated underwriting.
August 12, 2021

From: Fred Andersen, Chair
The Indexed Universal Life (IUL) Illustration (A) Subgroup

To: Mike Boerner, Chair
The Life Actuarial (A) Task Force

Subject: The Report of the Indexed Universal Life (A) Subgroup to the Life Actuarial (A) Task Force

The Indexed Universal Life Illustration (A) Subgroup has not met since the Spring National Meeting. Research is being conducted on market developments following the adoption of Actuarial Guideline XLIX-A, The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest Sold On or After November 25, 2020 (AG 49-A). It is expected that a Subgroup call will be scheduled to present findings related to the research prior to the Fall National Meeting.
The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met July 21, 2021. The following Subgroup members participated: Bruce Sartain, Chair, and Vincent Tsang (IL); Ted Chang, Ahmad Kamil, Elaine Lam and Thomas Reedy (CA); Lei Rao-Knight (CT); Mike Yanacheak (IA); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello and Amanda Fenwick (NY); Rachel Hemphill and Karen Jiang (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA). Also participating was: John Robinson (MN).

1. **Discussed the ARCWG Fixed Annuity Proposal**

Mr. Sartain discussed exposing the American Academy of Actuaries’ (Academy) Annuity Reserves and Capital Working Group (ARCWG) fixed annuity reserving framework proposal. Ms. Hemphill suggested that if the proposal is exposed, the cover page could indicate that the proposal is being considered, not endorsed, by the Subgroup.

Ben Slutsker (ARCWG) provided an overview of the fixed annuity reserving framework (Attachment One). He said the framework follows the structure of VM-21, Requirements for Principle-Based Reserves for Variable Annuities. He said the proposal uses “to be determined” in places where language for the standard projection amount is needed. He said Section 5, which covers reinsurance, goes into more depth than the corresponding section in VM-21. He suggested that commenters give that section a more rigorous review than some of the other sections that follow VM-21 more closely. He said Section 7, Exclusion Testing, borrows heavily from VM-20, Requirements for Principle-Based Reserves for Life Products. He noted that Section 13 retains the current language from VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities, which will apply to contracts that pass an exclusion test. Mr. Slutsker said that in the Annuity Products section, the proposal provides criteria for differentiating fixed and variable annuities. Mr. Serbinowski suggested that perhaps specific definitions of fixed and variable annuities are needed. He said there are indexed products that are classified without considering risk as a criterion. Mr. Slutsker agreed that the line between the products is blurry. He said the framework lends itself to a principle-based approach to delineating fixed and variable products. Mr. Sartain asked whether amendment proposals adopted for the 2021 Valuation Manual and 2022 Valuation Manual are included in the fixed annuity framework proposal. Mr. Slutsker said the framework used the 2020 Valuation Manual as its basis. Mr. Sartain said the “VM-22 Exposure Priorities” document (Attachment Two) specifies items that commenters should consider as they review the fixed annuity framework.

2. **Exposed Alternative Definitions for Reserve Categories**

Mr. Chupp discussed the VM-22 product descriptions as modified (Attachment Three) to be considered as payout annuity reserve categories. He said that changes made since the Subgroup’s July 7 meeting are highlighted in yellow. He noted that the definitions for “pension risk transfer” and “longevity risk” are provided in the fixed annuity framework proposal. Mr. Serbinowski asked if a product that does not meet any of the payout annuity product descriptions would by default be considered an accumulation product. Mr. Chupp said that is the intent. Mr. Sartain said one of the challenges the Subgroup faces is to decide whether to use a bright line such as in this product description approach or to rely on a principle-based approach. Mr. Serbinowski suggested listing longevity reinsurance separately from pension risk transfer annuities.

Mr. Sartain discussed the principle-based reserving (PBR) category definitions (Attachment Four). He said the previous version of the definition required that the category determination be made based on the risks at issue. The current version changes “at issue” to “as of the valuation date.”

Mr. Serbinowski made a motion, seconded by Mr. Reedy, to expose the fixed annuity framework, the modified VM-22 product descriptions reserving category definition, and the PBR category definitions for a 90-day public comment period ending October 19. The motion passed unanimously.

3. **Exposed VM-22 Exposure Priorities**

Mr. Chupp made a motion, seconded by Mr. Reedy, to expose the VM-22 Exposure Priorities for a 90-day public comment period ending October 19. The motion passed unanimously.

Having no further business, the VM-22 (A) Subgroup adjourned.
July 16, 2021  
Bruce Sartain, Chair  
Valuation Manual (VM)-22 (A) Subgroup  
Life Actuarial (A) Task Force  
National Association of Insurance Commissioners (NAIC)

Dear Mr. Sartain,

The American Academy of Actuaries\(^1\) Annuity Reserves and Capital Work Group (ARCWG) presented a fixed annuity principle-based reserving (PBR) framework proposal to the VM-22 Subgroup during its October 21, 2020 meeting. This document provides ARCWG’s initial draft of NAIC Valuation Manual Section II and VM-22 requirements associated with the ARCWG proposal. We ask for the VM-22 Subgroup’s consideration of the language herein as a foundation for further drafting efforts, in your efforts to advance toward an NAIC fixed annuity PBR framework.

Please let us know if you have any follow-up inquiries in response to this document. Again, we appreciate the opportunity to propose the fixed annuity framework and all of the efforts made by the VM-22 Subgroup to focus on this topic.

Sincerely,

Ben Slutsker  
Chairperson, Annuity Reserves and Capital Work Group  
American Academy of Actuaries

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\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
VM-22 PBR: Requirements for Principle-Based Reserves for Non-Variable Annuities

Drafting Overview: This document is the ARCWG-proposed draft Valuation Manual wording for VM-22 PBR for non-variable annuities. The edits reflected in this draft are made in association with the recommendations in the Annuity Reserves Work Group-proposed VM-22 presentation, exposed by the VM-22 Subgroup in October 2020. Each section shows editorial mark-ups compared to existing VM-20 or VM-21 wording, which is included as a draft note at the beginning of each section (with the only exceptions being Sections 1 and 2 that do not contain mark-ups to existing Valuation Manual wording).

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Section 1: Background

Drafting Note: All revisions shown in this section are in comparison to Section 1 in VM-21.

A. Purpose

These requirements establish the minimum reserve valuation standard for non-variable annuity ("contracts") as defined in the Section 2.A. and issued on or after 1/1/2024 operative date of the Valuation Manual as required by Model #820. For all contracts encompassed by the Scope, these requirements constitute the Commissioners Annuity Reserve Valuation Method (CARVM) and, for certain contracts encompassed in Section 2.A, the Commissioners Reserve Valuation Method (CRVM).

Guidance Note: CRVM requirements apply to some group pension contracts.

The contracts subject to these requirements may be aggregated with the contracts subject to Actuarial Guideline XLIII—CARVM for Variable Annuities (AG 43), published in Appendix C of the AP&P Manual, for purposes of performing and documenting the reserve calculations.

Guidance Note:

Effectively, through reference in AG 43, the reserve requirements in VM-21 also apply to those contracts issued prior to Jan. 1, 2017, that would not otherwise be encompassed by the scope of VM-21. Reserves for contracts subject to VM-21 or AG 43 may be computed as a single group. If a company chooses to aggregate business subject to AG 43 with business subject to VM-21 in calculating the reserve, then the provisions in VM-G apply to this aggregate principle-based valuation.

Guidance Note:

Relationship to RBC Requirements

These requirements anticipate that the projections described herein are used for the determination of RBC for all of the contracts falling within the scope of these requirements. These requirements and the RBC requirements for the topics covered within Sections 4.A through 4.E are identical. However, while the projections described in these requirements are performed on a basis that ignores federal income tax, a company may elect to conduct the projections for calculating the RBC requirements by including projected federal income tax in the cash flows and reducing the discount interest rates used to reflect the effect of federal income tax as described in the RBC requirements. A company that has elected to calculate RBC requirements in this manner may not switch back to using a calculation that ignores the effect of federal income tax without approval from the domiciliary commissioner.

B. Principles

The projection methodology used to calculate the stochastic reserve, as well as the approach used to develop the Alternative Methodology, is based on the following set of principles. These principles should be followed when interpreting and applying the methodology in these requirements and analyzing the resulting reserves.
Guidance Note: The principles should be considered in their entirety, and it is required that companies meet these principles with respect to those contracts that fall within the scope of these requirements and are in force as of the valuation date to which these requirements are applied.

Principle 1: The objective of the approach used to determine the stochastic reserve is to quantify the amount of statutory reserves needed by the company to be able to meet contractual obligations in light of the risks to which the company is exposed with an element of conservatism consistent with statutory reporting objectives.

Principle 2: The calculation of the stochastic reserve is based on the results derived from an analysis of asset and liability cash flows produced by the application of a stochastic cash-flow model to equity return and interest rate scenarios. For each scenario, the greatest present value of accumulated deficiency is calculated. The analysis reflects prudent estimate assumptions for deterministic variables and is performed in aggregate (subject to limitations related to contractual provisions) to allow the natural offset of risks within a given scenario. The methodology uses a projected total cash flow analysis by including all projected income, benefit, and expense items related to the business in the model and sets the stochastic reserve at a degree of confidence using the CTE measure applied to the set of scenario specific greatest present values of accumulated deficiencies that is deemed to be reasonably conservative over the span of economic cycles.

Guidance Note: Examples where full aggregation between contracts may not be possible include experience rated group contracts and the operation of reinsurance treaties.

Principle 3: The implementation of a model involves decisions about the experience assumptions and the modeling techniques to be used in measuring the risks to which the company is exposed. Generally, assumptions are to be based on the conservative end of the confidence interval. The choice of a conservative estimate for each assumption may result in a distorted measure of the total risk. Conceptually, the choice of assumptions and the modeling decisions should be made so that the final result approximates what would be obtained for the stochastic reserve at the required CTE level if it were possible to calculate results over the joint distribution of all future outcomes. In applying this concept to the actual calculation of the stochastic reserve, the company should be guided by evolving practice and expanding knowledge base in the measurement and management of risk.

Guidance Note: The intent of Principle 3 is to describe the conceptual framework for setting assumptions. Section 10 provides the requirements and guidance for setting contract holder behavior assumptions and includes alternatives to this framework if the company is unable to fully apply this principle.

Principle 4: While a stochastic cash-flow model attempts to include all real-world risks relevant to the objective of the stochastic cash-flow model and relationships among the risks, it will still contain limitations because it is only a model. The calculation of the stochastic reserve is based on the results derived from the application of the stochastic cash-flow model to scenarios, while the actual statutory reserve needs of the company arise from the risks to...
which the company is (or will be) exposed in reality. Any disconnect between the model and reality should be reflected in setting prudent estimate assumptions to the extent not addressed by other means.

**Principle 5:** Neither a cash-flow scenario model nor a method based on factors calibrated to the results of a cash-flow scenario model can completely quantify a company’s exposure to risk. A model attempts to represent reality but will always remain an approximation thereto and, hence, uncertainty in future experience is an important consideration when determining the stochastic reserve. Therefore, the use of assumptions, methods, models, risk management strategies (e.g., hedging), derivative instruments, structured investments or any other risk transfer arrangements (such as reinsurance) that serve solely to reduce the calculated stochastic reserve without also reducing risk on scenarios similar to those used in the actual cash-flow modeling are inconsistent with these principles. The use of assumptions and risk management strategies should be appropriate to the business and not merely constructed to exploit “foreknowledge” of the components of the required methodology.

C. Risks Reflected

1. The risks reflected in the calculation of reserves under these requirements arise from actual or potential events or activities that are both:
   a. Directly related to the contracts falling under the scope of these requirements or their supporting assets; and
   b. Capable of materially affecting the reserve.

2. Categories and examples of risks reflected in the reserve calculations include, but are not necessarily limited to:
   a. Asset risks
      i. Separate account fund performance.
      ii. Credit risks (e.g., default or rating downgrades).
      iii. Commercial mortgage loan roll-over rates (roll-over of bullet loans).
      iv. Uncertainty in the timing or duration of asset cash flows (e.g., shortening (prepayment risk) and lengthening (extension risk)).
      v. Performance of equities, real estate, and Schedule BA assets.
      vi. Call risk on callable assets.
      viii. Risk associated with hedge instrument (includes basis, gap, price, parameter estimation risks, and variation in assumptions).
   viii. Currency risk.
b. Liability risks
   i. Reinsurer default, impairment, or rating downgrade known to have occurred before or on the valuation date.
   ii. Mortality/longevity, persistency/lapse, partial withdrawal, and premium payment risks.
   iii. Utilization risk associated with guaranteed living benefits.
   iv. Anticipated mortality trends based on observed patterns of mortality improvement or deterioration, where permitted.
   v. Annuitzation risks.
   vi. Additional premium dump-ins or deposits (high interest rate guarantees in low interest rate environments).
   vii. Applicable expense risks, including fluctuation maintenance expenses directly attributable to the business, future commission expenses, and expense inflation/growth.

c. Combination risks
   i. Risks modeled in the company’s risk assessment processes that are related to the contracts, as described above.
   ii. Disintermediation risk (including such risk related to payment of surrender or partial withdrawal benefits).
   iii. Risks associated with revenue-sharing income.

3. The risks not necessarily reflected in the calculation of reserves under these requirements are:
   a. Those not reflected in the determination of RBC.
   b. Those reflected in the determination of RBC but arising from obligations of the company not directly related to the contracts falling under the scope of these requirements, or their supporting assets, as described above.
   a. Those not associated with the policies or contracts being valued, or their supporting assets.
   b. Determined to not be capable of materially affecting the reserve.

4. Categories and examples of risks not reflected in the reserve calculations include, but are not necessarily limited to:
   a. Asset risks
i. Liquidity risks associated with sudden and significant levels of withdrawals and surrenders “run on the bank.”

b. Liability risks
i. Reinsurer default, impairment or rating downgrade occurring after the valuation date.

ii. Catastrophic events (e.g., epidemics or terrorist events).

iii. Major breakthroughs in life extension technology that have not yet fundamentally altered recently observed mortality experience.

iv. Significant future reserve increases as an unfavorable scenario is realized.

c. General business risks
i. Deterioration of reputation.

ii. Future changes in anticipated experience (reparameterization in the case of stochastic processes), which would be triggered if and when adverse modeled outcomes were to actually occur.

iii. Poor management performance.

iv. The expense risks associated with fluctuating amounts of new business.

v. Risks associated with future economic viability of the company.

vi. Moral hazards.

vii. Fraud and theft.

D. Specific Definitions for VM-22

Buffer Annuity
Interchangeable term for Registered Index-Linked Annuity (RILA). See definition for Registered Index-Linked Annuity below.

Deferred Income Annuity (DIA)
An annuity which guarantees a periodic payment for the life of the annuitant or a term certain and payments begin one year or later after (or from) the issue date if the contract holder survives to a predetermined future age.

Fixed Indexed Annuity (FIA)
An annuity with an account value where the contract holder has the option for a portion or all of the account value to grow at a rate linked to an external index, typically with guaranteed principal.
Flexible Premium Deferred Annuity (FPDA)
An annuity with an account value established with a premium amount but allows for additional deposits to be paid into the annuity over time, resulting in an increase to the account value. The contract also has a guaranteed interest rate during the accumulation phase and has guaranteed mortality and interest rates applicable at the time of conversion to the payout phase.

Funding Agreement
A contract issued to an institutional investor (domestic and international non-qualified fixed income investors) that provides fixed or floating interest rate guarantees.

Guaranteed Investment Contract (GIC)
Insurance contract typically issued to a retirement plan (defined contribution) under which the insurer accepts a deposit (or series of deposits) from the purchaser and guarantees to pay a specified interest rate on the funds deposited during a specified period of time.

Index Credit Hedge Margin
A margin capturing the risk of inefficiencies in the company’s hedging program supporting index credits. This includes basis risk, persistency risk, and the risk associated with modeling decisions and simplifications. It also includes any uncertainty of costs associated with managing the hedging program and changes due to investment and management decisions.

Index Credit
Any interest credit, multiplier, factor, bonus, charge reduction, or other enhancement to policy values that is linked to an index or indices. Amounts credited to the policy resulting from a floor on an index account are included.

Index Crediting Strategy
The strategy defined in a contract to determine index credits for a contract. This refers to underlying index, index parameters, date, timing, and other elements of the crediting method.

Index Parameter
Cap, floor, participation rate, spreads, or other features describing how the contract utilizes the index.

Longevity Reinsurance
An agreement, typically a reinsurance arrangement covering one or more group or individual annuity contracts, under which an insurance company assumes the longevity risk associated with periodic payments made to specified annuitants under one or more immediate or deferred payout annuity contracts. A common example is participants in one or more underlying retirement plans.

Typically, the reinsurer pays a portion of the actual benefits due to the underlying annuitants (or, in some cases, a pre-agreed amount per annuitant), while the ceding insurance company retains the assets supporting the reinsured annuity payments and pays periodic, ongoing premiums to the reinsurer over the expected lifetime of benefits paid to the specified annuitants. Such agreements may contain net settlement provisions such that only one party makes ongoing cash payments in a particular period. Under these agreements, longevity risk may be transferred on either a
permanent basis or for a prespecified period of time, and these agreements may or may not permit early termination.

Agreements which are not treated as reinsurance under Statement of Statutory Accounting Principles (SSAP) No. 61R are not included in this definition. In particular, contracts under which payments are made based on the aggregate mortality experience of a population of lives which are not covered by an underlying group or individual annuity contract (e.g., mortality index-based longevity swaps) are not included in this definition.

**Market Value Adjustment (MVA) Annuity**
An annuity with an account value where withdrawals and full surrenders are subject to adjustments based on interest rates or index returns at the time of withdrawal/surrender. There could be ceilings and floors on the amount of the market-value adjustment.

**Modified Guaranteed Annuity (MGA)**
A type of market-value adjusted annuity contract where the underlying assets are held in an insurance company separate account and the value of which are guaranteed if held for specified periods of time. The contract contains nonforfeiture values that are based upon a market-value adjustment formula if held for shorter periods.

**Multiple Year Guaranteed Annuity (MYGA)**
A type of fixed annuity that provides a pre-determined and contractually guaranteed interest rate for specified periods of time, after which there is typically an annual reset or renewal of a multiple year guarantee period.

**Pension Risk Transfer (PRT) Annuity**
An annuity, typically a group contract or reinsurance agreement, issued by an insurance company providing periodic payments to annuitants receiving immediate or deferred benefits from one or more retirement plans. Typically, the insurance company holds the assets supporting the benefits, which may be held in the general or separate account, and retains not only longevity risk but also asset risks (e.g., credit risk and reinvestment risk).

**Registered Index-Linked Annuity (RILA)**
An annuity with an account value where the contract holder has the option for a portion or all of the account value to grow at a rate linked to an external index, similar to a Fixed Indexed Annuity, but with downside risk exposure that may not guarantee full principal repayment. These contracts may include a cap on upside returns, and may also include a floor on downside returns which may be below zero percent.

**Single Premium Immediate Annuity (SPIA)**
An annuity purchased with a single premium amount which guarantees a periodic payment for the life of the annuitant or a term certain and payments begin within one year after (or from) the issue date.

**Single Premium Deferred Annuity (SPDA)**
An annuity with an account value established with a single premium amount that grows with a guaranteed interest rate during the accumulation phase and has guaranteed mortality and interest
rates applicable at the time of conversion to the payout phase. May also include cases where the
premium is accepted for a limited amount of time early in the contract life, such as only in the
first duration.

**Stable Value Contract**
A contract that provides limited investment guarantees, typically preserving principal while
crediting steady, positive returns and protecting against losses or declines in yield. Underlying
asset portfolios typically consist of fixed income securities, which may sit in the insurer’s general
account, a separate account, or in a third-party trust. These contracts often support defined
contribution or defined benefit retirement plan liabilities.

**Structured Settlement Contract (SSC)**
A contract that provides periodic benefits and is purchased with a single premium amount
stemming from various types of claims pertaining to court settlements or out-of-court
settlements from tort actions arising from accidents, medical malpractice, and other causes.
Adverse mortality is typically expected for these contracts.

**Synthetic GIC**
Contract that simulates the performance of a traditional GIC through a wrapper, swap, or other
financial instruments, with the main difference being that the assets are owned by the
policyholder or plan trust.

**Term Certain Payout Annuity**
A contract issued, which offers guaranteed periodic payments for a specified period of time,
not contingent upon mortality or morbidity of the annuitant.

**Two-Tiered Annuity**
A deferred annuity with two tiers of account values. One, with a higher accumulation interest
rate, is only available for annuitization or death. The other typically contains a lower
accumulation interest rate, and is only available upon surrender.

1. The term “cash surrender value” means, for the purposes of these requirements, the amount
available to the contract holder upon surrender of the contract. Generally, it is equal to the
account value less any applicable surrender charges, where the surrender charge reflects
the availability of any free partial surrender option. However, for contracts where all or a
portion of the amount available to the contract holder upon surrender is subject to a market
value adjustment, the cash surrender value shall reflect the market value adjustment
consistent with the required treatment of the underlying assets. That is, the cash surrender
value shall reflect any market value adjustments where the underlying assets are reported
at market value, but it shall not reflect any market value adjustments where the underlying
assets are reported at book value.

2. The term “clearly defined hedging strategy” (CDHS) is defined in VM-01. In order to be
designated as a CDHS, the strategy must meet the principles outlined in Section 1.B
(particularly Principle 5) and shall, at a minimum, identify:

   a. The specific risks being hedged (e.g., delta, rho, vega, etc.).
   b. The hedge objectives.
   c. The risks not being hedged (e.g., variation from expected mortality, withdrawal,
...and other utilization or decrement rates assumed in the hedging strategy, etc.).

d. The financial instruments that will be used to hedge the risks.

e. The hedge trading rules, including the permitted tolerances from hedging objectives.

f. The metric(s) for measuring hedging effectiveness.

g. The criteria that will be used to measure hedging effectiveness.

h. The frequency of measuring hedging effectiveness.

i. The conditions under which hedging will not take place.

j. The person or persons responsible for implementing the hedging strategy.

Guidance Note: It is important to note that strategies involving the offsetting of the risks associated with VA guarantees with other products outside of the scope of these requirements (e.g., equity-indexed annuities) do not currently qualify as a clearly defined hedging strategy under these requirements.

3. The term “guaranteed minimum death benefit” (GMDB) means a provision (or provisions) for a guaranteed benefit payable on the death of a contract holder, annuitant, participant or insured where the amount payable is either (i) a minimum amount; or (ii) exceeds the minimum amount and is:

--- is increased by an amount that may be either specified by or computed from other policy or contract values; and

--- has the potential to produce a contractual total amount payable on such death that exceeds the account value, or

--- in the case of an annuity providing income payments, guarantees payment upon such death of an amount payable on death in addition to the continuation of any guaranteed income payments.

Guidance Note: The definition of GMDB includes benefits that are based on a portion of the excess of the account value over the net of premiums paid less partial withdrawals made (e.g., an earnings enhanced death benefit).

4. The term “total asset requirement” (TAR) means the sum of the reserve determined from the VM-21 requirements prior to any adjustment for the elective phase-in pursuant to Section 2.B plus the C3 RBC amount from LR027 step (paragraph D) prior to any adjustment for phase-in or smoothing.
Section 2: Scope and Effective Date

Drafting Note: There are no revisions shown in this section compared to VM-21 or other chapters Valuation Manual, since the write-up is largely new for VM-22.

A. Scope

Subject to the requirements of this VM-22 are annuity contracts, certificates and contract features, whether group or individual, including both life contingent and term-certain-only, directly written or assumed through reinsurance issued on or after 1/1/2024, with the exception of contracts or benefits listed below.

Products out of scope include:

- Contracts or benefits that are subject to VM-21 (such as variable annuities, RILAs, buffer annuities, and structured annuities)
- GICs
- Synthetic GICs
- Stable Value Contracts
- Funding Agreements

Products in scope of VM-22 include fixed annuities which consist of, but are not limited to, the following list:

- **Account Value Based Annuities**
  - Deferred Annuities (SPDA & FPDA)
  - Multi-Year Guarantee Annuities (MYGA)
  - Fixed Indexed Annuities (FIA)
  - Market-Value Adjustments (MVA)
  - Two-tiered Annuities
  - Guarantees/Benefits/Riders on Fixed Annuity Contracts

- **Payout Annuities**
  - Single Premium Immediate Annuities (SPIA)
  - Deferred Income Annuities (DIA)
  - Term Certain Payout Annuity
  - Pension Risk Transfer Annuities (PRT)
  - Structured Settlement Contracts (SSC)
  - Longevity Reinsurance

The company may elect to exclude one or more groups of contracts from the stochastic reserve calculation in certain situations, pursuant to the exclusion test requirements defined in Section 3.E of VM-22.

B. Effective Date & Transition

**Effective Date**

These requirements apply for valuation dates on or after January 1, 2024.
Transition

A company may elect to establish minimum reserves pursuant to applicable requirements in VM-A and VM-C for business otherwise subject to VM-22 PBR requirements and issued during the first three years following the effective date of VM-22 PBR. If a company during the three years elects to apply VM-22 PBR to a block of such business, then a company must continue to apply the requirements of VM-22 PBR for future issues of this business. Irrespective of the transition date, a company shall apply VM-22 PBR requirements to applicable blocks of business on a prospective basis starting at least three years after the effective date.
Section 3: Reserve Methodology

Drafting Note: All revisions shown in this section are in comparison to Section 3 in VM-21.

A. Aggregate Reserve

The aggregate reserve for contracts falling within the scope of these requirements shall equal the stochastic reserve (following the requirements of Section 4) plus the additional standard projection amount (following the requirements of Section 6) less any applicable PIMR for all contracts not valued under applicable requirements in VM-A and VM-C—the Alternative Methodology (Section 7), plus the reserve for any contracts determined using the Alternative Methodology valued under applicable requirements in VM-A and VM-C (following the requirements of Section 7).

Guidance Note: Contracts valued under applicable requirements in VM-A and VM-C are ones that pass the exclusion test and elect to not model PBR stochastic reserves, per the requirements in Section 3.E.

B. Impact of Reinsurance Ceded

Where reinsurance is ceded for all or a portion of the contracts, all components in the aggregate reserve shall be determined post-reinsurance ceded, that is net of any reinsurance cash flows arising from treaties that meet the statutory requirements that would allow the treaty to be accounted for as reinsurance. A, and pre-reinsurance ceded reserve also needs to be determined by, that is ignoring all reinsurance cash flows (such costs and benefits) in the reserve calculation.

C. To Be Determined The Additional Standard Projection Amount

The additional standard projection amount is determined by applying one of the two standard projection methods defined in Section 6. The same method must be used for all contracts within a group of contracts that are aggregated together to determine the reserve, and the additional standard projection amount excluding any contracts whose reserve is determined using the Alternative Methodology. The company shall elect which method they will use to determine the additional standard projection amount. The company may not change that election for a future valuation without the approval of the domiciliary commissioner.

D. The Stochastic Reserve

1. The stochastic reserve shall be determined based on asset and liability projections for the contracts falling within the scope of these requirements, excluding those contracts valued using the methodology pursuant to applicable requirements in VM-A and VM-C—Alternative Methodology, over a broad range of stochastically generated projection scenarios described in Section 8 and using prudent estimate assumptions as required in Section 3.F herein. The stochastic reserve may be determined in aggregate for all contracts falling within the scope of these requirements—i.e., a single model segment—or, at the option of the company, it may be determined by subgrouping contracts into model segments.

2. The stochastic reserve amount for any group of contracts shall be determined as CTE70 of the scenario reserves following the requirements of Section 4, with the exception of groups of contracts for which a company elects the Deterministic Certification Option in Section 7.E, which shall be determined as the scenario reserve following the requirements of Section 4.
3. The reserve may be determined in aggregate across various groups of contracts as a single model segment when determining the stochastic reserve if the business and risks are not managed separately or are part of the same integrated risk management program. Aggregation is permitted if a resulting group of contracts (or model segment) follows the listed principles:

   a. Aggregate in a manner that is consistent with the company’s risk management strategy and reflects the likelihood of any change in risk offsets that could arise from shifts between product types, and

   b. Using prudent actuarial judgement, consider the following elements when aggregating groups of contracts: whether groups of contracts are part of the same portfolio (or different portfolios that interact), same integrated risk management system, administered/managed together

4. Do not aggregate groups of contracts for which the company elects to use the Deterministic Certification Option in Section 7.E with any groups of contracts that do not use such option.

5. To the extent that these limits on aggregation result in more than one model segment, the stochastic reserve shall equal the sum of the stochastic reserve amounts computed for each model segment and scenario reserve amounts computed for each model segment for which the company elects to use the Deterministic Certification Option in Section 7.E.

E. Exclusion Test Alternative Methodology

For a group of variable deferred annuity contracts that contain either no guaranteed benefits or only GMDBs—i.e., no VAGLBs—the reserve may be determined using the Alternative Methodology described in Section 7 rather than using the approach described in Section 3.C and Section 3.D. However, in the event that the approach described in Section 3.C and Section 3.D has been used in prior valuations for that group of contracts, the Alternative Methodology may not be used without approval from the domiciliary commissioner.

The reserve for the group of contracts to which the Alternative Methodology is applied shall not be less than the aggregate cash surrender value of those contracts.

1. To the extent that certain groups of contracts pass one of the defined stochastic exclusion tests in Section 7.B, these groups of contracts may be valued using the methodology pursuant to applicable requirements in VM-A and VM-C, with the statutory maximum valuation rate for immediate annuities specified in Section 13.

   a. For dividend-paying contracts, a dividend liability shall be established upon following requirements in VM-A and VM-C, as described above, for the base contract.

   Guidance Note: The intention of contracts that pass the stochastic exclusion test is to provide the option to value contracts under VM-A and VM-C. This may apply to pre-PBR CARVM requirements in accordance with Actuarial Guideline XXXIII (AG33) methodology with type A, B, C rates for SPIAs issued before 2018; AG33 methodology with pre-PBR VM-22 rates for SPIAs issued on/after 2018; Actuarial Guideline XXXV (AG35) pre-PBR methodology for Fixed Indexed Annuities; and AG33 methodology (with interest rate updates for modernization initiatives on new contracts) for non-SPIAs.

   2. The approach for grouping contracts when performing the exclusion tests should follow the same principles that underlie the aggregation approach for model segments discussed for Stochastic Reserves in Section D above.
F. Allocation of the Aggregate Reserve to Contracts

The aggregate reserve shall be allocated to the contracts falling within the scope of these requirements using the method outlined in Section 12.

G. Prudent Estimate Assumptions:

1. With respect to the Stochastic Reserve in Section 3.C, the company shall establish the prudent estimate assumption for each risk factor in compliance with the requirements in Section 12 of Model #820 and must periodically review and update the assumptions as appropriate in accordance with these requirements.

2. The qualified actuary, to whom responsibility for this group of contracts is assigned, shall annually review relevant emerging experience for the purpose of assessing the appropriateness of the anticipated experience assumption. If the results of statistical testing or other testing indicate that previously anticipated experience for a given factor is inadequate, then the qualified actuary shall set a new, adequate, anticipated experience assumption for the factor.

4-3. To determine the prudent estimate assumptions, the stochastic reserve shall also follow the requirements in Sections 4 and 9 for asset assumptions, Section 10 for policyholder behavior assumptions, and Section 11 for mortality assumptions.

G. Reserve to Be Held in the General Account

The portion of the aggregate reserve held in the general account shall not be less than the excess of the aggregate reserve over the aggregate cash surrender value held in the separate account and attributable to the separate account portion of all such contracts. For contracts for which a cash surrender value is not defined, the company shall substitute for cash surrender value held in the separate account the implicit amount for which the contract holder is entitled to receive income based on the performance of the separate account. For example, for a variable payout annuity for which a specific number of units is payable, the implicit amount could be the present value of that number of units, discounted at the assumed investment return and defined mortality, times the unit value at the valuation date.

Guidance Note: This approach is equivalent to assuming that the separate account performance is equal to the assumed investment return.
Section 4: Determination of Stochastic Reserve

Drafting Note: All revisions shown in this section are in comparison to Section 4 in VM-21.

A. Projection of Accumulated Deficiencies

1. General Description of Projection

The projection of accumulated deficiencies shall be made ignoring federal income tax in both cash flows and discount rates, and it shall reflect the dynamics of the expected cash flows for the entire group of contracts, reflecting all product features, including any guarantees provided under the contracts using prudent estimate liability assumptions defined in Sections 10 and 11 and asset assumptions defined in Section 4.D. The company shall project cash flows including the following:

a. Revenues received by the company including gross premiums received from the policyholder (including any due premiums as of the projected start date).

b. All material benefits projected to be paid to policyholders—including, but not limited to, death claims, surrender benefits and withdrawal benefits—reflecting the impact of all guarantees and adjusted to take into account amounts projected to be charged to account values on general account business. Any guarantees, in addition to market value adjustments assessed on projected withdrawals or surrenders, shall be taken into account.

Guidance Note: Amounts charged to account values on general account business are not revenue; examples include rider charges and expense charges.

c. Non-Guaranteed Elements (NGE) cash flows as described in Section 10.J.

d. Insurance company expenses (including overhead and investment expense), commissions, fund expenses, contractual fees and charges, and revenue-sharing income received by the company (net of applicable expenses), and

e. Net cash flows associated with any reinsurance.

f. Cash flows from hedging instruments as described in Section 4.A.4. are to be reflected on a basis consistent with the requirements herein.

g. Cash receipts or disbursements associated with invested assets (other than policy loans) as described in Section 4.D.4, including investment income, realized capital gains and losses, principal repayments, asset default costs, investment expenses, asset prepayments, and asset sales.

h. If modeled explicitly, cash flows related to policy loans as described in Section 10.I.2, including interest income, new loan payments and principal repayments.
Guidance Note: Future net policy loan cash flows include: policy loan interest paid in cash plus repayments of policy loan principal, including repayments occurring at death or surrender (note that the future benefits in Section 4.A.1.b are before consideration of policy loans), less additional policy loan principal (but excluding policy loan interest that is added to the policy loan principal balance). Cash flows from any fixed account options also shall be included. Any market value adjustment assessed on projected withdrawals or surrenders also shall be included (whether or not the cash surrender value reflects market value adjustments). Throughout the projection, all assumptions shall be determined based on the requirements herein. Accumulated deficiencies shall be determined at the end of each projection year as the sum of the accumulated deficiencies for all contracts within each model segment.

Guidance Note: Section 4.A.1 requires market value adjustments (MVAs) on liability cash flows to be reflected because in a cash flow model, assets are assumed to be liquidated at market value to cover the cash outflow of the cash surrender; therefore, inclusion of the market value adjustment aligns the asset and liability cash flows. This may differ from the treatment of MVAs in the definition of cash surrender value (Section 1.D), which defines the statutory reserve floor for which the values must be aligned with the annual statement value of the assets.

2. Grouping of Variable Funds and Subaccounts Index Crediting Strategies

The portion of the starting asset amount held in the separate account represented by the variable funds and the corresponding account values. Index crediting strategies may be grouped for modeling using an approach that recognizes the investment guidelines and objectives of the funds each index crediting strategy. In assigning each variable fund and the variable subaccounts index crediting strategy to a grouping for projection purposes, the fundamental characteristics of the fund index crediting strategy shall be reflected, and the parameters shall have the appropriate relationship to the stochastically generated projection scenarios described in Section 8. The grouping shall reflect characteristics of the efficient frontier (i.e., returns generally cannot be increased without assuming additional risk).

Index accounts sharing similar index crediting strategies may also be grouped for modeling to an appropriately crafted proxy strategy normally expressed as a linear combination of recognized market indices, sub-indices or funds, in order to develop the investment return paths and associated interest crediting. Each index crediting strategy’s specific risk characteristics, associated index parameters, and relationship to the stochastically generated scenarios in Section 8 should be considered before grouping or assigning to a proxy strategy. Grouping and/or development of a proxy strategy may not be done in a manner that intentionally understates the resulting reserve.

An appropriate proxy fund for each variable subaccount shall be designed in order to develop the investment return paths. The development of the scenarios for the proxy funds is a fundamental step in the modeling and can have a significant impact on results. As such, the company must map each variable account to an appropriately crafted proxy fund normally expressed as a linear combination of recognized market indices, sub-indices or funds.
3. Model Cells

Projections may be performed for each contract in force on the date of valuation or by assigning contracts into representative cells of model plans using all characteristics and criteria having a material impact on the size of the reserve. Assigning contracts to model cells may not be done in a manner that intentionally understates the resulting reserve.

4. Modeling of Hedges

a. For a company that does not have a CDHStie direct to the contracts falling under the scope of VM-22 stochastic reserve requirements:

i. The company shall not consider the cash flows from any future hedge purchases or any rebalancing of existing hedge assets in its modeling.

ii. Existing hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the starting assets. The hedge assets may then be considered in one of two ways:

   a) Include the asset cash flows from any contractual payments and maturity values in the projection model; or

   b) No hedge positions—in which case the hedge positions held on the valuation date are replaced with cash and/or other general account assets in an amount equal to the aggregate market value of these hedge positions.

Guidance Note: If the hedge positions held on the valuation date are replaced with cash, then as with any other cash, such amounts may then be invested following the company’s investment strategy.

A company may switch from method a) to method b) at any time, but it may only change from b) to a) with the approval of the domiciliary commissioner.

b. For a company with a CDHSthat has a future hedging program tied directly to the contracts falling under the scope of VM-22 stochastic reserve requirements:

i. For a hedging program with hedge payoffs that offset interest credits associated with indexed interest strategies (indexed interest credits):

   a) In modeling cash flows, the company shall include the cash flows from future hedge purchases or any rebalancing of existing hedge assets that are intended solely to offset interest credits to policyholders

   b) Existing hedging instruments that are currently held by the company for this purpose in support of the contracts falling under the scope of these requirements shall be included in the starting assets. Existing hedging instruments that are currently held by the
c) An Index Credit Hedge Margin for these instruments shall be reflected by reducing index interest credit hedge payoffs by a margin multiple that shall be justified by sufficient and credible company experience and be no less than \([X\%]\) multiplicatively of the interest credited. In the absence of sufficient and credible company experience, a margin of \([Y\%]\) shall be assumed. There is no cap on the index credit hedge margin if company experience indicates actual error is greater than \([Y\%]\). It is permissible to substitute stress-testing for sufficient and credible experience if such stress-testing comprehensively considers a robust range of future market conditions.

ii. For a company that hedges any contractual obligation or risks other than indexed interest credits, the detailed requirements for the modeling of hedges are defined in Section 9. The following requirements do not supersede the detailed requirements.

a) The appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the projections used in the determination of the stochastic reserve.

b) The projections shall take into account the appropriate costs and benefits of hedge positions expected to be held in the future through the execution of CDHS. Because models do not always accurately portray the results of hedge programs, the company shall, through back-testing and other means, assess the accuracy of the hedge modeling. The company shall determine a stochastic reserve as the weighted average of two CTE values; first, a CTE70 (“best efforts”) representing the company’s projection of all of the hedge cash flows, including future hedge purchases, and a second CTE70 (“adjusted”) which shall use only hedge assets held by the company on the valuation date and only future hedge purchases associated with indexed interest credited. These are discussed in greater detail in Section 9. The stochastic reserve shall be the weighted average of the two CTE70 values, where the weights reflect the error factor \((E)\) determined following the guidance of Section 9.C.4.

c) Consistent with Section 4.A.4.b.i., the index credit hedge margin for instruments associated with indexed interest credited shall be reflected by reducing hedge payoffs by a margin multiple as defined in Section 4.A.4.b.i.e).
The use of products not falling under the scope of these requirements (e.g., equity-indexed annuities) as a hedge shall not be recognized in the determination of accumulated deficiencies.

**Guidance Note:** Section 4.A.4.b.i is intended to address common situations for products with index crediting strategies where the company only hedges index credits or clearly separates index credit hedging from other hedging. In this case the hedge positions are considered similarly to other fixed income assets supporting the contracts, and a margin is reflected rather than modeling using a CTE70 adjusted run with no future hedge purchases. If a company has a more comprehensive hedge strategy combining index credits, guaranteed benefit, and other risks (e.g., full fair value or economic hedging), an appropriate and documented bifurcation method should be used in the application of sections 4.A.4.b.i and 4.A.4.b.ii above for the hedge modeling and justification. Such bifurcation methods may quantify the specific risk exposure attributable to index credit liabilities versus other liabilities such as guaranteed living benefits, and apply such for the basis for allocation.

**Guidance Note:** The requirements of Section 4.A.4 govern the determination of reserves for annuity contracts and do not supersede any statutes, laws or regulations of any state or jurisdiction related to the use of derivative instruments for hedging purposes and should not be used in determining whether a company is permitted to use such instruments in any state or jurisdiction.

5. Revenue Sharing

If applicable, projections of accumulated deficiencies may include income from projected future revenue sharing, net of applicable projected expenses (net revenue-sharing income) if each of the following requirements set forth in VM 21 Section 4.A.5 are met:

- The net revenue-sharing income is received by the company.
- Signed contractual agreement(s) are in place as of the valuation date and support the current payment of the net revenue-sharing income.
- The net revenue-sharing income is not already accounted for directly or indirectly as a company asset.

**Guidance Note:** For purposes of this section, net revenue-sharing income is considered to be received by the company if it is paid directly to the company through a contractual agreement with either the entity providing the net revenue-sharing income or an affiliated company that receives the net revenue-sharing income. Net revenue-sharing income also would be considered to be received if it is paid to a subsidiary that is owned by the company and if 100% of the statutory income from that subsidiary is reported as statutory income of the company. In this case, the company needs to assess the likelihood that future net revenue-sharing income is reduced due to the reported statutory income of the subsidiary being less than future net revenue-sharing income received.

Signed contractual agreement(s) are in place as of the valuation date and support the current payment of the net revenue-sharing income.

The net revenue-sharing income is not already accounted for directly or indirectly as a company asset.
The amount of net revenue-sharing income to be used shall reflect the company’s assessment of factors that include, but are not limited to, the following (not all of these factors will necessarily be present in all situations):

- The terms and limitations of the agreement(s), including anticipated revenue, associated expenses and any contingent payments incurred or made by either the company or the entity providing the net revenue sharing as part of the agreement(s).
- The relationship between the company and the entity providing the net revenue-sharing income that might affect the likelihood of payment and the level of expenses.
- The benefits and risks to both the company and the entity paying the net revenue-sharing income of continuing the arrangement.
- The likelihood that the company will collect the net revenue-sharing income during the term(s) of the agreement(s) and the likelihood of continuing to receive future revenue after the agreement(s) has ended.
- The ability of the company to replace the services provided to it by the entity providing the net revenue-sharing income or to provide the services itself, along with the likelihood that the replaced or provided services will cost more to provide.
- The ability of the entity providing the net revenue-sharing income to replace the services provided to it by the company or to provide the services itself, along with the likelihood that the replaced or provided services will cost more to provide.

The amount of projected net revenue-sharing income shall reflect a margin (which decreases the assumed net revenue-sharing income) directly related to the uncertainty of the revenue. The greater the uncertainty, the larger the margin. Such uncertainty is driven by many factors, including the potential for changes in the securities laws and regulations, mutual fund board responsibilities and actions, and industry trends. Since it is prudent to assume that uncertainty increases over time, a larger margin shall be applied as time that has elapsed in the projection increases.

All expenses required or assumed to be incurred by the company in conjunction with the arrangement providing the net revenue-sharing income, as well as any expenses assumed to be incurred by the company in conjunction with the assumed replacement of the services provided to it (as discussed in Section 4.A.5.b.v), shall be included in the projections as company expenses under the requirements of Section 4.A.1. In addition, expenses incurred by either the entity providing the net revenue-sharing income or an affiliate of the company shall be included in the applicable expenses discussed in Section 4.A.1 and Section 4.A.5.a that reduce the net revenue-sharing income.

The company is responsible for reviewing the revenue-sharing agreements and verifying compliance with these requirements.

The amount of net revenue-sharing income assumed in a given scenario shall not exceed the sum of (i) and (ii), where:
Is the contractually guaranteed net revenue-sharing income projected under the scenario; and

Is the company’s estimate of non-contractually guaranteed net revenue-sharing income before reflecting any margins for uncertainty multiplied by the following factors:

1.00 in the first projection year.
0.95 in the second projection year.
0.90 in the third projection year.
0.85 in the fourth projection year.
0.80 in the fifth and all subsequent projection years.

6. Length of Projections

Projections of accumulated deficiencies shall be run for as many future years as needed so that no materially greater reserve value would result from longer projection periods.

7. Interest Maintenance Reserve (IMR)

The IMR shall be handled consistently with the treatment in the company’s cash flow testing, and the amounts should be adjusted to a pre-tax basis.

B. Determination of Scenario Reserve

1. For a given scenario, the scenario reserve is the sum of:

   a) The starting asset amount plus the greatest present value, as of the projection start date, of the projected accumulated deficiencies; and

   Guidance Note: The greatest present value of accumulated deficiencies can be negative.

   b) The direct iteration method, where the scenario reserve is determined by solving for the amount of starting assets which, when projected along with all contract cash flows, result in the defeasement of all projected future benefits and expenses at the end of the projection horizon with no positive accumulated deficiencies at the end of any projection year during the projection period starting asset amount. When using the direct iteration method, the scenario reserve will equal the final starting asset amount determined according to Section 4.B.4.

The scenario reserve for any given scenario shall not be less than the cash surrender value in aggregate on the valuation date for the group of contracts modeled in the projection.

2. Discount Rates
In determining the scenario reserve, unless using the direct iteration method pursuant to Section 4.B.1.b, the accumulated deficiencies shall be discounted at the NAER on additional assets, as defined in Section 4.B.3.

3. Determination of NAER on Additional Invested Asset Portfolio

a. The additional invested asset portfolio for a scenario is a portfolio of general account assets as of the valuation date, outside of the starting asset portfolio, that is required in that projection scenario so that the projection would not have a positive accumulated deficiency at the end of any projection year. This portfolio may include only (i) General Account assets available to the company on the valuation date that do not constitute part of the starting asset portfolio; and (ii) cash assets.

Guidance Note:

Additional invested assets should be selected in a manner such that if the starting asset portfolio were revised to include the additional invested assets, the projection would not be expected to experience any positive accumulated deficiencies at the end of any projection year.

It is assumed that the accumulated deficiencies for this scenario projection are known.

b. To determine the NAER on additional invested assets for a given scenario:

i. Project the additional invested asset portfolio as of the valuation date to the end of the projection period,

   a) Investing any cash in the portfolio and reinvesting all investment proceeds using the company's investment policy.

   b) Excluding any liability cash flows.

   c) Incorporating the appropriate returns, defaults and investment expenses for the given scenario.

ii. If the value of the projected additional invested asset portfolio does not equal or exceed the accumulated deficiencies at the end of each projection year for the scenario, increase the size of the initial additional invested asset portfolio as of the valuation date, and repeat the preceding step.

   iii. Determine a vector of annual earned rates that replicates the growth in the additional invested asset portfolio from the valuation date to the end of the projection period for the scenario. This vector will be the NAER for the given scenario.

   iii-iv. If the depletion of assets within the projection results in an unreasonably high negative NAER upon borrowing, the NAER may be set to the assumed cost of borrowing associated with each projected time period, in accordance with Section 4.D.3.c, as a safe harbor.
Guidance Note: There are multiple ways to select the additional invested asset portfolio at the valuation date. Similarly, there are multiple ways to determine the earned rate vector. The company shall be consistent in its choice of methods, from one valuation to the next.

4. Direct Iteration In lieu of the method described in Section 4.B.2 and Section 4.B.3 above, the company may solve for the amount of starting assets which, when projected along with all contract cash flows, result in the defeasement of all projected future benefits and expenses at the end of the projection horizon with no accumulated deficiencies at the end of any projection year during the projection period.

C. Projection Scenarios

1. Number of Scenarios

The number of scenarios for which the scenario reserve shall be computed shall be the responsibility of the company, and it shall be considered to be sufficient if any resulting understatement in the stochastic reserve, as compared with that resulting from running additional scenarios, is not material.

2. Economic Scenario Generation

Treasury Department interest rate curves, as well as investment return paths for general account equity index funds, equities, and fixed income assets and separate account fund performance shall be determined on a stochastic basis using the methodology described in Section 8. If the company uses a proprietary generator to develop scenarios, the company shall demonstrate that the resulting scenarios meet the requirements described in Section 8.

D. Projection of Assets

1. Starting Asset Amount

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

i. All of the separate account assets supporting the contracts;

ii. Any hedge instruments held in support of the contracts being valued; and

iii. An amount of assets held in the general account equal to the approximate value of statutory reserves as of the start of the projections less the amount in (i) and (ii).

Guidance Note: Deferred hedge gains/losses developed under SSAP No. 108—Derivatives Hedging Variable Annuity Guarantees are not included in the starting assets.
b. If the amount of initial general account assets is negative, the model should reflect a projected interest expense. General account assets chosen for use as described above shall be selected on a consistent basis from one reserve valuation hereunder to the next.

To the extent that the sum of the value of hedge assets, or cash, or other general account assets in an amount equal to the aggregate market value of such hedge assets, and the value of separate account assets supporting the contracts is greater than the approximate value of statutory reserves as of the start of the projections, then the company shall include enough negative general account assets or cash such that the starting asset amount equals the approximate value of statutory reserves as of the start of the projections.

2. Valuation of Projected Assets

For purposes of determining the projected accumulated deficiencies, the value of projected assets shall be determined in a manner consistent with their value at the start of the projection. For assets assumed to be purchased during a projection, the value shall be determined in a manner consistent with the value of assets at the start of the projection that have similar investment characteristics. However, for derivative instruments that are used in hedging and are not assumed to be sold during a particular projection interval, the company may account for them at an amortized cost in an appropriate manner elected by the company.

Guidance Note: Accounting for hedge assets should recognize any methodology prescribed by a company’s state of domicile.

3. Separate Account Assets

For purposes of determining the starting asset amounts in Section 4.D.1 and the valuation of projected assets in Section 4.D.2, assets held in a separate account shall be summarized into asset categories determined by the company as discussed in Section 4.A.2.

4.3. General Account Assets

a. General account assets shall be projected, net of projected defaults, using assumed investment returns consistent with their book value and expected to be realized in future periods as of the date of valuation. Initial assets that mature during the projection and positive cash flows projected for future periods shall be invested in a manner that is representative of and consistent with the company’s investment policy, subject to the following requirements:

i. The final maturities and cash flow structures of assets purchased in the model, such as the patterns of gross investment income and principal repayments or a fixed or floating rate interest basis, shall be determined by the company as part of the model representation;

ii. The combination of price and structure for fixed income investments and derivative instruments associated with fixed income investments shall
appropriately reflect the projected Treasury Department curve along the
relevant scenario and the requirements for gross asset spread assumptions
stated below;

iii. For purchases of public non-callable corporate bonds, follow the
requirements defined in VM-20 Sections 7.E, 7.F and 9.F. The prescribed
spreads reflect current market conditions as of the model start date and
grade to long-term conditions based on historical data at the start of
projection year four;

iv. For transactions of derivative instruments associated with fixed income
investments, reflect the prescribed assumptions in VM-20 Section 9.F for
interest rate swap spreads;

v. For purchases of other fixed income investments, if included in the model
investment strategy, set assumed gross asset spreads over U.S. Treasuries
in a manner that is consistent with, and results in reasonable relationships
to, the prescribed spreads for public non-callable corporate bonds and
interest rate swaps.

b. Notwithstanding the above requirements, the model investment strategy and any
non-prescribed asset spreads shall be adjusted as necessary so that the aggregate
reserve is not less than that which would be obtained by substituting an alternative
investment strategy in which all fixed income reinvestment assets are public non-
callable corporate bonds with gross asset spreads, asset default costs, and
investment expenses by projection year that are consistent with a credit quality
blend of:

i. 5% Treasury

ii. 150% PBR credit rating 3 (Aa2/AA)

iii. 40% 6 (A2/A) and 50% PBR credit rating 63 (Aa2/AA)

iv. 40% PBR credit rating 9 (Baa/BBB)

Policy loans, equities and derivative instruments associated with the execution of
a clearly defined hedging strategy are not affected by this requirement.

Drafting Note: This limitation is being referred to Life Actuarial (A) Task Force for review.

b-c. Any disinvestment shall be modeled in a manner that is consistent with the
company’s investment policy and that reflects the company’s cost of borrowing
where applicable, provided that the assumed cost of borrowing is not lower than
the rate at which positive cash flows are reinvested in the same time period, taking
into account duration, ratings, and other attributes of the borrowing mechanism.
Gross asset spreads used in computing market values of assets sold in the model
shall be consistent with, but not necessarily the same as, the gross asset spreads in
Section 4.D.4.a.iii and Section 4.D.4.a.iv, recognizing that initial assets that mature
during the projection may have different characteristics than modeled reinvestment assets.

**Guidance Note:** This limitation is being referred to Life Actuarial (A) Task Force for review. The simple language above “provided that the assumed cost of borrowing is not lower than the rate at which positive cash flows are reinvested in the same time period” is not intended to impose a literal requirement. It is intended to reflect a general concept to prevent excessively optimistic borrowing assumptions. It is recognized that borrowing parameters and rules can be complicated, such that modeling limitations may not allow for literal compliance, in every time step, as long as the reserve is not materially affected. However, if the company is unable to fully apply this restriction, prudence dictates that a company shall not allow borrowing assumptions to materially reduce the reserve.

§-A.5  Cash Flows from Invested Assets

a. Cash flows from general account fixed income assets, including starting and reinvestment assets, shall be reflected in the projection as follows:

i. Model gross investment income and principal repayments in accordance with the contractual provisions of each asset and in a manner consistent with each scenario.

ii. Reflect asset default costs as prescribed in VM-20 Section 9.F and anticipated investment expenses through deductions to the gross investment income.

iii. Model the proceeds arising from modeled asset sales and determine the portion representing any realized capital gains and losses.

iv. Reflect any uncertainty in the timing and amounts of asset cash flows related to the paths of interest rates, equity returns or other economic values directly in the projection of asset cash flows. Asset defaults are not subject to this requirement, since asset default assumptions must be determined by the prescribed method in VM-20 Sections 7.E, 7.F and 9.F.

b. Cash flows from general account index funds and equity assets—i.e., non-fixed income assets having substantial volatility of returns, such as common stocks and real estate— including starting and reinvestment assets, shall be reflected in the projection as follows:

i. Determine the grouping for asset categories and the allocation of specific assets to each category in a manner that is consistent with that used for separate account assets index crediting strategies, as discussed in Section 4.A.2.

ii. Project the gross investment return including realized and unrealized capital gains in a manner that is consistent with the stochastically generated scenarios.
Model the timing of an asset sale in a manner that is consistent with the investment policy of the company for that type of asset. Reflect expenses through a deduction to the gross investment return using prudent estimate assumptions.

c. Cash flows for each projection interval for policy loan assets shall follow the requirements in Section 10.I.

E. Projection of Annuity Benefits (Including GMIBs and GMWBs)

1. Assumed Annuity Purchase Rates at Election

a. For payouts specified at issue (such as single premium immediate annuities, deferred income annuities, and certain structured settlements), such payout rates shall reflect the payout rate specified in the contract.

b. For purposes of projecting future elective annuitization benefits (including annuitizations stemming from the election of a GMIB) and withdrawal amounts from GMWBs, the projected annuitization purchase rates shall be determined assuming that market interest rates available at the time of election are the interest rates used to project general account assets, as determined in Section 4.D.4. In contrast, for payouts specified at issue, the payout rates modeled should be consistent with those specified in the contract.

2. Projected Election of GMIBs, GMWBs and Other Annuity Options

a. For contracts projected to elect future annuitization options (including annuitizations stemming from the election of a GMIB) or for projections of GMWB benefits once the account value has been depleted, the projections may assume one of the following at the company’s option:

   The contract is treated as if surrendered at an amount equal to the statutory reserve that would be required at such time for a fixed payout annuity benefit equivalent to the guaranteed benefit amount (e.g., GMIB or GMWB benefit payments)

   The contract is assumed to will stay in force, and the projected periodic payments are paid, and the associated maintenance expenses are incurred.

b. Where mortality improvement is used to project future annuitization purchase rates, as discussed in Section 4.E.1 above, mortality improvement also shall be reflected on a consistent basis in either the determination of the reserve in Section 4.E.2.a.i above or the projection of the periodic payments in Section 4.E.2.a.ii.

3. Projected Statutory Reserve for Payout Annuity Benefits

If the statutory reserve for payout annuity benefits referenced above in Section 4.E.2.a requires a parameter that is not determined in a formulaic fashion, the company must make a reasonable and supportable assumption regarding this parameter.
F. Frequency of Projection and Time Horizon

1. Use of an annual cash-flow frequency (“timestep”) is generally acceptable for benefits/features that are not sensitive to projection frequency. The lack of sensitivity to projection frequency should be validated by testing wherein the company should determine that the use of a more frequent—i.e., shorter—time step does not materially increase reserves. A more frequent time increment should always be used when the product features are sensitive to projection period frequency.

2. Care must be taken in simulating fee income and expenses when using an annual time step. For example, recognizing fee income at the end of each period after market movements, but prior to persistency decrements, would normally be an inappropriate assumption. It is also important that the frequency of the investment return model be linked appropriately to the projection horizon in the liability model. In particular, the horizon should be sufficiently long so as to capture the vast majority of costs (on a present value basis) from the scenarios.

**Guidance Note:** As a general guide, the forecast horizon should not be less than 20 years.

G. Compliance with ASOPs

When determining a stochastic reserve, the analysis shall conform to the ASOPs as promulgated from time to time by the ASB.

Under these requirements, an actuary will make various determinations, verifications and certifications. The company shall provide the actuary with the necessary information sufficient to permit the actuary to fulfill the responsibilities set forth in these requirements and responsibilities arising from each applicable ASOP.
Section 5: Reinsurance Ceded and Assumed

Drafting Note: All revisions shown in this section are in comparison to Section 5 in VM-21.

A. Treatment of Reinsurance Ceded in the Aggregate Reserve

1. Aggregate Reserve Pre- and Post-Reinsurance Ceded

As noted in Section 3.B, the aggregate reserve is determined both pre-reinsurance ceded and post-reinsurance ceded. Therefore, it is necessary to determine the components needed to determine the aggregate reserve—i.e., the additional standard projection amount, the stochastic reserve determined using projections, and/or the reserve amount valued using requirements in VM-A and VM-C determined using the Alternative Methodology, as applicable—on both bases. Sections 5.A.2 and through 5.A.34 discuss adjustments to inputs necessary to determine these components on both a post-reinsurance ceded and a pre-reinsurance ceded basis. Note that due allowance for reasonable approximations may be used where appropriate.

2. Stochastic Reserve

a. In order to determine the aggregate reserve post-reinsurance ceded, accumulated deficiencies, scenario reserves, and the resulting stochastic reserve shall be determined reflecting the effects of reinsurance treaties that meet the statutory requirements that would allow the treaty to be accounted for as reinsurance within statutory accounting. This involves including, where appropriate, all anticipated projected reinsurance premiums or other costs and all reinsurance recoveries, where the reinsurance cash flows reflect all the provisions in the reinsurance agreement, using prudent estimate assumptions both premiums and recoveries are determined by recognizing any limitations in the reinsurance treaties, such as caps on recoveries or floors on premiums.

i. All significant terms and provisions within reinsurance treaties shall be reflected. In addition, it shall be assumed that each party is knowledgeable about the treaty provisions and will exercise them to their advantage.

Guidance Note: Renegotiation of the treaty upon the expiration of an experience refund provision or at any other time shall not be assumed if such would be beneficial to the company and not beneficial to the counterparty. This is applicable to both the ceding party and assuming party within a reinsurance arrangement.

ii. If the company has knowledge that a counterparty is financially impaired, the company shall establish a margin for the risk of default by the counterparty. In the absence of knowledge that the counterparty is financially impaired, the company is not required to establish a margin for the risk of default by the counterparty.

i.iii. A company shall include the cash flows from a reinsurance agreement or amendment in calculating the aggregate reserve if such qualifies for credit in compliance with Appendix A-791 of the Accounting Practices and Procedures Manual. If a reinsurance agreement or amendment does not qualify for credit for reinsurance but treating the reinsurance agreement or amendment as if it did so qualify would result in a reduction to the company’s surplus, then the company shall increase the minimum reserve by the absolute value of such reductions in surplus.
b. In order to determine the stochastic reserve on a pre-reinsurance ceded basis, accumulated deficiencies, scenario reserves, and the resulting stochastic reserve shall be determined ignoring the effects of reinsurance ceded within the projections. Different approaches may be used to determine the starting assets on the ceded portion of the contracts, dependent upon the characteristics of a given treaty:

i. For a standard coinsurance treaty, where the assets supporting the ceded liabilities were transferred to the assuming reinsurer, one acceptable approach involves a projection based on using the same starting assets on the ceded portion of the policies that are similar to those supporting the retained portion of the ceded policies or supporting similar types of policies. Scaling up each asset supporting the retained portion of the contract is also an acceptable method amount as for the aggregate reserve post reinsurance ceded and by ignoring, where appropriate, all anticipated reinsurance premiums or other costs and all reinsurance recoveries in the projections.

Guidance Note: For standard pro rata insurance treaties (does not include experience refunds), where allocated expenses are similar to the renewal expense allowance, reflecting the quota share applied to the present value of future reinsurance cash flows pertaining to the reinsured block of business may be considered as a possible approach to determine the ceded reserves.

ii. Alternatively, a treaty may contain an identifiable portfolio of assets associated with the ceded liabilities. This could be the case for several forms of reinsurance: funds withheld coinsurance; modified coinsurance; coinsurance with a trust. To the extent these assets would be available to the cedant, an acceptable approach could involve modeling this portfolio of assets. To the extent that these assets were insufficient to defease the ceded liabilities, the modeling would partially default to the approach discussed for a standard coinsurance treaty. To the extent these assets exceeded what might be needed to defease the ceded liabilities (perhaps an over collateralization requirement in a trust), the inclusion of such assets shall be limited.

Guidance Note: Section 3.5.2 in ASOP No. 52, Principle-Based Reserves for Life Products under the NAIC Valuation Manual, provides possible methods for constructing a hypothetical pre-reinsurance asset portfolio, if necessary, for purposes of the pre-reinsurance reserve calculation.

c. An assuming company shall use assumptions to project cash flows to and from ceding companies that reflect the assuming company’s experience for the business segment to which the reinsured policies belong and reflect the terms of the reinsurance agreement.

3. Reserve Determined Upon Passing the Exclusion Test using the Alternative Methodology

If a company passes chooses to use the Alternative Methodology stochastic exclusion test and elects to use a methodology pursuant to applicable Sections VM-A and VM-C, as allowed in Section 3.E, it is important to note that the methodology produces reserves on a pre-reinsurance ceded basis. Therefore, where reinsurance is ceded, the Alternative Methodology reserve must be modified to reflect the reinsurance costs and reinsurance recoveries under the reinsurance treaties in the determination of the aggregate reserve post reinsurance ceded adjusted for any reinsurance ceded accordingly. In addition, the reserves valued under applicable Sections in VM-A and VM-C, the Alternative Methodology, unadjusted for reinsurance, shall be applied to the contracts falling under the scope of these requirements to determine the aggregate reserve prior to reinsurance.

It should be noted that the pre-reinsurance and post-reinsurance reserves may result in different outcomes for the exclusion test. In particular, it is possible that the pre-reinsurance reserves would pass the relevant exclusion test (and allow the use of VM-A and VM-C) while the post-reinsurance reserves might not.
4. **To Be Determined** Additional Standard Projection Amount

Where reinsurance is ceded, the additional standard projection amount shall be calculated as described in Section 6 to reflect the reinsurance costs and reinsurance recoveries under the reinsurance treaties. The additional standard projection amount shall also be calculated pre-reinsurance ceded using the methods described in Section 6 but ignoring the effects of the reinsurance ceded.
Section 7: Exclusion Testing

Drafting Note: All revisions shown in this section are in comparison to Section 6 in VM-20.

A. Stochastic Exclusion Test Requirement Overview

1. Requirements to pass the Stochastic Exclusion Test:

   a. If the company does not elect to calculate the SET for one or more groups of contracts, or the company calculates the SET and fails the test for such groups of contracts, the reserve methodology described in Section 4 shall be used for calculating the aggregate reserve for those groups of contracts.

   b. If the company elects to calculate the SET for one or more groups of contracts, and passes the test for such groups of contracts, then the company shall choose whether or not to use the reserve methodology described in Section 4 for those groups of contracts. If the reserve methodology described in Section 4 is not used for one or more groups of contracts, then the company shall use the reserve methodology pursuant to applicable requirements in VM-A and VM-C to calculate the aggregate reserve for those groups of contracts.

   c. A company may not exclude a group of contracts from the stochastic reserve requirements if there are one or more future hedging programs associated with the contracts, with the exception of hedging programs solely supporting index credits as described in Section 9.A.1.

B. Types of Stochastic Exclusion Tests

Groups of contracts pass the SET if one of the following is met:

1. Stochastic Exclusion Ratio Test (SERT) — Annually and within 12 months before the valuation date the company demonstrates that the groups of contracts policies pass the SERT defined in Section 7.C6.A.2.

2. Stochastic Exclusion Demonstration Test — In the first year and at least once every three calendar years thereafter, the company provides a demonstration in the PBR Actuarial Report as specified in Section 7.D6.A.3.

3. SET Certification Method — For groups of contracts policies other than variable life that do not have guaranteed living benefits, future hedging programs, or ULSG pension risk transfer business in the first year and at least every third calendar year thereafter, the company provides a certification by a qualified actuary that the group of contracts policies is not subject to material aggregate risk levels across interest rate risk, longevity risk, or asset return volatility risk (i.e., the risk on non-fixed-income investments having substantial volatility of returns, such as common stocks and real estate investments). The company shall provide the certification and documentation supporting the certification to the commissioner upon request.

Guidance Note: The qualified actuary should develop documentation to support the actuarial certification that presents his or her analysis clearly and in detail sufficient for another actuary to...
understand the analysis and reasons for the actuary’s conclusion that the group of policies is not subject to material interest rate risk, longevity risk, or asset return volatility risk. Examples of methods a qualified actuary could use to support the actuarial certification include, but are not limited to:

a) A demonstration that the requirements under VM-A and VM-C for the group of policies calculated according to Section 3 are at least as great as the assets required to support the group of policies using the company’s cash-flow testing model under each of the 16 scenarios identified in Section 6 or alternatively each of the New York seven scenarios.

b) A demonstration that the group of policies passed the SERT within 36 months prior to the valuation date and the company has not had a material change in its interest rate risk.

c) A qualitative risk assessment of the group of policies that concludes that the group of policies does not have material interest rate risk or asset return volatility. Such assessment would include an analysis of product guarantees, the company’s non-guaranteed elements (NGEs) policy, assets backing the group of policies and the company’s investment strategy.

C. Stochastic Exclusion Ratio Test

1. In order to exclude a group of policies from the stochastic reserve requirements using the method allowed under Section 6.A.1.a, the stochastic exclusion ratio test (SERT), a company shall demonstrate that the ratio of (b-a)/ca is less than 6% where:

   a. a = the adjusted deterministic scenario reserve described in Section 6.A.2.b.ii below using economic scenario 9, the baseline economic scenario, as described in Appendix 1.E of VM-20.

   b. b = the largest adjusted scenario reserve described in Section 6.A.2.b.ii Paragraph C.2.b below under any of the other 15 economic scenarios described in Appendix 1.E of VM-20 under both [95]% and [105]% of anticipated experience mortality excluding margins.

   iii. c = an amount calculated from the baseline economic scenario described in Appendix 1.E that represents the present value of benefits for the policies, adjusted for reinsurance by subtracting ceded benefits. For clarity, premium, ceded premium, expense, reinsurance expense allowance, modified coinsurance reserve adjustment and reinsurance experience refund cash flows shall not be considered “benefits,” but items such as death benefits, surrender or withdrawal benefits and policyholder dividends shall be. For this purpose, the company shall use the benefits cash flows from the calculation of quantity “a” and calculate the present value of those cash flows using the same path of discount rates as used for “a.”

Guidance Note: Note that the numerator should be the largest adjusted DR scenario reserve for scenarios other than the baseline economic scenario, minus the adjusted DR scenario reserve for
the baseline economic scenario. This is not necessarily the same as the biggest difference from the adjusted DR scenario reserve for the baseline economic scenario, or the absolute value of the biggest difference from the adjusted DR scenario reserve for the baseline economic scenario, both of which could lead to an incorrect test result.

2. In calculating the ratio in Section 6.A.2. subsection (1) above:

   a. The company shall calculate an adjusted deterministic scenario reserve for the group of contracts for each of the 16 scenarios that is equal to either (ai) or (bii) below:

   i. The deterministic scenario reserve defined in Section 4.A, but with the following differences:

      a) Using anticipated experience assumptions with no margins, with the exception of mortality factors described in Paragraph C.1.b of this section.

      b) Using the interest rates and equity return assumptions specific to each scenario.

      c) Using NAER and discount rates defined in Section 7.H4 specific to each scenario to discount the cash flows.

      d) Shall reflect future mortality improvement in line with anticipated experience assumptions.

      e) Shall not reflect correlation between longevity and economic risks.

   ii. The gross premium reserve developed from the cash flows from the company’s asset adequacy analysis models, using the experience assumptions of the company’s cash-flow analysis, but with the following differences:

      a) Using the interest rates and equity return assumptions specific to each scenario.

      b) Using the mortality scalars described in Paragraph C.1.b of this section.

      c) Using the methodology to determine NAER and discount rates defined in Section 7.H4 specific to each scenario to discount the cash flows, but using the company’s cash-flow testing assumptions for default costs and reinvestment earnings.

   b. The company shall use the most current available baseline economic scenario and the 16 economic scenarios published by the NAIC. The methodology for creating these scenarios can be found in Appendix 1 of VM-20.

   c. The company shall use assumptions within each scenario that are dynamically adjusted as appropriate for consistency with each tested scenario.

   d. The company may not group together contract types with significantly different risk profiles for purposes of calculating this ratio.
e. Mortality improvement beyond the projection start date may not be reflected in the mortality assumption for the purpose of calculating the stochastic exclusion ratio.

e. If the company has reinsurance arrangements that are pro rata coinsurance and do not materially impact the interest rate risk, longevity risk, or asset return volatility in the contract, then the company may elect to not conduct the exclusion test under a pre-reinsurance-ceded basis upon determining the pre-reinsurance reserve-ceded aggregate reserve.

3. If the ratio calculated in Section 6.A.2.a above is less than 6% pre-YRT non-proportional reinsurance, but is greater than 6% post-YRT non-proportional reinsurance, the group of contracts/policies will still pass the SERT if the company can demonstrate that the sensitivity of the adjusted deterministic scenario reserve to economic scenarios is comparable pre- and post-YRT non-proportional reinsurance.

a. An example of an acceptable demonstration:

i. For convenience in notation • SERT = the ratio \((b-a)/a\) defined in Section 7.C.1(a) above

a) The pre-YRT non-proportional reinsurance results are “gross of YRT non-proportional,” with a subscript “\(\text{gy}\),” so denoted \(SERT_{\text{gy}}\).

b) The post-YRT non-proportional results are “net of YRT non-proportional,” with subscript “\(\text{ny}\),” so denoted \(SERT_{\text{ny}}\).

ii. If a block of business being tested is subject to one or more YRT non-proportional reinsurance cessions as well as other forms of reinsurance, such as pro rata coinsurance, take “gross of YRT non-proportional” to mean net of all non-YRT pro rata reinsurance but ignoring the YRT non-proportional contract(s), and “net of YRT non-proportional” to mean net of all reinsurance contracts. That is, treat YRT non-proportional reinsurance as the last reinsurance in, and compute certain values below with and without that last component.

iii. So, if \(SERT_{\text{gy}} < 0.060, SERT_{\text{gn}} < [x]\) but \(SERT_{\text{ny}} > 0.060, SERT_{\text{nn}} > [x]\), then compute the largest percent increase in reserve \(\text{LPIR} = (b-a)/a\), both “gross of YRT non-proportional” and “net of YRT non-proportional.”

\[
\text{LPIR}_{\text{gy}} = \frac{(b_{\text{gy}} - a_{\text{gy}}) / a_{\text{gy}}}{a_{\text{gy}}} \\
\text{LPIR}_{\text{ny}} = \frac{(b_{\text{ny}} - a_{\text{ny}}) / a_{\text{ny}}}{a_{\text{ny}}}
\]

Note that the scenario underlying \(b_{\text{gy}}\) could be different from the scenario underlying \(b_{\text{gy}}\).

If \(SERT_{\text{gy}} \times \text{LPIR}_{\text{gy}} / \text{LPIR}_{\text{ny}} < 0.060, SERT_{\text{gn}} \times \text{LPIR}_{\text{gn}} / \text{LPIR}_{\text{nn}} < [x]\), then the block of contracts/policies passes the SERT.
b. Another more qualitative approach is to calculate the adjusted deterministic scenario reserves for the 16 scenarios both gross and net of reinsurance to demonstrate that there is a similar pattern of sensitivity by scenario.

4. The SERT may not be used for a group of contracts if, using the current year’s data, (i) the stochastic exclusion demonstration test defined in Section 7.D had already been attempted using the method of Section 6.A.3.b.i or Section 6.A.3.b.ii in this section and did not pass; or (ii) the qualified actuary had actively undertaken to perform the certification method of Section 6.A.1.a.iii in this section and concluded that such certification could not legitimately be made.

D. Stochastic Exclusion Demonstration Test

1. In order to exclude a group of contracts from the stochastic reserve requirements using the methodology as allowed under Section 6.A.1.a.ii above in this section, the company must provide a demonstration in the PBR Actuarial Report in the first year and at least once every three calendar years thereafter that complies with the following:

a. The demonstration shall provide a reasonable assurance that if the stochastic reserve was calculated on a stand-alone basis for the group of contracts subject to the stochastic reserve exclusion, the resulting stochastic minimum reserve for those groups of policies contracts would not be higher than the statutory reserve determined pursuant to the applicable requirements in VM-A and VM-C increase. The demonstration shall take into account whether changing conditions over the current and two subsequent calendar years would be likely to change the conclusion to exclude the group of policies contracts from the stochastic reserve requirements.

b. If, as of the end of any calendar year, the company determines the minimum aggregate reserve for the group of policies contracts no longer adequately provides for all material risks, the exclusion shall be discontinued, and the company fails the SERT for those policies contracts.

c. The demonstration may be based on analysis from a date that precedes the valuation date for the initial year to which it applies if the demonstration includes an explanation of why the use of such a date will not produce a material change in the outcome, as compared to results based on an analysis as of the valuation date.

d. The demonstration shall provide an effective evaluation of the residual risk exposure remaining after risk mitigation techniques, such as derivative programs and reinsurance.

2. The company may use one of the following or another method acceptable to the insurance commissioner to demonstrate compliance with Section 6.A.3.a subsection 7.D.1 above:

a. Demonstrate that the statutory reserve calculated in accordance with VM-A and VM-C greater of [the quantity A and the quantity B] is greater than the stochastic reserve calculated on a stand-alone basis, where:
A = the deterministic reserve, and

B = the NPR less any associated due and deferred premium asset.

bii. Demonstrate that the statutory reserve calculated in accordance with VM-A and VM-

\[ \text{greater of \{the quantity } A \text{ and the quantity } B \} \] is greater than the scenario reserve

that results from each of a sufficient number of adverse deterministic scenarios, where:

A = the deterministic reserve, and

B = the NPR less any associated due and deferred premium asset.

c. Demonstrate that the statutory reserve calculated in accordance with VM-A and VM-

\[ \text{greater of \{the quantity } A \text{ and the quantity } B \} \] is greater than the stochastic reserve

calculated on a stand-alone basis, but using a representative sample of

contracts/policies in the stochastic reserve calculations, where:

A = the deterministic reserve, and

B = the NPR less any associated due and deferred premium asset.

d. Demonstrate that any risk characteristics that would otherwise cause the stochastic

reserve calculated on a stand-alone basis to exceed greater of the deterministic

reserve and the NPR, less any associated due and deferred premium asset the statutory

reserve calculated in accordance with VM-A and VM-C, are not present or have been

substantially eliminated through actions such as hedging, investment strategy,

reinsurance or passing the risk on to the policyholder by contract provision.

E. Deterministic Certification Option

1. The company has the option to determine the stochastic reserve for a group of

contracts using a single deterministic economic scenario, subject to the following

conditions.

a. The company certifies that economic conditions do not materially influence

anticipated contract holder behavior for the group of policies. Examples of

contract holder options that are materially influenced by economic conditions

include surrender benefits, recurring premium payments, and guaranteed living

benefits.

b. The company certifies that the group of policies is not supported by a

reinvestment strategy that contains future hedge purchases.

c. The company must perform and disclose results from the stochastic exclusion

ratio test following the requirements in Section 7.C, thereby disclosing the

scenario reserve volatility across various economic scenarios.

d. The company must disclose a description of contracts and associated features in

the certification.
2. The stochastic reserve for the group of contracts under the Deterministic Certification Option is determined as follows:

   a. Cash flows are projected in compliance with the applicable requirements in Section 4, Section 5, Section 10, and Section 11 of VM-22 over a single economic scenario (scenario 12 found in Appendix 1 of VM-20).

   b. The stochastic reserve equals the scenario reserve following the requirements for Section 4.

Guidance Note: The Deterministic Certification Option is intended to provide a non-stochastic option for Single Premium Immediate Annuities (SPIAs) and similar payout annuity products that contain limited or no optionality in the asset and liability cash flow projections.
Section 9: Modeling Hedges under a Future Hedging Strategy

Drafting Note: All revisions shown in this section are in comparison to Section 9 in VM-21.

A. Initial Considerations

1. This section applies to modeling of hedges other than situations where the company (a) only hedges index credits, or (b) clearly separates index credit hedging from other hedging. In those situations, the modeling of hedges supporting index credits can be simplified including applying an index credit hedge margin, following the requirements in Section 4.A.4.b.i.

2. Subject to Section 9.C.2., the appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the calculation of the stochastic reserve, determined in accordance with Section 3.D and Section 4.D.

3. If the company is following a CDHS, in accordance with an investment policy adopted by the board of directors, or a committee of board members, the company shall take into account the costs and benefits of hedge positions expected to be held by the company in the future along each scenario based on the execution of the hedging strategy, and it is eligible to reduce the amount of the stochastic reserve using projections otherwise calculated. The investment policy must clearly articulate the company’s hedging objectives, including the metrics that drive rebalancing/trading. This specification could include maximum tolerable values for investment losses, earnings, volatility, exposure, etc. in either absolute or relative terms over one or more investment horizons vis-à-vis the chance of occurrence. Company management is responsible for developing, documenting, executing and evaluating the investment strategy for future hedge purchases. Prior to reflection in projections, the strategy for future hedge purposes shall be the actual practice of the company for a period of time not less than [6] months. including the hedging strategy, used to implement the investment policy.

4. For this purpose, the investment assets refer to all the assets, including derivatives supporting covered products and guarantees. This also is referred to as the investment portfolio. The investment strategy is the set of all asset holdings at all points in time in all scenarios. The hedging portfolio, which also is referred to as the hedging assets, is a subset of the investment assets. The hedging strategy is the hedging asset holdings at all points in time in all scenarios. There is no attempt to distinguish what is the hedging portfolio and what is the investment portfolio in this section. Nor is the distinction between investment strategy and hedging strategy formally made here. Where necessary to give effect to the intent of this section, the requirements applicable to the hedging portfolio or the hedging strategy are to apply to the overall investment portfolio and investment strategy.

5. This particularly applies to restrictions on the reasonableness or acceptability of the models that make up the stochastic cash-flow model used to perform the projections, since these restrictions are inherently restrictions on the joint modeling of the hedging and non-hedging portfolio. To give effect to these requirements, they must apply to the overall investment strategy and investment portfolio. Before either a new or revised hedging strategy can be used to reduce the amount of the stochastic reserve otherwise calculated, the hedging strategy should be in place (i.e., effectively implemented by the company) for at least three months. The company may meet the time requirement by having evaluated...
the effective implementation of the hedging strategy for at least three months without actually having executed the trades indicated by the hedging strategy (e.g., mock testing or by having effectively implemented the strategy with similar annuity products for at least three months).

B. Modeling Approaches

1. The analysis of the impact of the hedging strategy on cash flows is typically performed using either one of two types of methods as described below. Although a hedging strategy normally would be expected to reduce risk provisions, the nature of the hedging strategy and the costs to implement the strategy may result in an increase in the amount of the stochastic reserve otherwise calculated.

2. The fundamental characteristic of the first type of method, referred to as the “explicit method,” is that hedging positions and their resulting cash flows are included in the stochastic cash-flow model used to determine the scenario reserve, as discussed in Section 3.D, for each scenario.

3. The fundamental characteristic of the second type of method, referred to as the “implicit method,” is that the effectiveness of the current hedging strategy on future cash flows is evaluated, in part or in whole, outside of the stochastic cash-flow model. There are multiple ways that this type of modeling can be implemented. In this case, the reduction to the stochastic reserve otherwise calculated should be commensurate with the degree of effectiveness of the hedging strategy in reducing accumulated deficiencies otherwise calculated.

4. Regardless of the methodology used by the company, the ultimate effect of the current hedging strategy (including currently held hedge positions) on the stochastic reserve needs to recognize all risks, associated costs, imperfections in the hedges and hedging mismatch tolerances associated with the hedging strategy. The risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, annuitization, etc.). Costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. In addition, the reduction to the stochastic reserve attributable to the hedging strategy may need to be limited due to the uncertainty associated with the company’s ability to implement the hedging strategy in a timely and effective manner. The level of operational uncertainty varies indirectly with the amount of time that the new or revised strategy has been in effect or mock tested.

Guidance Note: No hedging strategy is perfect. A given hedging strategy may eliminate or reduce some but not all risks, transform some risks into others, introduce new risks, or have other imperfections. For example, a delta-only hedging strategy does not adequately hedge the risks measured by the “Greeks” other than delta. Another example is that financial indices underlying typical hedging instruments typically do not perform exactly like the separate account funds, and hence the use of hedging instruments has the potential for introducing basis risk.

5. A safe harbor approach is permitted for CDHS reflection for those companies whose modeled hedge assets comprise only linear instruments not sensitive to implied volatility. For companies with option-based hedge strategies, electing this approach would require representing the option-based portion of the strategy as a delta-rho two-Greek hedge program. The normally modeled option portfolio would be replaced with a set of linear instruments that have the same first-order Greeks as the original option portfolio.
C. Calculation of Stochastic Reserve (Reported)

1. The company shall calculate CTE70 (best efforts)—the results obtained when the CTE70 is based on incorporating the CDHS modeling of hedges (including both currently held and future hedge positions) into the stochastic cash-flow model on a best efforts basis, including all of the factors and assumptions needed to execute the CDHS model the hedges (e.g., stochastic implied volatility). The determination of CTE70 (best efforts) may utilize either explicit or implicit modeling techniques.

2. The company shall calculate a CTE70 (adjusted) by recalculating the CTE70 assuming the company has no CDHS hedging strategy except those to hedge interest credits and hedge assets held by the company on the valuation date, therefore following the requirements of Section 4.A.4.a and 4.A.4.b.i.

3. Because most models will include at least some approximations or idealistic assumptions, CTE70 (best efforts) may overstate the impact of the hedging strategy. To compensate for potential overstatement of the impact of the hedging strategy, the value for the stochastic reserve is given by:

\[
\text{Stochastic reserve} = \text{CTE70 (best efforts)} + E \times \max[0, \text{CTE70 (adjusted)} - \text{CTE70 (best efforts)}]
\]

4. The company shall specify a value for \(E\) (the “error factor”) in the range from 5% to 100% to reflect the company’s view of the potential error resulting from the level of sophistication of the stochastic cash-flow model and its ability to properly reflect the parameters of the hedging strategy (i.e., the Greeks being covered by the strategy), as well as the associated costs, risks and benefits. The greater the ability of the stochastic model to capture all risks and uncertainties, the lower the value of \(E\). The value of \(E\) may be as low as 5% only if the model used to determine the CTE70 (best efforts) effectively reflects all of the parameters used in the hedging strategy. If certain economic risks are not hedged, yet the model does not generate scenarios that sufficiently capture those risks, \(E\) must be in the higher end of the range, reflecting the greater likelihood of error. Likewise, simplistic hedge cash-flow models shall assume a higher likelihood of error.

5. The company shall conduct a formal back-test, based on an analysis of at least the most recent 12 months, to assess how well the model is able to replicate the hedging strategy in a way that supports the determination of the value used for \(E\).

6. Such a back-test shall involve one of the following analyses:

a. For companies that model hedge cash flows directly (“explicit method”), replace the stochastic scenarios used in calculating the CTE70 (best efforts) with a single scenario that represents the market path that actually manifested over the selected back-testing period and compare the projected hedge asset gains and losses against the actual hedge asset gains and losses—both realized and unrealized—observed over the same time period. For this calculation, the model assumptions may be replaced with parameters that reflect actual experience during the back-testing period. In order to isolate the comparison between the modeled hedge results and actual hedge results for this calculation, the projected liabilities should accurately reflect the actual liabilities throughout the back-testing period; therefore, adjustments that facilitate this accuracy (e.g. reflecting actual experience instead of model assumptions, including new business, etc.) are permissible.
To support the choice of a low value of $E$, the company should ascertain that the projected hedge asset gains and losses are within close range of 100% (e.g., 80–125%) of the actual hedge asset gains and losses. The company may also support the choice of a low value of $E$ by achieving a high R-squared (e.g., 0.80 or higher) when using a regression analysis technique.

b. For companies that model hedge cash flows implicitly by quantifying the cost and benefit of hedging using the fair value of the hedged item (an “implicit method” or “cost of reinsurance method”), calculate the delta, rho and vega coverage ratios in each month over the selected back-testing period in the following manner:

i. Determine the hedge asset gains and losses—both realized and unrealized—incurred over the month attributable to equity, interest rate, and implied volatility movements.

ii. Determine the change in the fair value of the hedged item over the month attributable to equity, interest rate, and implied volatility movements. The hedged item should be defined in a manner that reflects the proportion of risks hedged (e.g., if a company elects to hedge 50% of a contract’s market risks, it should quantify the fair value of the hedged item as 50% of the fair value of the contract).

iii. Calculate the delta coverage ratio as the ratio between (i) and (ii) attributable to equity movements.

iv. Calculate the rho coverage ratio as the ratio between (i) and (ii) attributable to interest rate movements.

v. Calculate the vega coverage ratio as the ratio between (i) and (ii) attributable to implied volatility movements.

vi. To support the company’s choice of a low value of $E$, the company should be able to demonstrate that the delta and rho coverage ratios are both within close range of 100% (e.g., 80–125%) consistently across the back-testing period.

vii. In addition, the company should be able to demonstrate that the vega coverage ratio is within close range of 100% in order to use the prevailing implied volatility levels as of the valuation date in quantifying the fair value of the hedged item for the purpose of calculating CTE70 (best efforts). Otherwise, the company shall quantify the fair value of the hedged item for the purpose of calculating CTE70 (best efforts) in a manner consistent with the realized volatility of the scenarios captured in the CTE (best efforts).

c. Companies that do not model hedge cash flows explicitly, but that also do not use the implicit method as outlined in Section 9.C.6.b above, shall conduct the formal back-test in a manner that allows the company to clearly illustrate the appropriateness of the selected method for reflecting the cost and benefit of hedging, as well as the value used for $E$.

7. A company that does not have 12 months of experience to date shall set $E$ to a value that reflects the amount of experience available, and the degree and nature of any change to the hedge program. For a material change in strategy, with no history, $E$ should be at least 0.50.
However, E may be lower than 0.50 if some reliable experience is available and/or if the change in strategy is a refinement rather than a substantial change in strategy.

**Guidance Note:** The following examples are provided as guidance for determining the E factor when there has been a change to the hedge program:

- The error factor should be temporarily large (e.g., ≥ 50%) for substantial changes in hedge methodology (e.g., moving from a fair-value based strategy to a stop-loss strategy) where the company has not been able to provide a meaningful simulation of hedge performance based on the new strategy.
- A temporary moderate increase (e.g., 15–30%) in error factor should be used for substantial modifications to hedge programs or CDHS modeling where meaningful simulation has not been created (e.g., adding second-order hedging, such as gamma or rate convexity).
- No increase in the error factor may be used for incremental modifications to the hedge strategy (e.g., adding death benefits to a program that previously covered only living benefits, or moving from swaps to Treasury Department futures).

**E. Additional Considerations for CTE70 (best efforts)**

If the company is following a CDHS, the fair value of the portfolio of contracts falling within the scope of these requirements shall be computed and compared to the CTE70 (best efforts) and CTE70 (adjusted). If the CTE70 (best efforts) is below both the fair value and CTE70 (adjusted), the company should be prepared to explain why that result is reasonable.

For the purposes of this analysis, the stochastic reserve and fair value calculations shall be done without requiring the scenario reserve for any given scenario to be equal to or in excess of the cash surrender value in aggregate for the group of contracts modeled in the projection.

**D. Specific Considerations and Requirements**

1. As part of the process of choosing a methodology and assumptions for estimating the future effectiveness of the current hedging strategy (including currently held hedge positions) for purposes of reducing the stochastic reserve, the company should review actual historical hedging effectiveness. The company shall evaluate the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, the mix of business and other items that are likely to result in materially adverse results. This includes an analysis of model assumptions that, when combined with the reliance on the hedging strategy, are likely to result in adverse results relative to those modeled. The parameters and assumptions shall be adjusted (based on testing contingent on the strategy used and other assumptions) to levels that fully reflect the risk based on historical ranges and foreseeable future ranges of the assumptions and parameters. If this is not possible by parameter adjustment, the model shall be modified to reflect them at either anticipated experience or adverse estimates of the parameters.

2. A discontinuous hedging strategy is a hedging strategy where the relationships between the sensitivities to equity markets and interest rates (commonly referred to as the Greeks) associated with the guaranteed contract holder options embedded in the variable fixed indexed annuities and other in-scope products and these same sensitivities associated with the hedging assets are subject to material discontinuities. This includes, but is not limited
to, a hedging strategy where material hedging assets will be obtained when the variable fixed indexed annuity account balances reach a predetermined level in relationship to the guarantees. Any hedging strategy, including a delta hedging strategy, can be a discontinuous hedging strategy if implementation of the strategy permits material discontinuities between the sensitivities to equity markets and interest rates associated with the guaranteed contract holder options embedded in the variable fixed indexed annuities and other in-scope products and these same sensitivities associated with the hedging assets. There may be scenarios that are particularly costly to discontinuous hedging strategies, especially where those result in large discontinuous changes in sensitivities (Greeks) associated with the hedging assets. Where discontinuous hedging strategies contribute materially to a reduction in the stochastic reserve, the company must evaluate the interaction of future trigger definitions and the discontinuous hedging strategy, in addition to the items mentioned in the previous paragraph. This includes an analysis of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.

3. A strategy that has a strong dependence on acquiring hedging assets at specific times that depend on specific values of an index or other market indicators may not be implemented as precisely as planned.

4. The combination of elements of the stochastic cash-flow model—including the initial actual market asset prices, prices for trading at future dates, transaction costs and other assumptions—should be analyzed by the company as to whether the stochastic cash-flow model permits hedging strategies that make money in some scenarios without losing a reasonable amount in some other scenarios. This includes, but is not limited to:

   a. Hedging strategies with no initial investment that never lose money in any scenario and in some scenarios make money.

   b. Hedging strategies that, with a given amount of initial money, never make less than accumulation at the one-period risk-free rates in any scenario but make more than this in one or more scenarios.

5. If the stochastic cash-flow model allows for such situations, the company should be satisfied that the results do not materially rely directly or indirectly on the use of such strategies. If the results do materially rely directly or indirectly on the use of such strategies, the strategies may not be used to reduce the stochastic reserve otherwise calculated.

6. In addition to the above, the method used to determine prices of financial instruments for trading in scenarios should be compared to actual initial market prices. In addition to comparisons to initial market prices, there should be testing of the pricing models that are used to determine subsequent prices when scenarios involve trading financial instruments. This testing should consider historical relationships. For example, if a method is used where recent volatility in the scenario is one of the determinants of prices for trading in that scenario, then that model should approximate actual historic prices in similar circumstances in history.
Section 10: Guidance and Requirements for Setting Contract Holder Behavior Prudent Estimate Assumptions

Drafting Note: All revisions shown in this section are in comparison to Section 10 in VM-21.

A. General

Contract holder behavior assumptions encompass actions such as lapses, withdrawals, transfers, recurring deposits, benefit utilization, option election, etc. Contract holder behavior is difficult to predict accurately, and variance in behavior assumptions can significantly affect the results. In the absence of relevant and fully credible empirical data, the company should set behavior assumptions as guided by Principle 3 in Section 1.B.

In setting behavior assumptions, the company should examine, but not be limited by, the following considerations:

1. Behavior can vary by product, market, distribution channel, fund-index performance, interest credited (current and guaranteed rates), time/product duration, etc.
2. Options embedded in the product may affect behavior.
3. Utilization of options may be elective or non-elective in nature. Living benefits often are elective, and death benefit options are generally non-elective.
4. Elective contract holder options may be more driven by economic conditions than non-elective options.
5. As the value of a product option increases, there is an increased likelihood that contract holders will behave in a manner that maximizes their financial interest (e.g., lower lapses, higher benefit utilization, etc.).
6. Behavior formulas may have both rational and irrational components (irrational behavior is defined as situations where some contract holders may not always act in their best financial interest). The rational component should be dynamic, but the concept of rationality need not be interpreted in strict financial terms and might change over time in response to observed trends in contract holder behavior based on increased or decreased financial efficiency in exercising their contractual options.
7. Options that are ancillary to the primary product features may not be significant drivers of behavior. Whether an option is ancillary to the primary product features depends on many things, such as:
   a. For what purpose was the product purchased?
   b. Is the option elective or non-elective?
   c. Is the value of the option well-known?
8. External influences may affect behavior.

B. Aggregate vs. Individual Margins

1. Prudent estimate assumptions are developed by applying a margin for uncertainty to the anticipated experience assumption. The issue of whether the level of the margin applied to
the anticipated experience assumption is determined in aggregate or independently for each
and every behavior assumption is discussed in Principle 3 in Section 1.B.

2. Although this principle discusses the concept of determining the level of margins in
aggregate, it notes that the application of this concept shall be guided by evolving practice
and expanding knowledge. From a practical standpoint, it may not always be possible to
completely apply this concept to determine the level of margins in aggregate for all
behavior assumptions.

3. Therefore, the company shall determine prudent estimate assumptions independently for
each behavior (e.g., mortality, lapses and benefit utilization), using the requirements and
guidance in this section and throughout these requirements, unless the company can
demonstrate that an appropriate method was used to determine the level of margin in
aggregate for two or more behaviors.

C. Sensitivity Testing

The impact of behavior can vary by product, time period, etc. For any assumption that is not
prescribed or stochastically modeled, the qualified actuary to whom responsibility for this group of
contracts is assigned shall use sensitivity testing to ensure that the assumption is set at the
conservative end of the plausible range. The company shall sensitivity test:

- Surrenders.
- Partial withdrawals.
- Benefit utilization.
- Other behavior assumptions if relevant to the risks in the product.

Sensitivity testing of assumptions is required and shall be more complex than, for example, base
lapse assumption plus or minus 4X% across all contracts. A more appropriate sensitivity test in this
example might be to devise parameters in a dynamic lapse formula to reflect more out-of-the-
money contracts lapsing and/or more holders of in-the-money contracts persisting and eventually
using the guarantee. The company should apply more caution in setting assumptions for behaviors
where testing suggests that stochastic modeling results are sensitive to small changes in such
assumptions. For such sensitive behaviors, the company shall use higher margins when the
underlying experience is less than fully relevant and credible.

The company shall examine the results of sensitivity testing to understand the materiality of
prudent estimate assumptions on the modeled reserve. The company shall update the sensitivity
tests periodically as appropriate, considering the materiality of the results of the tests. The
company may update the tests less frequently when the tests show less sensitivity of the modeled
reserve to changes in the assumptions being tested or the experience is not changing rapidly.
Providing there is no material impact on the results of the sensitivity testing, the company may
perform sensitivity testing:

1. Using samples of the contracts in force rather than performing the entire valuation for
each alternative assumption set.

4-2. Using data from prior periods.
D. Specific Considerations and Requirements

1. Within materiality considerations, the company should consider all relevant forms of contract holder behavior and persistency, including, but not limited to, the following:
   a. Mortality (additional guidance and requirements regarding mortality is contained in Section 11).
   b. Surrenders.
   c. Partial withdrawals (systematic and elective).
   d. Fund Account transfers (switching/exchanges).
   e. Resets/ratchets of the guaranteed amounts (automatic and elective).
   f. Future deposits.
   g. Income start date
   h. Commutation of benefit (from periodic payment to lump sum)

2. It may be acceptable to ignore certain items that might otherwise be explicitly modeled in an ideal world, particularly if the inclusion of such items reduces the calculated provisions. For example:
   a. The impact of fund account transfers (intra-contract fund index “switching”) might be ignored, unless required under the terms of the contract (e.g., automatic asset re-allocation/rebalancing, dollar cost averaging accounts, etc.) or if the contract provisions incentivize the contract holders to transfer between accounts.
   b. Future deposits might be excluded from the model, unless required by the terms of the contracts under consideration and then only in such cases where future premiums can reasonably be anticipated (e.g., with respect to timing and amount).
   c. For some non-elective benefits (nursing home benefits for example), a zero incidence rate after the surrender charge has ended, or the cash value has depleted, may be acceptable since use of a non-zero rate could reduce the modeled reserve.

Guidance Note: For some non-elective benefits (nursing home benefits for example), unless relevant company experience exists to the contrary, the use of incidence rates greater than zero after the surrender charge has ended, or the cash value has depleted might be inappropriate may not be prudent since it would reduce the modeled reserve.

3. However, the company should exercise caution in assuming that current behavior will be indefinitely maintained. For example, it might be appropriate to test the impact of a shifting asset mix and/or consider future deposits to the extent they can reasonably be anticipated and increase the calculated amounts.
4. Normally, the underlying model assumptions would differ according to the attributes of the contract being valued. This would typically mean that contract holder behavior and persistency may be expected to vary according to such characteristics as (this is not an exhaustive list):

   a. Gender.
   b. Attained age.
   c. Issue age.
   d. Contract duration.
   e. Time to maturity.
   f. Tax status.
   g. Fund Account value.
   h. Interest credited (current and guaranteed).
   i. Investment option. Available indices.
   j. Guaranteed benefit amounts.
   k. Surrender charges, transaction transfer fees or other contract charges.
   l. Distribution channel.

5. Unless there is clear evidence to the contrary, behavior assumptions should be no less conservative than past experience. Margins for contract holder behavior assumptions shall assume, without relevant and credible experience or clear evidence to the contrary, that contract holders’ efficiency will increase over time.

6. In determining contract holder behavior assumptions, the company shall use actual experience data directly applicable to the business segment (i.e., direct data) if it is available. In the absence of direct data, the company should then look to use data from a segment that is similar to the business segment (i.e., other than direct experience), whether or not the segment is directly written by the company. If data from a similar business segment are used, the assumption shall be adjusted to reflect differences between the two segments. Margins shall reflect the data uncertainty associated with using data from a similar but not identical business segment.

7. Where relevant and fully credible empirical data do not exist for a given contract holder behavior assumption, the company shall set the contract holder behavior assumption to reflect the increased uncertainty such that the contract holder behavior assumption is shifted towards the conservative end of the plausible range of expected experience that serves to increase the stochastic reserve. If there are no relevant data, the company shall set the contract holder behavior assumption to reflect the increased uncertainty such that the contract holder behavior assumption is at the conservative end of the range. Such adjustments shall be consistent with the definition of prudent estimate, with the principles described in Section 1.B, and with the guidance and requirements in this section.

8. Ideally, contract holder behavior would be modeled dynamically according to the simulated economic environment and/or other conditions. It is important to note, however, that contract holder behavior should neither assume that all contract holders act with 100%
E. Dynamic Assumptions

1. Consistent with the concept of prudent estimate assumptions described earlier, the liability model should incorporate margins for uncertainty for all risk factors that are not dynamic (i.e., the non-scenario tested assumptions) and are assumed not to vary according to the financial interest of the contract holder.

2. The company should exercise care in using static assumptions when it would be more natural and reasonable to use a dynamic model or other scenario-dependent formulation for behavior. With due regard to considerations of materiality and practicality, the use of dynamic models is encouraged, but not mandatory. Risk factors that are not scenario tested but could reasonably be expected to vary according to a stochastic process, or future states of the world (especially in response to economic drivers) may require higher margins and/or signal a need for higher margins for certain other assumptions.

3. Risk factors that are modeled dynamically should encompass the plausible range of behavior consistent with the economic scenarios and other variables in the model, including the non-scenario tested assumptions. The company shall test the sensitivity of results to understand the materiality of making alternate assumptions and follow the guidance discussed above on setting assumptions for sensitive behaviors.

F. Consistency with the CTE Level

1. All behaviors (i.e., dynamic, formulaic and non-scenario tested) should be consistent with the scenarios used in the CTE calculations (generally, the top 30% of the loss distribution). To maintain such consistency, it is not necessary to iterate (i.e., successive runs of the model) in order to determine exactly which scenario results are included in the CTE measure. Rather, in light of the products being valued, the company should be mindful of the general characteristics of those scenarios likely to represent the tail of the loss distribution and consequently use prudent estimate assumptions for behavior that are reasonable and appropriate in such scenarios. For variable–fixed annuities, these “valuation” scenarios would typically display one or more of the following attributes:

   a. Declining and/or volatile separate account asset index values, where applicable.
   b. Market index volatility, price gaps and/or liquidity constraints.
   c. Rapidly changing interest rates or persistently low interest rates.
   d. Volatile credit spreads.

2. The behavior assumptions should be logical and consistent both individually and in aggregate, especially in the scenarios that govern the results. In other words, the company should not set behavior assumptions in isolation, but give due consideration to other elements of the model. The interdependence of assumptions (particularly those governing customer behaviors) makes this task difficult and by definition requires professional judgment, but it is important that the model risk factors and assumptions:

   a. Remain logically and internally consistent across the scenarios tested.
b. Represent plausible outcomes.

c. Lead to appropriate, but not excessive, asset requirements.

4. The company should remember that the continuum of “plausibility” should not be confined or constrained to the outcomes and events exhibited by historic experience.

5. Companies should attempt to track experience for all assumptions that materially affect their risk profiles by collecting and maintaining the data required to conduct credible and meaningful studies of contract holder behavior.

G. Additional Considerations and Requirements for Assumptions Applicable to Guaranteed Living Benefits

Experience for contracts without guaranteed living benefits may be of limited use in setting a lapse assumption for contracts with in-the-money or at-the-money guaranteed living benefits. Such experience may only be used if it is appropriate (e.g., lapse experience on contracts without a living benefit may have relevance to the early durations of contracts with living benefits) and relevant to the business.

H. Policy Loans

If policy loans are applicable for the block of business, the company shall determine cash flows for each projection interval for policy loan assets by modeling existing loan balances either explicitly or by substituting assets that are a proxy for policy loans (e.g., bonds, cash, etc.) subject to the following:

1. If the company substitutes assets that are a proxy for policy loans, the company must demonstrate that such substitution:
   a. Produces reserves that are no less than those that would be produced by modeling existing loan balances explicitly.
   b. Complies with the contract holder behavior requirements stated in Section 10 above in this section.

2. If the company models policy loans explicitly, the company shall:
   a. Treat policy loan activity as an aspect of contract holder behavior and subject to the requirements above in this section.
   b. Assign loan balances either to exactly match each policy’s utilization or to reflect average utilization over a model segment or sub-segments.
   c. Model policy loan interest in a manner consistent with policy provisions and with the scenario. Include interest paid in cash as a positive policy loan cash flow in that projection interval, but do not include interest added to the loan balance as a policy loan cash flow. (The increased balance will require increased repayment cash flows in future projection intervals.)
   d. Model policy loan principal repayments, including those that occur automatically upon death or surrender. Include policy loan principal repayments as a positive policy loan cash flow, per Section 4.A.1.h.
e. Model additional policy loan principal. Include additional policy loan principal as a negative policy loan cash flow per Section 4.A.1.h (but do not include interest added to the loan balance as a negative policy loan cash flow).

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

I. Non-Guaranteed Elements

Consistent with the definition in VM-01, Non-Guaranteed Elements (NGEs) are elements within a contract that affect policy costs or values and not guaranteed or not determined at issue. NGEs consist of elements affecting contract holder costs or values that are both established and subject to change at the discretion of the insurer.

Examples of NGEs specific to fixed annuities include but are not limited to the following: fixed credited rates, index parameters (caps, spreads, participation rates, etc.), rider fees, rider benefit features being subject to change (rollup rates, rollup period, etc.), account value charges, and dividends under participating policies or contracts.

1. Except as noted below in Section 10.J.5, the company shall include NGE in the models to project future cash flows beyond the time the company has authorized their payment or crediting.

2. The projected NGE shall reflect factors that include, but are not limited to, the following (not all of these factors will necessarily be present in all situations):
   a. The nature of contractual guarantees.
   b. The company’s past NGE practices and established NGE policies.
   c. The timing of any change in NGE relative to the date of recognition of a change in experience.
   d. The benefits and risks to the company of continuing to authorize NGE.

3. Projected NGE shall be established based on projected experience consistent with how actual NGE are determined.

4. Projected levels of NGE in the cash-flow model must be consistent with the experience assumptions used in each scenario. Contract holder behavior assumptions in the model must be consistent with the NGE assumed in the model.

5. The company may exclude any portion of an NGE that:
   a. Is not based on some aspect of the policy’s or contract’s experience.
   b. Is authorized by the board of directors and documented in the board minutes, where the documentation includes the amount of the NGE that arises from other sources. However, if the board has guaranteed a portion of the NGE into the future, the company must model that amount. In other words, the company cannot exclude from its model any NGE that the board has guaranteed for future years, even if it could have otherwise excluded them, based on this subsection.
6. The liability for contract holder dividends declared but not yet paid that has been established according to statutory accounting principles as of the valuation date is reported separately from the statutory reserve. The contract holder dividends that give rise to this dividend liability as of the valuation date may or may not be included in the cash-flow model at the company’s option.

   a. If the contract holder dividends that give rise to the dividend liability are not included in the cash-flow model, then no adjustment is needed to the resulting aggregate stochastic reserve.

   b. If the contract holder dividends that give rise to the dividend liability are included in the cash-flow model, then the resulting aggregate stochastic reserve should be reduced by the amount of the dividend liability.

7. All projected cash flows associated with NGEs shall reflect margins for adverse deviations and estimation error in prudent estimate assumptions.
Section 11: Guidance and Requirements for Setting Prudent Estimate Mortality Assumptions

Drafting Note: All revisions shown in this section are in comparison to Section 11 in VM-21.

A. Overview

1. Intent

The guidance and requirements in this section apply to setting prudent estimate mortality assumptions when determining either the stochastic reserve or the reserve for any contracts determined using the Alternative Methodology. The intent is for prudent estimate mortality assumptions to be based on facts, circumstances and appropriate actuarial practice, with only a limited role for unsupported actuarial judgment. (Where more than one approach to appropriate actuarial practice exists, the company should select the practice that the company deems most appropriate under the circumstances.)

2. Description

Prudent estimate mortality assumptions shall be determined by first developing expected mortality curves based on either available experience or published tables. Where necessary, margins shall be applied to the experience to reflect data uncertainty. The expected mortality curves shall then be adjusted based on the credibility of the experience used to determine the expected mortality curve. Section 11.B addresses guidance and requirements for determining expected mortality curves, and Section 11.C addresses guidance and requirements for adjusting the expected mortality curves to determine prudent estimate mortality.

Finally, the credibility-adjusted tables shall be adjusted for mortality improvement (where such adjustment is permitted or required) using the guidance and requirements in Section 11.D.

3. Business Segments

For purposes of setting prudent estimate mortality assumptions, the products falling under the scope of these requirements shall be grouped into business segments with different mortality assumptions. The grouping, at a minimum, should differentiate the payout annuities or deferred annuity contracts that contain VAGLBs, and where the no-VAGLB segments would include both deferred annuity contracts with no guaranteed benefits or contract with only GMDBs. Where appropriate, the grouping should also differentiate between segments which are known or expected to contain contract holders with sociodemographic, geographic, or health factors reasonably expected to impact the mortality assumptions for the segment (e.g., annuitants drawn from different countries, geographic areas, industry groups, or impaired lives on individually underwritten contracts such as structured settlements). The grouping should also generally follow the pricing, marketing, management and/or reinsurance programs of the company.

Guidance Note: This paragraph contemplates situations where it may be appropriate to differentiate mortality assumptions by segment or even by contract due to varying sociodemographic, geographic, or health factors. Particularly, though not exclusively, in the context of group payout annuity contracts, companies may have credible, contract-specific mortality experience data or relevant pooled data from annuitants drawn from...
similar industries or geographies that may be used to sub-divide inforce blocks into business segments for purposes of setting prudent estimate mortality assumptions.

For example, a company may sell group PRT contracts both to union plans in the U.S. and to private single-employer plans in another country. While both are “PRT contracts,” it would be appropriate to differentiate them for mortality assumption purposes, similar to how payout annuities vs. deferred annuities are distinguished.

Guidance Note: Distinct mortality or liability assumptions among different contracts within a group of contracts does not in itself preclude the group of contracts from being aggregated for the purposes of the broader stochastic reserve calculation.

4. Margin for Data Uncertainty

The expected mortality curves that are determined in Section 11.B may need to include a margin for data uncertainty. The margin could be in the form of an increase or a decrease in mortality, depending on the business segment under consideration. The margin shall be applied in a direction (i.e., increase or decrease in mortality) that results in a higher reserve. A sensitivity test may be needed to determine the appropriate direction of the provision for uncertainty to mortality. The test could be a prior year mortality sensitivity analysis of the business segment or an examination of current representative cells of the segment.

For purposes of this section, if mortality must be increased (decreased) to provide for uncertainty, the business segment is referred to as a plus (minus) segment.

It may be necessary, because of a change in the mortality risk profile of the segment, to reclassify a business segment from a plus (minus) segment to a minus (plus) segment to the extent compliance with this section requires such a reclassification. For example, a segment could require reclassification depending on whether it is gross or net of reinsurance.

B. Determination of Expected Mortality Curves

1. Experience Data

In determining expected mortality curves, the company shall use actual experience data directly applicable to the business segment (i.e., direct data) if it is available. In the absence of direct data, the company should then look to use data from a segment that is similar to the business segment (i.e., other than direct experience). See Section 11.B.2. for additional considerations. Finally, if there is no data, the company shall use the applicable table, as required in Section 11.B.3.

2. Data Other Than Direct Experience

Adjustments shall be applied to the data to reflect differences between the business segments, and margins shall be applied to the adjusted expected mortality curves to reflect the data uncertainty associated with using data from a similar but not identical business segment.

To the extent the mortality of a business segment is reinsured, any mortality charges that are consistent with the company’s own pricing and applicable to a substantial portion of the mortality risk also may be a reasonable starting point for the determination of the company’s expected mortality curves.
3. No Data Requirements

   i. When little or no experience or information is available on a business segment, the company shall use expected mortality curves that would produce expected deaths no less than:

      a. \([2021\ \text{SOA Deferred Annuity Mortality Table} \text{ with } \text{Projection Scale G2}]\) for individual deferred annuities that do not contain guaranteed living benefits

      \[q_x^{20XX+n} = q_x^{20XX} (1 - G2_x)^n\]

   ii. When little or no experience or information is available on a business segment, the company shall use expected mortality curves that would produce expected deaths no greater than:

      a. \([\text{The appropriate percentage } (F_x) \text{ from Table 11.1 applied to the 2012 IAM Basic Mortality Table} \text{ with } \text{Projection Scale G2}]\) for individual payout annuity contracts and deferred annuity contracts with guaranteed living benefits

      \[q_x^{2012+n} = q_x^{2017} (1 - G2_x)^n * F_x\]

      b. \([1983 \text{ Table “a”}]\) for structured settlements or other contracts with impaired mortality

      c. \([1994\ \text{GAR Table}]\) with \([\text{Projection Scale AA}]\) for group annuities

\[q_x^{1994+n} = q_x^{1994} (1 - AA_x)^n\]

The appropriate percentage \((F_x)\) from Table 1 of the 2012 IAM Basic Table with Projection Scale G2 for contracts with no VAGLBs and expected deaths no greater than the appropriate percentage \((F_x)\) from Table 1 of the 2012 IAM Basic Mortality Table with Projection Scale G2 for contracts with VAGLBs. If mortality experience on the business segment is expected to be atypical (e.g., demographics of target markets are known to have higher [lower] mortality than typical), these “no data” mortality requirements may not be adequate.

Table 11.1

<table>
<thead>
<tr>
<th>Attained Age (x)</th>
<th>(F_x) for VA with GLB</th>
<th>(F_x) for All Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;=65</td>
<td>80.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>66</td>
<td>81.5%</td>
<td>102.0%</td>
</tr>
<tr>
<td>67</td>
<td>83.0%</td>
<td>104.0%</td>
</tr>
<tr>
<td>68</td>
<td>84.5%</td>
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<td>69</td>
<td>86.0%</td>
<td>108.0%</td>
</tr>
<tr>
<td>70</td>
<td>87.5%</td>
<td>110.0%</td>
</tr>
<tr>
<td>71</td>
<td>89.0%</td>
<td>112.0%</td>
</tr>
<tr>
<td>72</td>
<td>90.5%</td>
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<tr>
<td>73</td>
<td>92.0%</td>
<td>116.0%</td>
</tr>
<tr>
<td>74</td>
<td>93.5%</td>
<td>118.0%</td>
</tr>
<tr>
<td>75</td>
<td>95.0%</td>
<td>120.0%</td>
</tr>
<tr>
<td>76</td>
<td>96.5%</td>
<td>128.0%</td>
</tr>
</tbody>
</table>
### iii. For a business segment with non-U.S. insureds, an established industry or national mortality table may be used, with approval from the domiciliary commissioner.

#### 4. Additional Considerations Involving Data

The following considerations shall apply to mortality data specific to the business segment for which assumptions are being determined (i.e., direct data discussed in Section 11.B.1 or other than direct data discussed in Section 11.B.2).

**a. Underreporting of Deaths**

Mortality data shall be examined for possible underreporting of deaths. Adjustments shall be made to the data if there is any evidence of underreporting. Alternatively, exposure by lives or amounts on contracts for which death benefits were in the money may be used to determine expected mortality curves. Underreporting on such exposures should be minimal; however, this reduced subset of data will have less credibility.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>77</td>
<td>98.0%</td>
<td>118.0%</td>
</tr>
<tr>
<td>78</td>
<td>99.5%</td>
<td>117.0%</td>
</tr>
<tr>
<td>79</td>
<td>101.0%</td>
<td>116.0%</td>
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<tr>
<td>80</td>
<td>102.5%</td>
<td>115.0%</td>
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<tr>
<td>81</td>
<td>104.0%</td>
<td>114.0%</td>
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<tr>
<td>82</td>
<td>105.5%</td>
<td>113.0%</td>
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<td>83</td>
<td>107.0%</td>
<td>112.0%</td>
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<tr>
<td>84</td>
<td>108.5%</td>
<td>111.0%</td>
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<td>85</td>
<td>110.0%</td>
<td>110.0%</td>
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<td>86</td>
<td>110.0%</td>
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<td>87</td>
<td>110.0%</td>
<td>110.0%</td>
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<td>88</td>
<td>110.0%</td>
<td>110.0%</td>
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<tr>
<td>89</td>
<td>110.0%</td>
<td>110.0%</td>
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<tr>
<td>90</td>
<td>110.0%</td>
<td>110.0%</td>
</tr>
<tr>
<td>91</td>
<td>110.0%</td>
<td>110.0%</td>
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<tr>
<td>92</td>
<td>110.0%</td>
<td>110.0%</td>
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<tr>
<td>93</td>
<td>110.0%</td>
<td>110.0%</td>
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<tr>
<td>94</td>
<td>110.0%</td>
<td>110.0%</td>
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<tr>
<td>95</td>
<td>110.0%</td>
<td>110.0%</td>
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<tr>
<td>96</td>
<td>109.0%</td>
<td>109.0%</td>
</tr>
<tr>
<td>97</td>
<td>108.0%</td>
<td>108.0%</td>
</tr>
<tr>
<td>98</td>
<td>107.0%</td>
<td>107.0%</td>
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<tr>
<td>99</td>
<td>106.0%</td>
<td>106.0%</td>
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<tr>
<td>100</td>
<td>105.0%</td>
<td>105.0%</td>
</tr>
<tr>
<td>101</td>
<td>104.0%</td>
<td>104.0%</td>
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<tr>
<td>102</td>
<td>103.0%</td>
<td>103.0%</td>
</tr>
<tr>
<td>103</td>
<td>102.0%</td>
<td>102.0%</td>
</tr>
<tr>
<td>104</td>
<td>101.0%</td>
<td>101.0%</td>
</tr>
<tr>
<td>&gt;=105</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
b. Experience by Contract Duration

Experience of a plus segment shall be examined to determine if mortality by contract duration increases materially due to selection at issue. In the absence of information, the company shall assume that expected mortality will increase by contract duration for an appropriate select period. As an alternative, if the company determines that mortality is affected by selection, the company could apply margins to the expected mortality in such a way that the actual mortality modeled does not depend on contract duration.

c. Modification and Relevance of Data

Even for a large company, the quantity of life exposures and deaths are such that a significant amount of smoothing may be required to determine expected mortality curves from mortality experience. Expected mortality curves, when applied to the recent historic exposures (e.g., three to seven years), should not result in an estimate of aggregate number of deaths less (greater) than the actual number deaths during the exposure period for plus (minus) segments.

In determining expected mortality curves (and the credibility of the underlying data), older data may no longer be relevant. The “age” of the experience data used to determine expected mortality curves should be documented.

d. Other Considerations

In determining expected mortality curves, consideration should be given to factors that include, but are not limited to, trends in mortality experience, trends in exposure, volatility in year-to-year A/E mortality ratios, mortality by lives relative to mortality by amounts, changes in the mix of business and product features that could lead to mortality selection.

C. Adjustment for Credibility to Determine Prudent Estimate Mortality

1. Adjustment for Credibility

The expected mortality curves determined in Section 11.B shall be adjusted based on the credibility of the experience used to determine the curves in order to arrive at prudent estimate mortality. The adjustment for credibility shall result in blending the expected mortality curves with the mortality assumption described in Section 11.B.3.a mortality table consistent with a statutory valuation mortality table. For contracts with no VAGLBs, the table shall be consistent with the appropriate percentage (F_x) from Table 1 of the 2012 IAM Basic Table with Projection Scale G2; and for contracts with VAGLBs, the table shall be consistent with the appropriate percentage (F_x) from Table 1 of the 2012 IAM Basic Mortality Table with Projection Scale G2. The approach used to adjust the curves shall suitably account for credibility.

Guidance Note: For example, when credibility is zero, an appropriate approach should result in a mortality assumption consistent with 100% of the statutory valuation mortality table used in the blending.

2. Adjustment of Statutory Valuation Mortality for Improvement
For purposes of the adjustment for credibility, the statutory valuation mortality table for a plus segment may be and the statutory valuation mortality table for a minus segment must be adjusted for mortality improvement. Such adjustment shall reflect the mortality improvement scale described in Section 11.B.3 Projection Scale G2 from the effective date of the respective statutory valuation mortality table to the experience weighted average date underlying the data used to develop the expected mortality curves (discussed in Section 11.B).

3. Credibility Procedure

The credibility procedure used shall:

a. Produce results that are reasonable.
b. Not tend to bias the results in any material way.
c. Be practical to implement.
d. Give consideration to the need to balance responsiveness and stability.
e. Take into account not only the level of aggregate claims but the shape of the mortality curve.
f. Contain criteria for full credibility and partial credibility that have a sound statistical basis and be appropriately applied.

4. Further Adjustment of the Credibility-Adjusted Table for Mortality Improvement

The credibility-adjusted table used for plus segments may be and the credibility adjusted table used for minus segments must be adjusted for mortality improvement using the applicable mortality improvement scale described in Section 11.B.3 from the experience weighted average date underlying the company experience used in the credibility process to the valuation date.

Any adjustment for mortality improvement beyond the valuation date is discussed in Section 11.D.

D. Future Mortality Improvement

The mortality assumption resulting from the requirements of Section 11.C shall be adjusted for mortality improvements beyond the valuation date if such an adjustment would serve to increase the resulting stochastic reserve. If such an adjustment would reduce the stochastic reserve, such assumptions are permitted, but not required. In either case, the assumption must be based on current relevant data with a margin for uncertainty (increasing assumed rates of improvement if that results in a higher reserve or reducing them otherwise).
Section 12: Allocation of Aggregate Reserves to the Contract Level

Drafting Note: All revisions shown in this section are in comparison to Section 11 in VM-21.

Section 23.F states that the aggregate reserve shall be allocated to the contracts falling within the scope of these requirements. That allocation should be done for both the pre- and post-reinsurance ceded reserves. Contracts that have passed the stochastic exclusion test as defined in Section 7.B will not be included in the allocation of the aggregate reserve. For the purpose of this section, if a contract does not have a cash surrender value, then the cash surrender value is assumed to be zero.

Contracts for which the Deterministic Certification Option is elected in Section 7.E are intended to use the methodology described in this section to allocate aggregate reserves in excess of the cash surrender value to individual contracts.

The contract-level reserve for each contract shall be the sum of the following:

A. The contract’s cash surrender value.

Drafting Note: The American Academy of Actuaries Annuity Reserves and Capital Work Group is including two potential options for allocating the excess portion of the aggregate reserve over cash surrender value: (1) Use the same approach as VM-21 (2) Allocate based on an actuarial present value calculation.

The Work Group did not reach a consensus between these two approaches, so wording for both is included in the text below. The Work Group recommends field testing both approaches and considering the results in determining future decisions.

**Option 1: VM-21 Approach**

B. An allocated portion of the excess of the aggregate reserve over the aggregate cash surrender value shall be allocated to each contract based on a measure of the risk of that product relative to its cash surrender value in the context of the company’s in force contracts (assuming zero cash value for contracts that do not contain such). The measure of risk should consider the impact of risk mitigation programs, including hedge programs and reinsurance, that would affect the risk of the product. The specific method of assessing that risk and how it contributes to the company’s aggregate reserve shall be defined by the company. The method should provide for an equitable allocation based on risk analysis. For contracts valued under the alternative methodology, the alternative methodology calculations provide a contract level calculation that may be a reasonable basis for allocation.

1. As an example, consider a company with the results of the following three contracts:

Table 12.1: Sample Allocation of Aggregate Reserve

<table>
<thead>
<tr>
<th>Contract (i)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash Surrender Value, C</td>
<td>28</td>
<td>40</td>
<td>52</td>
<td>120</td>
</tr>
<tr>
<td>Risk adjusted measure, R</td>
<td>38</td>
<td>52</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Aggregate Reserve</td>
<td></td>
<td></td>
<td></td>
<td>140</td>
</tr>
</tbody>
</table>
2. In this example, the Aggregate Reserve exceeds the aggregate Cash Surrender Value by 20. The 20 is allocated proportionally across the three contracts based on the allocation basis of the larger of (i) zero; and (ii) a risk adjusted measure based on reserve principles. Therefore, contracts 1 and 2 receive 45% (9/22) and 55% (11/22), respectively, of the excess Aggregate Reserve. As Contract 3 presents no risk in excess of its cash surrender value, it does not receive an allocation of the excess Aggregate Reserve.

**Option 2: Actuarial Present Value Approach**

B. An allocated portion of the excess of the aggregate reserve over the aggregate cash surrender value is allocated to policies based on a calculation of the actuarial present value of projected liability cash flows in excess of the cash surrender value:

1. Discount the liability cash flows at the NAER, pursuant to requirements in Section 4, for the scenario that produces the scenario reserve closest to, but not less than the stochastic reserve defined in Section 3.D.
   
   a. Groups of contracts that elect the Deterministic Certification Option defined in Section 7.E shall use the NAER in the single scenario used to calculate the reserve to discount liability cash flows.

2. If the actuarial present value is less than the cash surrender value, then the excess actuarial present value to be used for allocating the excess aggregate reserve over the cash value shall be floored at zero.
   
   a. If all contracts have an excess actuarial present value that is floored at zero, then use the cash surrender value to allocate any excess aggregate reserve over the aggregate cash surrender value.

3. For projecting future liability cash flows, assume the same liability assumptions that were used to calculate the stochastic reserve defined in 3.D.

4. As a hypothetical example, consider a company with the results of the following five contracts:

<table>
<thead>
<tr>
<th>Allocation Basis for the excess of the Aggregate Reserve over the Cash Surrender Value</th>
<th>10</th>
<th>12</th>
<th>0</th>
<th>22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocation of the excess of the Aggregate Reserve over the Cash Surrender Value</td>
<td>9.09</td>
<td>10.91</td>
<td>0.00</td>
<td>20</td>
</tr>
<tr>
<td>Contract-level reserve Ci+ Li</td>
<td>37.09</td>
<td>50.91</td>
<td>52.00</td>
<td>140.00</td>
</tr>
</tbody>
</table>
### Table 12.1: Hypothetical Sample Allocation of Aggregate Reserve

<table>
<thead>
<tr>
<th>Contract</th>
<th>Example Product Type</th>
<th>CSV* (1)</th>
<th>Scenario APV (2)</th>
<th>Excess (Floored) of the scenario APV over CSV* (3) = ( \text{Max}(2, 0) )</th>
<th>Aggregate Reserve CTE 70 (4)</th>
<th>Excess of Aggregate Reserve over Aggregate CSV* (5) = ( \text{Max}(4 \text{ Total} – (1 \text{ Total}), 0) )</th>
<th>Allocated Excess Reserve (6) = (3) x ( \frac{(5 \text{ Total})}{(3 \text{ Total})} )</th>
<th>Total Contract Level Reserve (7) = (1) + (6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract 1: Indexed Annuity with no GLWB**</td>
<td>95.0</td>
<td>90.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>95.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract 2: Indexed Annuity with low benefit GLWB**</td>
<td>92.0</td>
<td>95.0</td>
<td>3.0</td>
<td>3.6</td>
<td>95.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract 3: Indexed Annuity with medium benefit GLWB**</td>
<td>90.0</td>
<td>100.0</td>
<td>10.0</td>
<td>12.0</td>
<td>102.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract 4: Indexed Annuity with high benefit GLWB**</td>
<td>88.0</td>
<td>105.0</td>
<td>17.0</td>
<td>20.4</td>
<td>108.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract 5: Fixed Life Contingent Payout Annuity</td>
<td>0.0</td>
<td>70.0</td>
<td>70.0</td>
<td>84.0</td>
<td>84.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>365.0</td>
<td>100.0</td>
<td>485.0</td>
<td>120.0</td>
<td>120.0</td>
<td>485.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Cash Surrender Value  
**Guaranteed Lifetime Withdrawal Benefit

**Guidance Note:** The actuarial present value (APV) in the section above is separate from the Guarantee Actuarial Present Value (GAPV) referred to in the additional standard projection amount calculation in VM-21. The GAPV is only applicable to guaranteed minimum benefits and uses prescribed liability assumptions. In contrast, the APV in this section applies to the entire contract, irrespective of whether guaranteed benefits are attached, and uses company prudent estimate liability assumptions.

3. shall be allocated to each contract based on a measure of the risk of that product relative to its cash surrender value in the context of the company’s in force contracts. The measure of risk should consider the impact of risk mitigation programs, including hedge programs and reinsurance, that would affect the risk of the product. The specific method of assessing that risk and how it contributes to the company’s aggregate reserve shall be defined by the company. The method should provide for an equitable allocation based on risk analysis. For contracts valued under the alternative methodology, the alternative methodology calculations provide a contract level calculation that may be a reasonable basis for allocation.

4. As an example, consider a company with the results of the following three contracts:

In this example, the Aggregate Reserve exceeds the aggregate Cash Surrender Value by 20. The 20 is allocated proportionally across the three contracts based on the allocation basis of the larger of (i) zero; and (ii) a risk adjusted measure based on reserve principles. Therefore, contracts 1 and 2 receive 45% (9/22) and 55% (11/22), respectively, of the excess Aggregate Reserve. As Contract 3 presents no risk in excess of its cash surrender value, it does not receive an allocation of the excess Aggregate Reserve.
Section 13: Statutory Maximum Valuation Interest Rates for Income Annuity Formulaic Reserves

Drafting Note: All revisions shown in this section are in comparison to the current VM-22 requirements.

A. Purpose and Scope

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

2. The following categories of contracts, certificates and contract features, whether group or individual, including both life contingent and term certain only contracts, directly written or assumed through reinsurance, with the exception of benefits arising from variable annuities, are covered in this section by VM-22:
   a. Immediate annuity contracts issued after Dec. 31, 2017;
   b. Deferred income annuity contracts issued after Dec. 31, 2017;
   c. Structured settlements in payout or deferred status issued after Dec. 31, 2017;
   d. Fixed payout annuities resulting from the exercise of settlement options or annuitizations of host contracts issued after Dec. 31, 2017;
   e. Fixed payout annuities resulting from the exercise of settlement options or annuitizations of host contracts issued during 2017, for fixed payouts commencing after Dec. 31, 2018, or, at the option of the company, for fixed payouts commencing after Dec. 31, 2017;
   f. Supplementary contracts, excluding contracts with no scheduled payments (such as retained asset accounts and settlements at interest), issued after Dec. 31, 2017;
   g. Fixed income payment streams, attributable to contingent deferred annuities (CDAs) issued after Dec. 31, 2017, once the underlying contract funds are exhausted;
   h. Fixed income payment streams attributable to guaranteed living benefits associated with deferred annuity contracts issued after Dec. 31, 2017, once the contract funds are exhausted; and
   i. Certificates with premium determination dates after Dec. 31, 2017, emanating from non-variable group annuity contracts specified in Model #820, Section 5.C.2, purchased for the purpose of providing certificate holders benefits upon their retirement.


3. Exemptions:
   a. With the permission of the domiciliary commissioner, for the categories of annuity contracts, certificates and/or contract features in scope as outlined in Section
13.A.2.d.1.B.4, Section 13.A.2.c.1.B.5, Section 13.A.2.f.1.B.6, Section 13.A.2.g.1.B.7 or Section 13.A.2.h.1.B.8, the company may use the same maximum valuation interest rate used to value the payment stream in accordance with the guidance applicable to the host contract. In order to obtain such permission, the company must demonstrate that its investment policy and practices are consistent with this approach.

4. The maximum valuation interest rates for the contracts, certificates and contract features within the scope of Section 13 of VM-22 supersede those described in Appendix VM-A and Appendix VM-C, but they do not otherwise change how those appendices are to be interpreted. In particular, Actuarial Guideline IX-B—Clarification of Methods Under Standard Valuation Law for Individual Single Premium Immediate Annuities, Any Deferred Payments Associated Therewith, Some Deferred Annuities and Structured Settlements Contracts (AG-9-B) (see VM-C) provides guidance on valuation interest rates and is, therefore, superseded by these requirements for contracts, certificates and contract features in scope. Likewise, any valuation interest rate references in Actuarial Guideline IX-C—Use of Substandard Annuity Mortality Tables in Valuing Impaired Lives Under Individual Single Premium Immediate Annuities (AG-9-C) (see VM-C) are also superseded by these requirements.

B. Definitions

1. The term “reference period” means the length of time used in assigning the Valuation Rate Bucket for the purpose of determining the statutory maximum valuation interest rate and is determined as follows:

   a. For contracts, certificates or contract features with life contingencies and substantially similar payments, the reference period is the length of time, rounded to the nearest year, from the premium determination date to the earlier of: i) the date of the last non-life-contingent payment under the contract, certificate or contract feature; and ii) the date of the first life-contingent payment under the contract, certificate or contract feature, or

   b. For contracts, certificates or contract features with no life-contingent payments and substantially similar payments, the reference period is the length of time, rounded to the nearest year, from the premium determination date to the date of the last non-life-contingent payment under the contract, certificate or contract feature, or

   c. For contracts, certificates or contract features where the payments are not substantially similar, the actuary should apply prudent judgment and select the Valuation Rate Bucket with Macaulay duration that is a best fit to the Macaulay duration of the payments in question.

   **Guidance Note:** Contracts with installment refunds or similar features should consider the length of the installment period calculated from the premium determination date as the non-life contingent period for the purpose of determining the reference period.

   **Guidance Note:** The determination in Section 13.B.1.c.2.A.3 above shall be made based on the materiality of the payments that are not substantially similar relative to the life-contingent payments.

2. The term “jumbo contract” means a contract with an initial consideration equal to or greater than $250 million. Considerations for contracts issued by an insurer to the same contract holder within 90 days shall be combined for purposes of determining whether the contracts meet this threshold.
3. The term “non-jumbo contract” means a contract that does not meet the definition of a jumbo contract.

4. The term “premium determination date” means the date as of which the valuation interest rate for the contract, certificate or contract feature being valued is determined.

5. The term “initial age” means the age of the annuitant as of his or her age last birthday relative to the premium determination date. For joint life contracts, certificates or contract features, the “initial age” means the initial age of the younger annuitant. If a contract, certificate or contract feature for an annuitant is being valued on a standard mortality table as an impaired annuitant, “initial age” means the rated age. If a contract, certificate or contract feature is being valued on a substandard mortality basis, “initial age” means an equivalent rated age.

6. The term “Table X spreads” means the prescribed VM-22 Section 13 current market benchmark spreads for the quarter prior to the premium determination date, as published on the Industry tab of the NAIC website. The process used to determine Table X spreads is the same as that specified in VM-20 Appendix 2.D for Table F, except that JP Morgan and Bank of America bond spreads are averaged over the quarter rather than the last business day of the month.

7. The term “expected default cost” means a vector of annual default costs by weighted average life. This is calculated as a weighted average of the VM-20 Table A prescribed annual default costs published on the Industry tab of the NAIC website in effect for the quarter prior to the premium determination date, using the prescribed portfolio credit quality distribution as weights.

8. The term “expected spread” means a vector of spreads by weighted average life. This is calculated as a weighted average of the Table X spreads, using the prescribed portfolio credit quality distribution as weights.

9. The term “prescribed portfolio credit quality distribution” means the following credit rating distribution:
   a. 5% Treasuries
   b. 15% Aa bonds (5% Aa1, 5% Aa2, 5% Aa3)
   c. 40% A bonds (13.33% A1, 13.33% A2, 13.33% A3)*
   d. 40% Baa bonds (13.33% Baa1, 13.33% Baa2, 13.33% Baa3)*
   *40%/3 is used unrounded in the calculations.

C. Determination of the Statutory Maximum Valuation Interest Rate

1. Valuation Rate Buckets
   a. For the purpose of determining the statutory maximum valuation interest rate, the contract, certificate or contract feature being valued must be assigned to one of four Valuation Rate Buckets labeled A through D.
b. If the contract, certificate or contract feature has no life contingencies, the Valuation Rate Bucket is assigned based on the length of the reference period (RP), as follows:

Table 3-1: Assignment to Valuation Rate Bucket by Reference Period Only

<table>
<thead>
<tr>
<th>RP ≤ 5 Years</th>
<th>5Y &lt; RP ≤ 10Y</th>
<th>10Y &lt; RP ≤ 15Y</th>
<th>RP &gt; 15Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
</tbody>
</table>


c. If the contract, certificate or contract feature has life contingencies, the Valuation Rate Bucket is assigned based on the length of the RP and the initial age of the annuitant, as follows:

Table 3-2: Assignment to Valuation Rate Bucket by Reference Period and Initial Age

<table>
<thead>
<tr>
<th>Initial Age</th>
<th>RP ≤ 5Y</th>
<th>5Y &lt; RP ≤ 10Y</th>
<th>10Y &lt; RP ≤ 15Y</th>
<th>RP &gt; 15Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>90+</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>80–89</td>
<td>B</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>70–79</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>&lt; 70</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td>D</td>
</tr>
</tbody>
</table>

2. Premium Determination Dates

a. The following table specifies the decision rules for setting the premium determination date for each of the contracts, certificates and contract features listed in Section 1:

Table 3-3: Premium Determination Dates

<table>
<thead>
<tr>
<th>Section</th>
<th>Item Description</th>
<th>Premium determination date</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.2.a</td>
<td>Immediate annuity</td>
<td>Date consideration is determined and committed to by contract holder</td>
</tr>
<tr>
<td>A.2.b</td>
<td>Deferred income annuity</td>
<td>Date consideration is determined and committed to by contract holder</td>
</tr>
<tr>
<td>A.2.c</td>
<td>Structured settlements</td>
<td>Date consideration is determined and committed to by contract holder</td>
</tr>
<tr>
<td>A.2.d and A.2.e</td>
<td>Fixed payout annuities resulting from settlement options or annuitizations from host contracts</td>
<td>Date consideration for benefit is determined and committed to by contract holder</td>
</tr>
<tr>
<td>A.2.f</td>
<td>Supplementary contracts</td>
<td>Date of issue of supplementary contract</td>
</tr>
</tbody>
</table>
Guidance Note: For the purposes of the items in the table above, the phrase “date consideration is determined and committed to by the contract holder” should be interpreted by the company in a manner that is consistent with its standard practices. For some products, that interpretation may be the issue date or the date the premium is paid.

b. Immaterial Change in Consideration

If the premium determination date is based on the consideration, and if the consideration changes by an immaterial amount (defined as a change in present value of less than 10% and less than $1 million) subsequent to the original premium determination date, such as due to a data correction, then the original premium determination date shall be retained. In the case of a group annuity contract where a single premium is intended to cover multiple certificates, certificates added to the contract after the premium determination date that do not trigger the company’s right to reprice the contract shall be treated as if they were included in the contract as of the premium determination date.

3. Statutory Maximum Valuation Interest Rate

a. For a given contract, certificate or contract feature, the statutory maximum valuation interest rate is determined based on its assigned Valuation Rate Bucket (Section 13.C.1A) and its Premium Determination Date (Section 13.C.2.B) and whether the contract associated with it is a jumbo contract or a non-jumbo contract.

b. Statutory maximum valuation interest rates for jumbo contracts are determined and published daily by the NAIC on the Industry tab of the NAIC website. For a given premium determination date, the statutory maximum valuation interest rate is the daily statutory maximum valuation interest rate published for that premium determination date.

c. Statutory maximum valuation interest rates for non-jumbo contracts are determined and published quarterly by the NAIC on the Industry tab of the NAIC website by the third business day of the quarter. For a given premium determination date, the statutory maximum valuation interest rate is the quarterly statutory maximum valuation interest rate published for the quarter in which the premium determination date falls.

d. Quarterly Valuation Rate:

For each Valuation Rate Bucket, the quarterly valuation rate is defined as follows:

\[ I_q = R + S - D - E \]

Where:
a. R is the reference rate for that Valuation Rate Bucket (defined in Section 13.C.4D);

b. S is the spread rate for that Valuation Rate Bucket (defined in Section 13.C.5E);

c. D is the default cost rate for that Valuation Rate Bucket (defined in Section 13.C.6F);

and

d. E is the spread deduction defined as 0.25%.

e. Daily Valuation Rate:

For each Valuation Rate Bucket, the daily valuation rate is defined as follows:

\[ I_d = I_q + C_{d,1} - C_q \]

Where:

a. \( I_q \) is the quarterly valuation rate for the calendar quarter preceding the business day immediately preceding the premium determination date;

b. \( C_{d,1} \) is the daily corporate rate (defined in Section 13.C.7G) for the business day immediately preceding the premium determination date; and

c. \( C_q \) is the average daily corporate rate (defined in Section 13.C.8H) corresponding to the same period used to develop \( I_q \).

For jumbo contracts, the daily statutory maximum valuation interest rate is the daily valuation rate (\( I_d \)) rounded to the nearest one-hundredth of one percent (1/100 of 1%).

4. Reference Rate

Reference rates are updated quarterly as described below:

a. The “quarterly Treasury rate” is the average of the daily Treasury rates for a given maturity over the calendar quarter prior to the premium determination date. The quarterly Treasury rate is downloaded from https://fred.stlouisfed.org, and is rounded to two decimal places.

b. Download the quarterly Treasury rates for two-year, five-year, 10-year and 30-year U.S. Treasuries.

c. The reference rate for each Valuation Rate Bucket is calculated as the weighted average of the quarterly Treasury rates using Table 1 weights (defined in Section 13.C.9I) effective for the calendar year in which the premium determination date falls.

5. Spread

The spreads for each Valuation Rate Bucket are updated quarterly as described below:

a. Use the Table X spreads from the NAIC website for WALs two, five, 10 and 30 years only to calculate the expected spread.
b. Calculate the spread for each Valuation Rate Bucket, which is a weighted average of the expected spreads for WALs two, five, 10 and 30 using Table 2 weights (defined in Section 3.1) effective for the calendar year in which the premium determination date falls.

6. Default costs for each Valuation Rate Bucket are updated annually as described below:
   a. Use the VM-20 prescribed annual default cost table (Table A) in effect for the quarter prior to the premium determination date for WAL two, WAL five and WAL 10 years only to calculate the expected default cost. Table A is updated and published annually on the Industry tab of the NAIC website during the second calendar quarter and is used for premium determination dates starting in the third calendar quarter.
   b. Calculate the default cost for each Valuation Rate Bucket, which is a weighted average of the expected default costs for WAL two, WAL five and WAL 10, using Table 3 weights (defined in Section 13.C.9I) effective for the calendar year in which the premium determination date falls.

7. Daily Corporate Rate

Daily corporate rates for each valuation rate bucket are updated daily as described below:

   a. Each day, download the Bank of America Merrill Lynch U.S. corporate effective yields as of the previous business day’s close for each index series shown in the sample below from the St. Louis Federal Reserve website: https://research.stlouisfed.org/fred2/categories/32348. To access a specific series, search the St. Louis Federal Reserve website for the series name by inputting the name into the search box in the upper right corner, or input the following web address: https://research.stlouisfed.org/fred2/series/[replace with series name from the table below].

<table>
<thead>
<tr>
<th>Maturity</th>
<th>Series Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1Y – 3Y</td>
<td>BAMLC1A0C13YEY</td>
</tr>
<tr>
<td>3Y – 5Y</td>
<td>BAMLC2A0C35YEY</td>
</tr>
<tr>
<td>5Y – 7Y</td>
<td>BAMLC3A0C57YEY</td>
</tr>
<tr>
<td>7Y – 10Y</td>
<td>BAMLC4A0C710YEY</td>
</tr>
<tr>
<td>10Y – 15Y</td>
<td>BAMLC7A0C1015YEY</td>
</tr>
<tr>
<td>15Y+</td>
<td>BAMLC8A0C15PYEY</td>
</tr>
</tbody>
</table>

b. Calculate the daily corporate rate for each valuation rate bucket, which is a weighted average of the Bank of America Merrill Lynch U.S. corporate effective yields, using Table 4 weights (defined in Section 13.C.9I) effective for the calendar year in which the business date immediately preceding the premium determination date falls.

8. Average Daily Corporate Rate

Average daily corporate rates are updated quarterly as described below:
a. Download the quarterly average Bank of America Merrill Lynch U.S. corporate effective yields for each index series shown in Section 3.G.1 from the St. Louis Federal Reserve website: https://research.stlouisfed.org/fred2/categories/32348. To access a specific series, search the St. Louis Federal Reserve website for the series name by inputting the name into the search box in the upper right corner, or input the following web address: https://research.stlouisfed.org/fred2/series/[replace with series name from Section 13.C.7.aG.1].

b. Calculate the average daily corporate rate for each valuation rate bucket, which is a weighted average of the quarterly average Bank of America Merrill Lynch U.S. corporate effective yields, using Table 4 weights (defined in Section 13.C.9I) for the same calendar year as the weight tables (i.e. Tables 1, 2, and 3) used in calculating \( I_q \) in Section 13.C.3.e5.

9. Weight Tables 1 through 4

The system for calculating the statutory maximum valuation interest rates relies on a set of four tables of weights that are based on duration and asset/liability cash-flow matching analysis for representative annuities within each valuation rate bucket. A given set of weight tables is applicable to the calculations for every day of the calendar year.

In the fourth quarter of each calendar year, the weights used within each valuation rate bucket for determining the applicable valuation interest rates for the following calendar year will be updated using the process described below. In each of the four tables of weights, the weights in a given row (valuation rate bucket) must add to exactly 100%.

Weight Table 1

The process for determining Table 1 weights is described below:

a. Each valuation rate bucket has a set of representative annuity forms. These annuity forms are as follows:

i. Bucket A:
   a) Single Life Annuity age 91 with 0 and five-year certain periods.
   b) Five-year certain only.

ii. Bucket B:
   a) Single Life Annuity age 80 and 85 with 0, five-year and 10-year certain periods.
   b) 10-year certain only.

iii. Bucket C:
   a) Single Life Annuity age 70 with 0 and 15-year certain periods.
   b) Single Life Annuity age 75 with 0, 10-year and 15-year certain periods.
   c) 15-year certain only.

iv. Bucket D:
a) Single Life Annuity age 55, 60 and 65 with 0 and 15-year certain periods.

b) 25-year certain only.

b. Annual cash flows are projected assuming annuity payments are made at the end of each year. These cash flows are averaged for each valuation rate bucket across the annuity forms for that bucket using the statutory valuation mortality table in effect for the following calendar year for individual annuities for males (ANB).

c. The average daily rates in the third quarter for the two-year, five-year, 10-year and 30-year U.S. Treasuries are downloaded from https://fred.stlouisfed.org as input to calculate the present values in Step d4.

d. The average cash flows are summed into four time period groups: years 1–3, years 4–7, years 8–15 and years 16–30. (Note: The present value of cash flows beyond year 30 are discounted to the end of year 30 and included in the years 16–30 group. This present value is based on the lower of 3% and the 30-year Treasury rate input in Step c3.)

e. The present value of each summed cash-flow group in Step d4 is then calculated by using the Step 3 U.S. Treasury rates for the midpoint of that group (and using the linearly interpolated U.S. Treasury rate when necessary).

f. The duration-weighted present value of the cash flows is determined by multiplying the present value of the cash-flow groups by the midpoint of the time period for each applicable group.

g. Weightings for each cash-flow time period group within a valuation rate bucket are calculated by dividing the duration weighted present value of the cash flow by the sum of the duration weighted present value of cash flow for each valuation rate bucket.

Weight Tables 2 through 4

Weight Tables 2 through 4 are determined using the following process:

i. Table 2 is identical to Table 1.

ii. Table 3 is based on the same set of underlying weights as Table 1, but the 10-year and 30-year columns are combined since VM-20 default rates are only published for maturities of up to 10 years.

iii. Table 4 is derived from Table 1 as follows:

a) Column 1 of Table 4 is identical to column 1 of Table 1.

b) Column 2 of Table 4 is 50% of column 2 of Table 1.

c) Column 3 of Table 4 is identical to column 2 of Table 4.

d) Column 4 of Table 4 is 50% of column 3 of Table 1.

e) Column 5 of Table 4 is identical to column 4 of Table 4.

f) Column 6 of Table 4 is identical to column 4 of Table 1.

10. Group Annuity Contracts

For a group annuity purchased under a retirement or deferred compensation plan (Section 13.A.2.iB.9), the following apply:
a. The statutory maximum valuation interest rate shall be determined separately for each certificate, considering its premium determination date, the certificate holder’s initial age, the reference period corresponding to its form of payout and whether the contract is a jumbo contract or a non-jumbo contract.

**Guidance Note:** Under some group annuity contracts, certificates may be purchased on different dates.

b. In the case of a certificate whose form of payout has not been elected by the beneficiary at its premium determination date, the statutory maximum valuation interest rate shall be based on the reference period corresponding to the normal form of payout as defined in the contract or as is evidenced by the underlying pension plan documents or census file. If the normal form of payout cannot be determined, the maximum valuation interest rate shall be based on the reference period corresponding to the annuity form available to the certificate holder that produces the most conservative rate.

**Guidance Note:** The statutory maximum valuation interest rate will not change when the form of payout is elected.
Valuation Manual Section II. Reserve Requirements

Subsection 2: Annuity Products

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

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

C. Minimum reserve requirements for fixed annuity contracts issued prior to 1/1/2024 are those requirements as found in VM-A and VM-C as applicable, with the exception of the minimum requirements for the valuation interest rate for single premium immediate annuity contracts, and other similar contracts, issued after Dec. 31, 2017, including those fixed payout annuities emanating from host contracts issued on or after Jan. 1, 2017, and on or before Dec. 31, 2017. The maximum valuation interest rate requirements for those contracts and fixed payout annuities are defined in Section 13 of VM-22, Statutory Maximum Valuation Interest Rates for Income Annuity Formulaic Reserves.

C.D. Minimum reserve requirements for fixed annuity contracts issued on 1/1/2024 and later are those requirements as found in Sections 1 through 12 of VM-22.

E. The below principles may serve as key considerations for assessing whether VM-21 or VM-22 requirements apply:

1. Index-linked or modified guaranteed annuity contracts or riders that satisfy both of the following conditions may be a key consideration for application of VM-22 requirements:
   a. Guarantees the principal amount of purchase payments, net of any partial withdrawals, and interest credited thereto, less any deduction (without regard to its timing) for sales, administrative or other expenses or charges.
   b. Credits a rate of interest under the contract that is at least equal to the minimum rate required to be credited by the standard nonforfeiture law in the jurisdiction in which the contract is issued.

   Guidance Note: Paragraph E.1.b is intended to apply prior to the application of any market value adjustments for modified guaranteed annuities where the underlying assets are held in a separate account. If meeting Paragraph E.1.b prior to the application of any market value adjustments and Paragraph E.1.a above, it may be appropriate to value such contracts under VM-22 requirements.

2. Index-linked or modified guaranteed annuity contracts that do not satisfy either of the two conditions listed above in Paragraph E.1.i and E.1.ii may be a key consideration for application of VM-21 requirements.
Subsection 6: Riders and Supplemental Benefits

Drafting Note: All revisions shown in this section are in comparison to Subsection 6 in Section II of the Valuation Manual.

Guidance Note: Policies or contracts with riders and supplemental benefits which are created to simply disguise benefits, riders, or contracts subject to the Valuation Manual section describing the reserve methodology for the base product to which they are attached, VM-20 Section 3.A.1, or exploit a perceived loophole, must be reserved in a manner similar to more typical designs with similar riders.

A. If a rider or supplemental benefit is attached to a health insurance product, annuity product, deposit-type contract, or credit life or disability product, it may be valued with the base contract unless it is required to be separated by regulation or other requirements.

B. For supplemental benefits on life insurance policies or annuity contracts, including Guaranteed Insurability, Accidental Death or Disability Benefits, Convertibility, Nursing Home Benefits or Disability Waiver of Premium Benefits, the supplemental benefit may be valued with the base policy or contract and follow the reserve requirements for the base policy or contract under VM-20, VM-21, VM-22, VM-A, and/or VM-C, as applicable.

C. ULSG and other secondary guarantee riders on a life insurance policy shall be valued with the base policy and follow the reserve requirements for ULSG policies under VM-20, VM-A and/or VM-C, as applicable.

D. Any guaranteed minimum benefits on life insurance policies or annuity contracts not subject to Paragraph C above including, but not limited to, Guaranteed Minimum Accumulation Benefits, Guaranteed Minimum Death Benefits, Guaranteed Minimum Income Benefits, Guaranteed Minimum Withdrawal Benefits, Guaranteed Lifetime Income Benefits, Guaranteed Lifetime Withdrawal Benefits, Guaranteed Payout Annuity Floors, Waiver of Surrender Charges, Return of Premium, Systematic Withdrawal Benefits under Required Minimum Distributions, and all similar guaranteed benefits shall be valued with the base policy or contract and follow the reserve requirements for the base policy or contract under VM-20, VM-21, VM-22, and VM-A and/or VM-C, as applicable.

D-E. If a rider or supplemental benefit to a life insurance policy or annuity contract that is not addressed in Paragraphs B, C, or D above possesses any of the following attributes, the rider or supplemental benefit shall be valued with the base policy or contract and follow the reserve requirements for the base policy or contract under VM-20, VM-21, VM-22, and VM-A and/or VM-C, as applicable.

1. The rider or supplemental benefit does not have a separately identified premium or charge.

2. The rider or supplemental benefit premium, charge, value or benefits are determined by referencing the base policy or policy contract features or performance.

3. The base policy or policy contract value or benefits are determined by referencing the rider or supplemental benefit features or performance. The deduction of rider or benefit premium or charge from the contract value is not sufficient for a determination by reference.
**E. F.** If a term life insurance rider on the named insured[s] on the base life insurance policy does not meet the conditions of Paragraph DE above, and either (1) guarantees level or near level premiums until a specified duration followed by a material premium increase; or (2) for a rider for which level or near level premiums are expected for a period followed by a material premium increase, the rider is separated from the base policy and follows the reserve requirements for term policies under VM20, VM-A and/or VM-C, as applicable.

**F. G.** For all other riders or supplemental benefits on life insurance policies or annuity contracts not addressed in Paragraphs B through E above, the riders or supplemental benefits may be included with the base policy or contract and follow the reserve requirements for the base policy or contract under VM-20, VM-21, VM-22, VM-A and/or VM-C, as applicable. For a given rider, the election to include riders or supplemental benefits with the base policy or contract shall be determined at the policy form level, not on a policy-by-policy basis, and shall be treated consistently from year-to-year, unless otherwise approved by the domiciliary commissioner.

**G. H.** Any supplemental benefits and riders offered on life insurance policies or annuity contracts that would have a material impact on the reserve if elected later in the contract life, such as joint income benefits, nursing home benefits, or withdrawal provisions on annuity contracts, shall be considered when determining reserves using the following principles:

1. Policyholders with living benefits and annuitization in the same contract will generally use the more valuable of the two benefits.

2. When advantageous, policyholders will commence living benefit payouts if not started yet.
July 16, 2021
Bruce Sartain, Chair
Valuation Manual (VM)-22 (A) Subgroup
Life Actuarial (A) Task Force
National Association of Insurance Commissioners (NAIC)

Dear Mr. Sartain,

The American Academy of Actuaries\(^1\) Annuity Reserves and Capital Work Group (ARCWG) presented a fixed annuity principle-based reserving (PBR) framework proposal to the VM-22 Subgroup during its October 21, 2020 meeting. This document provides ARCWG’s initial draft of NAIC Valuation Manual Section II and VM-22 requirements associated with the ARCWG proposal. We ask for the VM-22 Subgroup’s consideration of the language herein as a foundation for further drafting efforts, in your efforts to advance toward an NAIC fixed annuity PBR framework.

Please let us know if you have any follow-up inquiries in response to this document. Again, we appreciate the opportunity to propose the fixed annuity framework and all of the efforts made by the VM-22 Subgroup to focus on this topic.

Sincerely,
Ben Slutsker
Chairperson, Annuity Reserves and Capital Work Group
American Academy of Actuaries

\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
VM-22 PBR: Requirements for Principle-Based Reserves for Non-Variable Annuities

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Section 1: Background

A. Purpose

These requirements establish the minimum reserve valuation standard for non-variable annuity contracts as defined in Section 2.A and issued on or after 1/1/2024. For all contracts encompassed by the Scope, these requirements constitute the Commissioners Annuity Reserve Valuation Method (CARVM) and, for certain contracts, the Commissioners Reserve Valuation Method (CRVM).

Guidance Note: CRVM requirements apply to some group pension contracts.

B. Principles

The projection methodology used to calculate the stochastic reserve is based on the following set of principles. These principles should be followed when interpreting and applying the methodology in these requirements and analyzing the resulting reserves.

Guidance Note: The principles should be considered in their entirety, and it is required that companies meet these principles with respect to those contracts that fall within the scope of these requirements and are in force as of the valuation date to which these requirements are applied.

Principle 1: The objective of the approach used to determine the stochastic reserve is to quantify the amount of statutory reserves needed by the company to be able to meet contractual obligations in light of the risks to which the company is exposed with an element of conservatism consistent with statutory reporting objectives.

Principle 2: The calculation of the stochastic reserve is based on the results derived from an analysis of asset and liability cash flows produced by the application of a stochastic cash-flow model to equity return and interest rate scenarios. For each scenario, the greatest present value of accumulated deficiency is calculated. The analysis reflects prudent estimate assumptions for deterministic variables and is performed in aggregate (subject to limitations related to contractual provisions) to allow the natural offset of risks within a given scenario. The methodology uses a projected total cash flow analysis by including all projected income, benefit, and expense items related to the business in the model and sets the stochastic reserve at a degree of confidence using the CTE measure applied to the set of scenario specific greatest present values of accumulated deficiencies that is deemed to be reasonably conservative over the span of economic cycles.

Principle 3: The implementation of a model involves decisions about the experience assumptions and the modeling techniques to be used in measuring the risks to which the company is exposed. Generally, assumptions are to be based on the conservative end of the confidence interval. The choice of a conservative estimate for each assumption may result in a distorted measure of the total risk. Conceptually, the choice of assumptions and the modeling decisions should be made so that the final result approximates what would be obtained for the
stochastic reserve at the required CTE level if it were possible to calculate results over the joint
distribution of all future outcomes. In applying this concept to the actual calculation of the
stochastic reserve, the company should be guided by evolving practice and expanding
knowledge base in the measurement and management of risk.

**Guidance Note:** The intent of Principle 3 is to describe the conceptual framework for setting
assumptions. Section 10 provides the requirements and guidance for setting contract holder
behavior assumptions and includes alternatives to this framework if the company is unable to
fully apply this principle.

**Principle 4:** While a stochastic cash-flow model attempts to include all real-world risks
relevant to the objective of the stochastic cash-flow model and relationships among the risks,
it will still contain limitations because it is only a model. The calculation of the stochastic
reserve is based on the results derived from the application of the stochastic cash-flow model
to scenarios, while the actual statutory reserve needs of the company arise from the risks to
which the company is (or will be) exposed in reality. Any disconnect between the model and
reality should be reflected in setting prudent estimate assumptions to the extent not addressed
by other means.

**Principle 5:** Neither a cash-flow scenario model nor a method based on factors calibrated to
the results of a cash-flow scenario model can completely quantify a company’s exposure to
risk. A model attempts to represent reality but will always remain an approximation thereto
and, hence, uncertainty in future experience is an important consideration when determining
the stochastic reserve. Therefore, the use of assumptions, methods, models, risk management
strategies (e.g., hedging), derivative instruments, structured investments or any other risk
transfer arrangements (such as reinsurance) that serve solely to reduce the calculated
stochastic reserve without also reducing risk on scenarios similar to those used in the actual
cash-flow modeling are inconsistent with these principles. The use of assumptions and risk
management strategies should be appropriate to the business and not merely constructed to
exploit “foreknowledge” of the components of the required methodology.

C. Risks Reflected

1. The risks reflected in the calculation of reserves under these requirements arise from actual
or potential events or activities that are both:
   a. Directly related to the contracts falling under the scope of these requirements or
      their supporting assets; and
   b. Capable of materially affecting the reserve.

2. Categories and examples of risks reflected in the reserve calculations include, but are not
necessarily limited to:
   a. Asset risks
      i. Credit risks (e.g., default or rating downgrades).
ii. Commercial mortgage loan roll-over rates (roll-over of bullet loans).

iii. Uncertainty in the timing or duration of asset cash flows (e.g., shortening (prepayment risk) and lengthening (extension risk)).

iv. Performance of equities, real estate, and Schedule BA assets.

v. Call risk on callable assets.

vi. Separate account fund performance.

vii. Risk associated with hedge instrument (includes basis, gap, price, parameter estimation risks, and variation in assumptions).

viii. Currency risk.

b. Liability risks

i. Reinsurer default, impairment, or rating downgrade known to have occurred before or on the valuation date.

ii. Mortality/longevity, persistency/lapse, partial withdrawal, and premium payment risks.

iii. Utilization risk associated with guaranteed living benefits.

iv. Anticipated mortality trends based on observed patterns of mortality improvement or deterioration, where permitted.

v. Annuitzation risks.

vi. Additional premium dump-ins or deposits (high interest rate guarantees in low interest rate environments).

vii. Applicable expense risks, including fluctuation maintenance expenses directly attributable to the business, future commission expenses, and expense inflation/growth.

c. Combination risks

i. Risks modeled in the company’s risk assessment processes that are related to the contracts, as described above.

ii. Disintermediation risk (including such risk related to payment of surrender or partial withdrawal benefits).

iii. Risks associated with revenue-sharing income.

3. The risks not necessarily reflected in the calculation of reserves under these requirements are:
a. Those not associated with the policies or contracts being valued, or their supporting assets.

b. Determined to not be capable of materially affecting the reserve.

4. Categories and examples of risks not reflected in the reserve calculations include, but are not necessarily limited to:

a. Asset risks
   i. Liquidity risks associated with sudden and significant levels of withdrawals and surrenders.

b. Liability risks
   i. Reinsurer default, impairment or rating downgrade occurring after the valuation date.
   ii. Catastrophic events (e.g., epidemics or terrorist events).
   iii. Major breakthroughs in life extension technology that have not yet fundamentally altered recently observed mortality experience.
   iv. Significant future reserve increases as an unfavorable scenario is realized.

c. General business risks
   i. Deterioration of reputation.
   ii. Future changes in anticipated experience (reparameterization in the case of stochastic processes), which would be triggered if and when adverse modeled outcomes were to actually occur.
   iii. Poor management performance.
   iv. The expense risks associated with fluctuating amounts of new business.
   v. Risks associated with future economic viability of the company.
   vi. Moral hazards.
   vii. Fraud and theft.

D. Specific Definitions for VM-22

**Buffer Annuity**
Interchangeable term for Registered Index-Linked Annuity (RILA). See definition for Registered Index-Linked Annuity below.

**Deferred Income Annuity (DIA)**
An annuity which guarantees a periodic payment for the life of the annuitant or a term certain and payments begin one year or later after (or from) the issue date if the contract holder survives to a predetermined future age.

**Fixed Indexed Annuity (FIA)**
An annuity with an account value where the contract holder has the option for a portion or all of the account value to grow at a rate linked to an external index, typically with guaranteed principal.

**Flexible Premium Deferred Annuity (FPDA)**
An annuity with an account value established with a premium amount but allows for additional deposits to be paid into the annuity over time, resulting in an increase to the account value. The contract also has a guaranteed interest rate during the accumulation phase and has guaranteed mortality and interest rates applicable at the time of conversion to the payout phase.

**Funding Agreement**
A contract issued to an institutional investor (domestic and international non-qualified fixed income investors) that provides fixed or floating interest rate guarantees.

**Guaranteed Investment Contract (GIC)**
Insurance contract typically issued to a retirement plan (defined contribution) under which the insurer accepts a deposit (or series of deposits) from the purchaser and guarantees to pay a specified interest rate on the funds deposited during a specified period of time.

**Index Credit Hedge Margin**
A margin capturing the risk of inefficiencies in the company’s hedging program supporting index credits. This includes basis risk, persistency risk, and the risk associated with modeling decisions and simplifications. It also includes any uncertainty of costs associated with managing the hedging program and changes due to investment and management decisions.

**Index Credit**
Any interest credit, multiplier, factor, bonus, charge reduction, or other enhancement to policy values that is linked to an index or indices. Amounts credited to the policy resulting from a floor on an index account are included.

**Index Crediting Strategy**
The strategy defined in a contract to determine index credits for a contract. This refers to underlying index, index parameters, date, timing, and other elements of the crediting method.

**Index Parameter**
Cap, floor, participation rate, spreads, or other features describing how the contract utilizes the index.

**Longevity Reinsurance**
An agreement, typically a reinsurance arrangement covering one or more group or individual annuity contracts, under which an insurance company assumes the longevity risk associated with
periodic payments made to specified annuitants under one or more immediate or deferred payout annuity contracts. A common example is participants in one or more underlying retirement plans.

Typically, the reinsurer pays a portion of the actual benefits due to the underlying annuitants (or, in some cases, a pre-agreed amount per annuitant), while the ceding insurance company retains the assets supporting the reinsured annuity payments and pays periodic, ongoing premiums to the reinsurer over the expected lifetime of benefits paid to the specified annuitants. Such agreements may contain net settlement provisions such that only one party makes ongoing cash payments in a particular period. Under these agreements, longevity risk may be transferred on either a permanent basis or for a prespecified period of time, and these agreements may or may not permit early termination.

Agreements which are not treated as reinsurance under Statement of Statutory Accounting Principles (SSAP) No. 61R are not included in this definition. In particular, contracts under which payments are made based on the aggregate mortality experience of a population of lives which are not covered by an underlying group or individual annuity contract (e.g., mortality index-based longevity swaps) are not included in this definition.

**Market Value Adjustment (MVA) Annuity**
An annuity with an account value where withdrawals and full surrenders are subject to adjustments based on interest rates or index returns at the time of withdrawal/surrender. There could be ceilings and floors on the amount of the market-value adjustment.

**Modified Guaranteed Annuity (MGA)**
A type of market-value adjusted annuity contract where the underlying assets are held in an insurance company separate account and the value of which are guaranteed if held for specified periods of time. The contract contains nonforfeiture values that are based upon a market-value adjustment formula if held for shorter periods.

**Multiple Year Guaranteed Annuity (MYGA)**
A type of fixed annuity that provides a pre-determined and contractually guaranteed interest rate for specified periods of time, after which there is typically an annual reset or renewal of a multiple year guarantee period.

**Pension Risk Transfer (PRT) Annuity**
An annuity, typically a group contract or reinsurance agreement, issued by an insurance company providing periodic payments to annuitants receiving immediate or deferred benefits from one or more retirement plans. Typically, the insurance company holds the assets supporting the benefits, which may be held in the general or separate account, and retains not only longevity risk but also asset risks (e.g., credit risk and reinvestment risk).

**Registered Index-Linked Annuity (RILA)**
An annuity with an account value where the contract holder has the option for a portion or all of the account value to grow at a rate linked to an external index, similar to a Fixed Indexed Annuity, but with downside risk exposure that may not guarantee full principal repayment. These contracts may include a cap on upside returns, and may also include a floor on downside returns which may be below zero percent.
Single Premium Immediate Annuity (SPIA)
An annuity purchased with a single premium amount which guarantees a periodic payment for the life of the annuitant or a term certain and payments begin within one year after (or from) the issue date.

Single Premium Deferred Annuity (SPDA)
An annuity with an account value established with a single premium amount that grows with a guaranteed interest rate during the accumulation phase and has guaranteed mortality and interest rates applicable at the time of conversion to the payout phase. May also include cases where the premium is accepted for a limited amount of time early in the contract life, such as only in the first duration.

Stable Value Contract
A contract that provides limited investment guarantees, typically preserving principal while crediting steady, positive returns and protecting against losses or declines in yield. Underlying asset portfolios typically consist of fixed income securities, which may sit in the insurer’s general account, a separate account, or in a third-party trust. These contracts often support defined contribution or defined benefit retirement plan liabilities.

Structured Settlement Contract (SSC)
A contract that provides periodic benefits and is purchased with a single premium amount stemming from various types of claims pertaining to court settlements or out-of-court settlements from tort actions arising from accidents, medical malpractice, and other causes. Adverse mortality is typically expected for these contracts.

Synthetic GIC
Contract that simulates the performance of a traditional GIC through a wrapper, swap, or other financial instruments, with the main difference being that the assets are owned by the policyholder or plan trust.

Term Certain Payout Annuity
A contract issued, which offers guaranteed periodic payments for a specified period of time, not contingent upon mortality or morbidity of the annuitant.

Two-Tiered Annuity
A deferred annuity with two tiers of account values. One, with a higher accumulation interest rate, is only available for annuitization or death. The other typically contains a lower accumulation interest rate, and is only available upon surrender.
Section 2: Scope and Effective Date

A. Scope

Subject to the requirements of this VM-22 are annuity contracts, certificates and contract features, whether group or individual, including both life contingent and term-certain-only, directly written or assumed through reinsurance issued on or after 1/1/2024, with the exception of contracts or benefits listed below.

Products out of scope include:

- Contracts or benefits that are subject to VM-21 (such as variable annuities, RILAs, buffer annuities, and structured annuities)
- GICs
- Synthetic GICs
- Stable Value Contracts
- Funding Agreements

Products in scope of VM-22 include fixed annuities which consist of, but are not limited to, the following list:

- **Account Value Based Annuities**
  - Deferred Annuities (SPDA & FPDA)
  - Multi-Year Guarantee Annuities (MYGA)
  - Fixed Indexed Annuities (FIA)
  - Market-Value Adjustments (MVA)
  - Two-tiered Annuities
  - Guarantees/Benefits/Riders on Fixed Annuity Contracts

- **Payout Annuities**
  - Single Premium Immediate Annuities (SPIA)
  - Deferred Income Annuities (DIA)
  - Term Certain Payout Annuity
  - Pension Risk Transfer Annuities (PRT)
  - Structured Settlement Contracts (SSC)
  - Longevity Reinsurance

The company may elect to exclude one or more groups of contracts from the stochastic reserve calculation in certain situations, pursuant to the exclusion test requirements defined in Section 3.E of VM-22.

B. Effective Date & Transition

**Effective Date**

These requirements apply for valuation dates on or after January 1, 2024.

**Transition**

A company may elect to establish minimum reserves pursuant to applicable requirements in VM-A and VM-C for business otherwise subject to VM-22 PBR requirements and issued during the
first three years following the effective date of VM-22 PBR. If a company during the three years elects to apply VM-22 PBR to a block of such business, then a company must continue to apply the requirements of VM-22 PBR for future issues of this business. Irrespective of the transition date, a company shall apply VM-22 PBR requirements to applicable blocks of business on a prospective basis starting at least three years after the effective date.
Section 3: Reserve Methodology

A. Aggregate Reserve

The aggregate reserve for contracts falling within the scope of these requirements shall equal the stochastic reserve (following the requirements of Section 4) less any applicable PIMR for all contracts not valued under applicable requirements in VM-A and VM-C, plus the reserve for any contracts valued under applicable requirements in VM-A and VM-C.

**Guidance Note:** Contracts valued under applicable requirements in VM-A and VM-C are ones that pass the exclusion test and elect to not model PBR stochastic reserves, per the requirements in Section 3.E.

B. Impact of Reinsurance Ceded

All components in the aggregate reserve shall be determined post-reinsurance ceded, that is net of any reinsurance cash flows arising from treaties that meet the statutory requirements that allow the treaty to be accounted for as reinsurance. A pre-reinsurance ceded reserve also needs to be determined by ignoring all reinsurance cash flows (costs and benefits) in the reserve calculation.

C. To Be Determined

D. The Stochastic Reserve

1. The stochastic reserve shall be determined based on asset and liability projections for the contracts falling within the scope of these requirements, excluding those contracts valued using the methodology pursuant to applicable requirements in VM-A and VM-C, over a broad range of stochastically generated projection scenarios described in Section 8 and using prudent estimate assumptions as required in Section 3.F herein.

2. The stochastic reserve amount for any group of contracts shall be determined as CTE70 of the scenario reserves following the requirements of Section 4, with the exception of groups of contracts for which a company elects the Deterministic Certification Option in Section 7.E, which shall be determined as the scenario reserve following the requirements of Section 4.

3. The reserve may be determined in aggregate across various groups of contracts as a single model segment when determining the stochastic reserve if the business and risks are not managed separately or are part of the same integrated risk management program. Aggregation is permitted if a resulting group of contracts (or model segment) follows the listed principles:
   a. Aggregate in a manner that is consistent with the company’s risk management strategy and reflects the likelihood of any change in risk offsets that could arise from shifts between product types, and
   b. Using prudent actuarial judgement, consider the following elements when aggregating groups of contracts: whether groups of contracts are part of the same portfolio (or different portfolios that interact), same integrated risk management system, administered/managed together

4. Do not aggregate groups of contracts for which the company elects to use the Deterministic Certification Option in Section 7.E with any groups of contracts that do not use such option.
5. To the extent that these limits on aggregation result in more than one model segment, the stochastic reserve shall equal the sum of the stochastic reserve amounts computed for each model segment and scenario reserve amounts computed for each model segment for which the company elects to use the Deterministic Certification Option in Section 7.E.

E. Exclusion Test

1. To the extent that certain groups of contracts pass one of the defined stochastic exclusion tests in Section 7.B, these groups of contracts may be valued using the methodology pursuant to applicable requirements in VM-A and VM-C, with the statutory maximum valuation rate for immediate annuities specified in Section 13.

   a. For dividend-paying contracts, a dividend liability shall be established upon following requirements in VM-A and VM-C, as described above, for the base contract.

Guidance Note: The intention of contracts that pass the stochastic exclusion test is to provide the option to value contracts under VM-A and VM-C. This may apply to pre-PBR CARVM requirements in accordance with Actuarial Guideline XXXIII (AG33) methodology with type A, B, C rates for SPIAs issued before 2018; AG33 methodology with pre-PBR VM-22 rates for SPIAs issued on/after 2018; Actuarial Guideline XXXV (AG35) pre-PBR methodology for Fixed Indexed Annuities; and AG33 methodology (with interest rate updates for modernization initiatives on new contracts) for non-SPIAs.

2. The approach for grouping contracts when performing the exclusion tests should follow the same principles that underlie the aggregation approach for model segments discussed for Stochastic Reserves in Section D above.

F. Allocation of the Aggregate Reserve to Contracts

The aggregate reserve shall be allocated to the contracts falling within the scope of these requirements using the method outlined in Section 12.

G. Prudent Estimate Assumptions:

1. With respect to the Stochastic Reserve in Section 3.C, the company shall establish the prudent estimate assumption for each risk factor in compliance with the requirements in Section 12 of Model #820 and must periodically review and update the assumptions as appropriate in accordance with these requirements.

2. The qualified actuary, to whom responsibility for this group of contracts is assigned, shall annually review relevant emerging experience for the purpose of assessing the appropriateness of the anticipated experience assumption. If the results of statistical testing or other testing indicate that previously anticipated experience for a given factor is inadequate, then the qualified actuary shall set a new, adequate, anticipated experience assumption for the factor.

3. To determine the prudent estimate assumptions, the stochastic reserve shall also follow the requirements in Sections 4 and 9 for asset assumptions, Section 10 for policyholder behavior assumptions, and Section 11 for mortality assumptions.
Section 4: Determination of Stochastic Reserve

A. Projection of Accumulated Deficiencies

1. General Description of Projection

   The projection of accumulated deficiencies shall be made ignoring federal income tax in both cash flows and discount rates, and it shall reflect the dynamics of the expected cash flows for the entire group of contracts, reflecting all product features, including any guarantees provided under the contracts using prudent estimate liability assumptions defined in Sections 10 and 11 and asset assumptions defined in Section 4.D. The company shall project cash flows including the following:

   a. Revenues received by the company including gross premiums received from the policyholder (including any due premiums as of the projected start date).

   b. All material benefits projected to be paid to policyholders—including, but not limited to, death claims, surrender benefits and withdrawal benefits—reflecting the impact of all guarantees and adjusted to take into account amounts projected to be charged to account values on general account business. Any guarantees, in addition to market value adjustments assessed on projected withdrawals or surrenders, shall be taken into account.

   Guidance Note: Amounts charged to account values on general account business are not revenue; examples include rider charges and expense charges.

   c. Non-Guaranteed Elements (NGE) cash flows as described in Section 10.J.

   d. Insurance company expenses (including overhead and investment expense), commissions, contractual fees and charges, and revenue-sharing income received by the company (net of applicable expenses).

   e. Net cash flows associated with any reinsurance.

   f. Cash flows from hedging instruments as described in Section 4.A.4.

   g. Cash receipts or disbursements associated with invested assets (other than policy loans) as described in Section 4.D.4, including investment income, realized capital gains and losses, principal repayments, asset default costs, investment expenses, asset prepayments, and asset sales.

   h. If modeled explicitly, cash flows related to policy loans as described in Section 10.I.2, including interest income, new loan payments and principal repayments.

   Guidance Note: Future net policy loan cash flows include: policy loan interest paid in cash plus repayments of policy loan principal, including repayments occurring at death or surrender (note that the future benefits in Section 4.A.1.b are before consideration of policy...
loans), less additional policy loan principal (but excluding policy loan interest that is added to the policy loan principal balance).

2. Grouping of Index Crediting Strategies

Index crediting strategies may be grouped for modeling using an approach that recognizes the investment guidelines and objectives of each index crediting strategy. In assigning each index crediting strategy to a grouping for projection purposes, the fundamental characteristics of the index crediting strategy shall be reflected, and the parameters shall have the appropriate relationship to the stochastically generated projection scenarios described in Section 8. The grouping shall reflect characteristics of the efficient frontier (i.e., returns generally cannot be increased without assuming additional risk).

Index accounts sharing similar index crediting strategies may also be grouped for modeling to an appropriately crafted proxy strategy normally expressed as a linear combination of recognized market indices, sub-indices or funds, in order to develop the investment return paths and associated interest crediting. Each index crediting strategy’s specific risk characteristics, associated index parameters, and relationship to the stochastically generated scenarios in Section 8 should be considered before grouping or assigning to a proxy strategy. Grouping and/or development of a proxy strategy may not be done in a manner that intentionally understates the resulting reserve.

3. Model Cells

Projections may be performed for each contract in force on the date of valuation or by assigning contracts into representative cells of model plans using all characteristics and criteria having a material impact on the size of the reserve. Assigning contracts to model cells may not be done in a manner that intentionally understates the resulting reserve.

4. Modeling of Hedges

a. For a company that does not have a future hedging program tied directly to the contracts falling under the scope of VM-22 stochastic reserve requirements:

   i. The company shall not consider the cash flows from any future hedge purchases or any rebalancing of existing hedge assets in its modeling.

   ii. Existing hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the starting assets. The hedge assets may then be considered in one of two ways:

      a) Include the asset cash flows from any contractual payments and maturity values in the projection model; or

      b) No hedge positions—in which case the hedge positions held on the valuation date are replaced with cash and/or other general account assets in an amount equal to the aggregate market value of these hedge positions.
Guidance Note: If the hedge positions held on the valuation date are replaced with cash, then as with any other cash, such amounts may then be invested following the company’s investment strategy.

A company may switch from method a) to method b) at any time, but it may only change from b) to a) with the approval of the domiciliary commissioner.

b. For a company that has a future hedging program tied directly to the contracts falling under the scope of VM-22 stochastic reserve requirements:

i. For a hedging program with hedge payoffs that offset interest credits associated with indexed interest strategies (indexed interest credits):

a) In modeling cash flows, the company shall include the cash flows from future hedge purchases or any rebalancing of existing hedge assets that are intended solely to offset interest credits to policyholders.

b) Existing hedging instruments that are currently held by the company for this purpose in support of the contracts falling under the scope of these requirements shall be included in the starting assets. Existing hedging instruments that are currently held by the company for any other purpose should be modeled consistently with the requirements of Section 4.A.4.a.ii.

c) An Index Credit Hedge Margin for these instruments shall be reflected by reducing index interest credit hedge payoffs by a margin multiple that shall be justified by sufficient and credible company experience and be no less than \([X\%]\) multiplicatively of the interest credited. In the absence of sufficient and credible company experience, a margin of \([Y\%]\) shall be assumed. There is no cap on the index credit hedge margin if company experience indicates actual error is greater than \([Y\%]\). It is permissible to substitute stress-testing for sufficient and credible experience if such stress-testing comprehensively considers a robust range of future market conditions.

ii. For a company that hedges any contractual obligation or risks other than indexed interest credits, the detailed requirements for the modeling of hedges are defined in Section 9. The following requirements do not supersede the detailed requirements.

a) The appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the projections used in the determination of the stochastic reserve.

b) The projections shall take into account the appropriate costs and benefits of hedge positions expected to be held in the future.
Because models do not always accurately portray the results of hedge programs, the company shall, through back-testing and other means, assess the accuracy of the hedge modeling. The company shall determine a stochastic reserve as the weighted average of two CTE values: first, a CTE70 (“best efforts”) representing the company’s projection of all of the hedge cash flows, including future hedge purchases, and a second CTE70 (“adjusted”) which shall use only hedge assets held by the company on the valuation date and only future hedge purchases associated with indexed interest credited. These are discussed in greater detail in Section 9.

c) Consistent with Section 4.A.4.b.i., the index credit hedge margin for instruments associated with indexed interest credited shall be reflected by reducing hedge payoffs by a margin multiple as defined in Section 4.A.4.b.i.c).

d) The use of products not falling under the scope of these requirements as a hedge shall not be recognized in the determination of accumulated deficiencies.

**Guidance Note:** Section 4.A.4.b.i is intended to address common situations for products with index crediting strategies where the company only hedges index credits or clearly separates index credit hedging from other hedging. In this case the hedge positions are considered similarly to other fixed income assets supporting the contracts, and a margin is reflected rather than modeling using a CTE70 adjusted run with no future hedge purchases. If a company has a more comprehensive hedge strategy combining index credits, guaranteed benefit, and other risks (e.g., full fair value or economic hedging), an appropriate and documented bifurcation method should be used in the application of sections 4.A.4.b.i and 4.A.4.b.ii above for the hedge modeling and justification. Such bifurcation methods may quantify the specific risk exposure attributable to index credit liabilities versus other liabilities such as guaranteed living benefits, and apply such for the basis for allocation.

**Guidance Note:** The requirements of Section 4.A.4 govern the determination of reserves for annuity contracts and do not supersede any statutes, laws or regulations of any state or jurisdiction related to the use of derivative instruments for hedging purposes and should not be used in determining whether a company is permitted to use such instruments in any state or jurisdiction.

5. **Revenue Sharing**

If applicable, projections of accumulated deficiencies may include income from projected future revenue sharing, net of applicable projected expenses (net revenue-sharing income) if each of the requirements set forth in VM 21 Section 4.A.5 are met.

6. **Length of Projections**

Projections of accumulated deficiencies shall be run for as many future years as needed so that no materially greater reserve value would result from longer projection periods.
7. Interest Maintenance Reserve (IMR)

The IMR shall be handled consistently with the treatment in the company’s cash flow testing, and the amounts should be adjusted to a pre-tax basis.

B. Determination of Scenario Reserve

1. For a given scenario, the scenario reserve shall be determined using one of two methods described below:

   a) The starting asset amount plus the greatest present value, as of the projection start date, of the projected accumulated deficiencies; or

   Guidance Note: The greatest present value of accumulated deficiencies can be negative.

   b) The direct iteration method, where the scenario reserve is determined by solving for the amount of starting assets which, when projected along with all contract cash flows, result in the defeasement of all projected future benefits and expenses at the end of the projection horizon with no positive accumulated deficiencies at the end of any projection year during the projection period.

   The scenario reserve for any given scenario shall not be less than the cash surrender value in aggregate on the valuation date for the group of contracts modeled in the projection.

2. Discount Rates

   In determining the scenario reserve, unless using the direct iteration method pursuant to Section 4.B.1.b, the accumulated deficiencies shall be discounted at the NAER on additional assets, as defined in Section 4.B.3.

3. Determination of NAER on Additional Invested Asset Portfolio

   a. The additional invested asset portfolio for a scenario is a portfolio of general account assets as of the valuation date, outside of the starting asset portfolio, that is required in that projection scenario so that the projection would not have a positive accumulated deficiency at the end of any projection year. This portfolio may include only (i) General Account assets available to the company on the valuation date that do not constitute part of the starting asset portfolio; and (ii) cash assets.

   Guidance Note:

   Additional invested assets should be selected in a manner such that if the starting asset portfolio were revised to include the additional invested assets, the projection would not be expected to experience any positive accumulated deficiencies at the end of any projection year.

   It is assumed that the accumulated deficiencies for this scenario projection are known.

   b. To determine the NAER on additional invested assets for a given scenario:
i. Project the additional invested asset portfolio as of the valuation date to the end of the projection period,
   a) Investing any cash in the portfolio and reinvesting all investment proceeds using the company’s investment policy.
   b) Excluding any liability cash flows.
   c) Incorporating the appropriate returns, defaults and investment expenses for the given scenario.

ii. If the value of the projected additional invested asset portfolio does not equal or exceed the accumulated deficiencies at the end of each projection year for the scenario, increase the size of the initial additional invested asset portfolio as of the valuation date, and repeat the preceding step.

iii. Determine a vector of annual earned rates that replicates the growth in the additional invested asset portfolio from the valuation date to the end of the projection period for the scenario. This vector will be the NAER for the given scenario.

iv. If the depletion of assets within the projection results in an unreasonably high negative NAER upon borrowing, the NAER may be set to the assumed cost of borrowing associated with each projected time period, in accordance with Section 4.D.3.c, as a safe harbor.

Guidance Note: There are multiple ways to select the additional invested asset portfolio at the valuation date. Similarly, there are multiple ways to determine the earned rate vector. The company shall be consistent in its choice of methods, from one valuation to the next.

C. Projection Scenarios

1. Number of Scenarios

   The number of scenarios for which the scenario reserve shall be computed shall be the responsibility of the company, and it shall be considered to be sufficient if any resulting understatement in the stochastic reserve, as compared with that resulting from running additional scenarios, is not material.

2. Economic Scenario Generation

   Treasury Department interest rate curves, as well as investment return paths for index funds, equities, and fixed income assets shall be determined on a stochastic basis using the methodology described in Section 8. If the company uses a proprietary generator to develop scenarios, the company shall demonstrate that the resulting scenarios meet the requirements described in Section 8.
D. Projection of Assets

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

      i. Any hedge instruments held in support of the contracts being valued; and

      ii. An amount of assets held in the general account equal to the approximate
          value of statutory reserves as of the start of the projections less the amount
          in (i).

   b. If the amount of initial general account assets is negative, the model should reflect
      a projected interest expense. General account assets chosen for use as described
      above shall be selected on a consistent basis from one reserve valuation hereunder
      to the next.

2. Valuation of Projected Assets

   For purposes of determining the projected accumulated deficiencies, the value of projected
   assets shall be determined in a manner consistent with their value at the start of the
   projection. For assets assumed to be purchased during a projection, the value shall be
   determined in a manner consistent with the value of assets at the start of the projection that
   have similar investment characteristics. However, for derivative instruments that are used
   in hedging and are not assumed to be sold during a particular projection interval, the
   company may account for them at an amortized cost in an appropriate manner elected by
   the company.

   **Guidance Note:** Accounting for hedge assets should recognize any methodology prescribed by a
   company’s state of domicile.

3. General Account Assets
   a. General account assets shall be projected, net of projected defaults, using assumed
      investment returns consistent with their book value and expected to be realized in
      future periods as of the date of valuation. Initial assets that mature during the
      projection and positive cash flows projected for future periods shall be invested in
      a manner that is representative of and consistent with the company’s investment
      policy, subject to the following requirements:

      i. The final maturities and cash flow structures of assets purchased in the
         model, such as the patterns of gross investment income and principal
         repayments or a fixed or floating rate interest basis, shall be determined
         by the company as part of the model representation;
ii. The combination of price and structure for fixed income investments and derivative instruments associated with fixed income investments shall appropriately reflect the projected Treasury Department curve along the relevant scenario and the requirements for gross asset spread assumptions stated below;

iii. For purchases of public non-callable corporate bonds, follow the requirements defined in VM-20 Sections 7.E, 7.F and 9.F. The prescribed spreads reflect current market conditions as of the model start date and grade to long-term conditions based on historical data at the start of projection year four;

iv. For transactions of derivative instruments associated with fixed income investments, reflect the prescribed assumptions in VM-20 Section 9.F for interest rate swap spreads;

v. For purchases of other fixed income investments, if included in the model investment strategy, set assumed gross asset spreads over U.S. Treasuries in a manner that is consistent with, and results in reasonable relationships to, the prescribed spreads for public non-callable corporate bonds and interest rate swaps.

b. Notwithstanding the above requirements, the model investment strategy and any non-prescribed asset spreads shall be adjusted as necessary so that the aggregate reserve is not less than that which would be obtained by substituting an alternative investment strategy in which all fixed income reinvestment assets are public non-callable corporate bonds with gross asset spreads, asset default costs, and investment expenses by projection year that are consistent with a credit quality blend of:

i. 5% Treasury

ii. 15% PBR credit rating 3 (Aa2/AA)

iii. 40% PBR credit rating 6 (A2/A)

iv. 40% PBR credit rating 9 (Baa/BBB)

c. Any disinvestment shall be modeled in a manner that is consistent with the company’s investment policy and that reflects the company’s cost of borrowing where applicable, provided that the assumed cost of borrowing is not lower than the rate at which positive cash flows are reinvested in the same time period, taking into account duration, ratings, and other attributes of the borrowing mechanism. Gross asset spreads used in computing market values of assets sold in the model shall be consistent with, but not necessarily the same as, the gross asset spreads in Section 4.D.4.a.ii and Section 4.D.4.a.iv, recognizing that initial assets that mature during the projection may have different characteristics than modeled reinvestment assets.
**Guidance Note:** This limitation is being referred to Life Actuarial (A) Task Force for review. The simple language above “provided that the assumed cost of borrowing is not lower than the rate at which positive cash flows are reinvested in the same time period” is not intended to impose a literal requirement. It is intended to reflect a general concept to prevent excessively optimistic borrowing assumptions. It is recognized that borrowing parameters and rules can be complicated, such that modeling limitations may not allow for literal compliance, in every time step, as long as the reserve is not materially affected. However, if the company is unable to fully apply this restriction, prudence dictates that a company shall not allow borrowing assumptions to materially reduce the reserve.

4. **Cash Flows from Invested Assets**
   
a. Cash flows from general account fixed income assets, including starting and reinvestment assets, shall be reflected in the projection as follows:
   
i. Model gross investment income and principal repayments in accordance with the contractual provisions of each asset and in a manner consistent with each scenario.
   
ii. Reflect asset default costs as prescribed in VM-20 Section 9.F and anticipated investment expenses through deductions to the gross investment income.
   
iii. Model the proceeds arising from modeled asset sales and determine the portion representing any realized capital gains and losses.
   
iv. Reflect any uncertainty in the timing and amounts of asset cash flows related to the paths of interest rates, equity returns or other economic values directly in the projection of asset cash flows. Asset defaults are not subject to this requirement, since asset default assumptions must be determined by the prescribed method in VM-20 Sections 7.E, 7.F and 9.F.
   
   b. Cash flows from general account index funds and equity assets—i.e., non-fixed income assets having substantial volatility of returns, such as common stocks and real estate— including starting and reinvestment assets, shall be reflected in the projection as follows:
   
i. Determine the grouping for asset categories and the allocation of specific assets to each category in a manner that is consistent with that used for index crediting strategies, as discussed in Section 4.A.2.
   
ii. Project the gross investment return including realized and unrealized capital gains in a manner that is consistent with the stochastically generated scenarios.
   
iii. Model the timing of an asset sale in a manner that is consistent with the investment policy of the company for that type of asset. Reflect expenses through a deduction to the gross investment return using prudent estimate assumptions.
c. Cash flows for each projection interval for policy loan assets shall follow the requirements in Section 10.I.

E. Projection of Annuitization Benefits

1. Assumed Annuitization Purchase Rates

   a. For payouts specified at issue (such as single premium immediate annuities, deferred income annuities, and certain structured settlements), such payout rates shall reflect the payout rate specified in the contract.

   b. For purposes of projecting future elective annuitization benefits and withdrawal amounts from GMWBs, the projected annuitization purchase rates shall be determined assuming that market interest rates available at the time of election are the interest rates used to project general account assets, as determined in Section 4.D.4. In contrast, for payouts specified at issue, the payout rates modeled should be consistent with those specified in the contract.

2. Projected Election of GMIBs, GMWBs and Other Annuitization Options

   For contracts projected to elect future annuitization options (including annuitizations stemming from the election of a GMIB) or for projections of GMWB benefits once the account value has been depleted, the projections may assume the contract will stay in force, the projected periodic payments are paid, and the associated maintenance expenses are incurred.

F. Frequency of Projection and Time Horizon

1. Use of an annual cash-flow frequency ("timestep") is generally acceptable for benefits/features that are not sensitive to projection frequency. The lack of sensitivity to projection frequency should be validated by testing wherein the company should determine that the use of a more frequent—i.e., shorter—time step does not materially increase reserves. A more frequent time increment should always be used when the product features are sensitive to projection period frequency.

2. Care must be taken in simulating fee income and expenses when using an annual time step. It is also important that the frequency of the investment return model be linked appropriately to the projection horizon in the liability model. In particular, the horizon should be sufficiently long so as to capture the vast majority of costs (on a present value basis) from the scenarios.

   Guidance Note: As a general guide, the forecast horizon should not be less than 20 years.

G. Compliance with ASOPs

When determining a stochastic reserve, the analysis shall conform to the ASOPs as promulgated from time to time by the ASB.

Under these requirements, an actuary will make various determinations, verifications and certifications. The company shall provide the actuary with the necessary information sufficient to
permit the actuary to fulfill the responsibilities set forth in these requirements and responsibilities arising from each applicable ASOP.
Section 5: Reinsurance Ceded and Assumed

A. Treatment of Reinsurance Ceded in the Aggregate Reserve

1. Aggregate Reserve Pre- and Post-Reinsurance Ceded

As noted in Section 3.B, the aggregate reserve is determined both pre-reinsurance ceded and post-reinsurance ceded. Therefore, it is necessary to determine the components needed to determine the aggregate reserve—i.e., the stochastic reserve and/or the reserve amount valued using requirements in VM-A and VM-C, as applicable—on both bases. Sections 5.A.2 and 5.A.3 discuss adjustments to inputs necessary to determine these components on both a post-reinsurance ceded and a pre-reinsurance ceded basis. Note that due allowance for reasonable approximations may be used where appropriate.

2. Stochastic Reserve

a. In order to determine the aggregate reserve post-reinsurance ceded, accumulated deficiencies, scenario reserves, and the resulting stochastic reserve shall be determined reflecting the effects of reinsurance treaties that meet the statutory requirements that would allow the treaty to be accounted for as reinsurance within statutory accounting. This involves including, where appropriate, all projected reinsurance premiums or other costs and all reinsurance recoveries, where the reinsurance cash flows reflect all the provisions in the reinsurance agreement, using prudent estimate assumptions.

i. All significant terms and provisions within reinsurance treaties shall be reflected. In addition, it shall be assumed that each party is knowledgeable about the treaty provisions and will exercise them to their advantage.

Guidance Note: Renegotiation of the treaty upon the expiration of an experience refund provision or at any other time shall not be assumed if such would be beneficial to the company and not beneficial to the counterparty. This is applicable to both the ceding party and assuming party within a reinsurance arrangement.

ii. If the company has knowledge that a counterparty is financially impaired, the company shall establish a margin for the risk of default by the counterparty. In the absence of knowledge that the counterparty is financially impaired, the company is not required to establish a margin for the risk of default by the counterparty.

iii. A company shall include the cash flows from a reinsurance agreement or amendment in calculating the aggregate reserve if such qualifies for credit in compliance with Appendix A-791 of the Accounting Practices and Procedures Manual. If a reinsurance agreement or amendment does not qualify for credit for reinsurance but treating the reinsurance agreement or amendment as if it did so qualify would result in a reduction to the company’s surplus, then the company shall increase the minimum reserve by the absolute value of such reductions in surplus.

b. In order to determine the stochastic reserve on a pre-reinsurance ceded basis, accumulated deficiencies, scenario reserves, and the resulting stochastic reserve shall be determined ignoring the effects of reinsurance ceded within the projections. Different approaches may be used to determine the starting assets on the ceded portion of the contracts, dependent upon the characteristics of a given treaty:

i. For a standard coinsurance treaty, where the assets supporting the ceded liabilities were transferred to the assuming reinsurer, one acceptable approach involves a projection.
based on using starting assets on the ceded portion of the policies that are similar to those supporting the retained portion of the ceded policies or supporting similar types of policies. Scaling up each asset supporting the retained portion of the contract is also an acceptable method.

**Guidance Note:** For standard pro rata insurance treaties (does not include experience refunds), where allocated expenses are similar to the renewal expense allowance, reflecting the quota share applied to the present value of future reinsurance cash flows pertaining to the reinsured block of business may be considered as a possible approach to determine the ceded reserves.

ii. Alternatively, a treaty may contain an identifiable portfolio of assets associated with the ceded liabilities. This could be the case for several forms of reinsurance: funds withheld coinsurance; modified coinsurance; coinsurance with a trust. To the extent these assets would be available to the cedant, an acceptable approach could involve modeling this portfolio of assets. To the extent that these assets were insufficient to defease the ceded liabilities, the modeling would partially default to the approach discussed for a standard coinsurance treaty. To the extent these assets exceeded what might be needed to defease the ceded liabilities (perhaps an over collateralization requirement in a trust), the inclusion of such assets shall be limited.

**Guidance Note:** Section 3.5.2 in ASOP No. 52, *Principle-Based Reserves for Life Products under the NAIC Valuation Manual*, provides possible methods for constructing a hypothetical pre-reinsurance asset portfolio, if necessary, for purposes of the pre-reinsurance reserve calculation.

c. An assuming company shall use assumptions to project cash flows to and from ceding companies that reflect the assuming company’s experience for the business segment to which the reinsured policies belong and reflect the terms of the reinsurance agreement.

3. Reserve Determined Upon Passing the Exclusion Test

If a company passes the stochastic exclusion test and elects to use a methodology pursuant to applicable Sections VM-A and VM-C, as allowed in Section 3.E, it is important to note that the methodology produces reserves on a pre-reinsurance ceded basis. Therefore, the reserve must be adjusted for any reinsurance ceded accordingly. In addition, reserves valued under applicable Sections in VM-A and VM-C, unadjusted for reinsurance, shall be applied to the contracts falling under the scope of these requirements to determine the aggregate reserve prior to reinsurance.

It should be noted that the pre-reinsurance and post-reinsurance reserves may result in different outcomes for the exclusion test. In particular, it is possible that the pre-reinsurance reserves would pass the relevant exclusion test (and allow the use of VM-A and VM-C) while the post-reinsurance reserves might not.

4. To Be Determined
Section 7: Exclusion Testing

A. Stochastic Exclusion Test Requirement Overview

1. The company may elect to exclude one or more groups of contracts from the stochastic reserve calculation if the stochastic exclusion test (SET) is satisfied for that group of contracts. The company has the option to calculate or not calculate the SET.

   a. If the company does not elect to calculate the SET for one or more groups of contracts, or the company calculates the SET and fails the test for such groups of contracts, the reserve methodology described in Section 4 shall be used for calculating the aggregate reserve for those groups of contracts.

   b. If the company elects to calculate the SET for one or more groups of contracts, and passes the test for such groups of contracts, then the company shall choose whether or not to use the reserve methodology described in Section 4 for those groups of contracts. If the reserve methodology described in Section 4 is not used for one or more groups of contracts, then the company shall use the reserve methodology pursuant to applicable requirements in VM-A and VM-C to calculate the aggregate reserve for those groups of contracts.

   c. A company may not exclude a group of contracts from the stochastic reserve requirements if there are one or more future hedging programs associated with the contracts, with the exception of hedging programs solely supporting index credits as described in Section 9.A.1.

B. Types of Stochastic Exclusion Tests

Groups of contracts pass the SET if one of the following is met:

1. Stochastic Exclusion Ratio Test (SERT)—Annually the company demonstrates that the groups of contracts pass the SERT defined in Section 7.C.

2. Stochastic Exclusion Demonstration Test—In the first year and at least once every three calendar years thereafter, the company provides a demonstration in the PBR Actuarial Report as specified in Section 7.D.

3. SET Certification Method—For groups of contracts that do not have guaranteed living benefits, future hedging programs, or pension risk transfer business in the first year and at least every third calendar year thereafter, the company provides a certification by a qualified actuary that the group of contracts is not subject to material aggregate risk levels across interest rate risk, longevity risk, or asset return volatility risk (i.e., the risk on non-fixed-income investments having substantial volatility of returns, such as common stocks and real estate investments). The company shall provide the certification and documentation supporting the certification to the commissioner upon request.

Guidance Note: The qualified actuary should develop documentation to support the actuarial certification that presents his or her analysis clearly and in detail sufficient for another actuary to understand the analysis and reasons for the actuary’s conclusion that the group of contracts is not subject to material interest rate risk, longevity risk, or asset return volatility risk. Examples of methods a qualified actuary could use to support the actuarial certification include, but are not limited to:
a) A demonstration that using requirements under VM-A and VM-C for the group of contracts calculated are at least as great as the assets required to support the group of contracts using the company’s cash-flow testing model under each of the 16 scenarios identified in this section or alternatively each of the New York seven scenarios.

b) A demonstration that the group of contracts passed the SERT within 36 months prior to the valuation date and the company has not had a material change in its interest rate risk.

c) A qualitative risk assessment of the group of contracts that concludes that the group of contracts does not have material interest rate risk or asset return volatility. Such assessment would include an analysis of product guarantees, the company’s non-guaranteed elements (NGEs) policy, assets backing the group of contracts and the company’s investment strategy.

C. Stochastic Exclusion Ratio Test

1. In order to exclude a group of contracts from the stochastic reserve requirements under the stochastic exclusion ratio test (SERT), a company shall demonstrate that the ratio of 
   \( \frac{b - a}{a} \) is less than \( [x\%] \) where:

   a. \( a \) = the adjusted scenario reserve described in Paragraph C.2.a.i below using economic scenario 9, the baseline economic scenario, as described in Appendix 1.E of VM-20.

   b. \( b \) = the largest adjusted scenario reserve described in Paragraph C.2.b below under any of the other 15 economic scenarios described in Appendix 1.E of VM-20 under both \([95\%]\) and \([105\%]\) of anticipated experience mortality excluding margins.

Guidance Note: Note that the numerator should be the largest adjusted scenario reserve for scenarios other than the baseline economic scenario, minus the adjusted scenario reserve for the baseline economic scenario. This is not necessarily the same as the biggest difference from the adjusted scenario reserve for the baseline economic scenario, or the absolute value of the biggest difference from the adjusted scenario reserve for the baseline economic scenario, both of which could lead to an incorrect test result.

2. In calculating the ratio in subsection (1) above:

   a. The company shall calculate an adjusted scenario reserve for the group of contracts for the 16 scenarios that is equal to either (i) or (ii) below:

      i. The scenario reserve defined in Section 4, but with the following differences:

         a) Using anticipated experience assumptions with no margins, with the exception of mortality factors described in Paragraph C.1.b of this section.

         b) Using the interest rates and equity return assumptions specific to each scenario.

         c) Using NAER and discount rates defined in Section 4 specific to each scenario to discount the cash flows.
d) Shall reflect future mortality improvement in line with anticipated experience assumptions.

e) Shall not reflect correlation between longevity and economic risks.

ii. The gross premium reserve developed from the cash flows from the company’s asset adequacy analysis models, using the experience assumptions of the company’s cash-flow analysis, but with the following differences:

a) Using the interest rates and equity return assumptions specific to each scenario.

b) Using the mortality scalars described in Paragraph C.1.b of this section.

c) Using the methodology to determine NAER and discount rates defined in Section 4 specific to each scenario to discount the cash flows, but using the company’s cash-flow testing assumptions for default costs and reinvestment earnings.

b. The company shall use the most current 16 economic scenarios published by the NAIC. The methodology for creating these scenarios can be found in Appendix 1 of VM-20.

c. The company shall use assumptions within each scenario that are dynamically adjusted as appropriate for consistency with each tested scenario.

d. The company may not group together contract types with significantly different risk profiles for purposes of calculating this ratio.

e. If the company has reinsurance arrangements that are pro rata coinsurance and do not materially impact the interest rate risk, longevity risk, or asset return volatility in the contract, then the company may elect to not conduct the exclusion test under a pre-reinsurance-ceded basis upon determining the pre-reinsurance reserve-ceded aggregate reserve.

3. If the ratio calculated in this section is less than [%] pre-non-proportional reinsurance, but is greater than [%] post-non-proportional reinsurance, the group of contracts will still pass the SERT if the company can demonstrate that the sensitivity of the adjusted scenario reserve to economic scenarios is comparable pre- and post-non-proportional reinsurance.

a. An example of an acceptable demonstration:

i. For convenience in notation • SERT = the ratio (b–a)/a defined in Section 7.C.1 above

a) The pre-non-proportional reinsurance results are “gross of non-proportional,” with a subscript “gn,” so denoted SERT_{gn}

b) The post-non-proportional results are “net of non-proportional,” with subscript “nn,” so denoted SERT_{nn}
ii. If a block of business being tested is subject to one or more non-proportional reinsurance cessions as well as other forms of reinsurance, such as pro rata coinsurance, take “gross of non-proportional” to mean net of all prorata reinsurance but ignoring the non-proportional contract(s), and “net of non-proportional” to mean net of all reinsurance contracts. That is, treat non-proportional reinsurance as the last reinsurance in, and compute certain values below with and without that last component.

iii. So, if \( SERT_{gn} \leq [x] \) but \( SERT_{nn} > [x] \), then compute the largest percent increase in reserve (LPIR) = \((b-a)/a\), both “gross of non-proportional” and “net of non-proportional.”

\[
LPIR_{gn} = \frac{b_{ny} - a_{y}}{a_{gn}} \\
LPIR_{nn} = \frac{b_{ny} - a_{y}}{a_{nn}}
\]

Note that the scenario underlying \( b_{gn} \) could be different from the scenario underlying \( b_{nn} \).

If \( SERT_{gn} \times LPIR_{nn}/LPIR_{gn} < [x] \), then the block of contracts passes the SERT.

b. Another more qualitative approach is to calculate the adjusted scenario reserves for the 16 scenarios both gross and net of reinsurance to demonstrate that there is a similar pattern of sensitivity by scenario.

4. The SERT may not be used for a group of contracts if, using the current year’s data, (i) the stochastic exclusion demonstration test defined in Section 7.D had already been attempted using the method in this section and did not pass; or (ii) the qualified actuary had actively undertaken to perform the certification method in this section and concluded that such certification could not legitimately be made.

D. Stochastic Exclusion Demonstration Test

1. In order to exclude a group of contracts from the stochastic reserve requirements using the methodology in this section, the company must provide a demonstration in the PBR Actuarial Report in the first year and at least once every three calendar years thereafter that complies with the following:

a. The demonstration shall provide a reasonable assurance that if the stochastic reserve was calculated on a stand-alone basis for the group of contracts subject to the stochastic reserve exclusion, the resulting stochastic reserve for those groups of contracts would not be higher than the statutory reserve determined pursuant to the applicable requirements in VM-A and VM-C. The demonstration shall take into account whether changing conditions over the current and two subsequent calendar years would be likely to change the conclusion to exclude the group of contracts from the stochastic reserve requirements.

b. If, as of the end of any calendar year, the company determines the aggregate reserve for the group of contracts no longer adequately provides for all material risks, the exclusion shall be discontinued, and the company fails the SERT for those contracts.
c. The demonstration may be based on an analysis from a date that precedes the valuation date for the initial year to which it applies if the demonstration includes an explanation of why the use of such a date will not produce a material change in the outcome, as compared to results based on an analysis as of the valuation date.

d. The demonstration shall provide an effective evaluation of the residual risk exposure remaining after risk mitigation techniques, such as derivative programs and reinsurance.

2. The company may use one of the following or another method acceptable to the insurance commissioner to demonstrate compliance with subsection 7.D.1 above:

   a. Demonstrate that the statutory reserve calculated in accordance with VM-A and VM-C is greater than the stochastic reserve calculated on a stand-alone basis.

   b. Demonstrate that the statutory reserve calculated in accordance with VM-A and VM-C is greater than the scenario reserve that results from each of a sufficient number of adverse deterministic scenarios.

   c. Demonstrate that the statutory reserve calculated in accordance with VM-A and VM-C is greater than the stochastic reserve calculated on a stand-alone basis, but using a representative sample of contracts in the stochastic reserve calculations.

   d. Demonstrate that any risk characteristics that would otherwise cause the stochastic reserve calculated on a stand-alone basis to exceed the statutory reserve calculated in accordance with VM-A and VM-C, are not present or have been substantially eliminated through actions such as hedging, investment strategy, reinsurance or passing the risk on to the policyholder by contract provision.

E. Deterministic Certification Option

1. The company has the option to determine the stochastic reserve for a group of contracts using a single deterministic economic scenario, subject to the following conditions.

   a. The company certifies that economic conditions do not materially influence anticipated contract holder behavior for the group of policies. Examples of contract holder options that are materially influenced by economic conditions include surrender benefits, recurring premium payments, and guaranteed living benefits.

   b. The company certifies that the group of policies is not supported by a reinvestment strategy that contains future hedge purchases.

   c. The company must perform and disclose results from the stochastic exclusion ratio test following the requirements in Section 7.C, thereby disclosing the scenario reserve volatility across various economic scenarios.
d. The company must disclose a description of contracts and associated features in the certification.

Drafting Note: Consider revisiting Paragraph E.1.c to possibly either require i) falling below a preset threshold for the exclusion ratio test under a single longevity/mortality scenario; or ii) to pass the exclusion test if longevity is not included as part of the ratio test.

2. The stochastic reserve for the group of contracts under the Deterministic Certification Option is determined as follows:

   a. Cash flows are projected in compliance with the applicable requirements in Section 4, Section 5, Section 10, and Section 11 of VM-22 over a single economic scenario (scenario 12 found in Appendix 1 of VM-20).

   b. The stochastic reserve equals the scenario reserve following the requirements for Section 4.

Guidance Note: The Deterministic Certification Option is intended to provide a non-stochastic option for Single Premium Immediate Annuities (SPIAs) and similar payout annuity products that contain limited or no optionality in the asset and liability cash flow projections.
Section 9: Modeling Hedges under a Future Hedging Strategy

A. Initial Considerations

1. This section applies to modeling of hedges other than situations where the company (a) only hedges index credits, or (b) clearly separates index credit hedging from other hedging. In those situations, the modeling of hedges supporting index credits can be simplified including applying an index credit hedge margin, following the requirements in Section 4.A.4.b.i.

2. The appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the calculation of the stochastic reserve, determined in accordance with Section 3.D and Section 4.D.

3. The company shall take into account the costs and benefits of hedge positions expected to be held by the company in the future along each scenario. Company management is responsible for developing, documenting, executing and evaluating the investment strategy for future hedge purchases. Prior to reflection in projections, the strategy for future hedge purposes shall be the actual practice of the company for a period of time not less than [6] months.

4. For this purpose, the investment assets refer to all the assets, including derivatives supporting covered products and guarantees. This also is referred to as the investment portfolio. The investment strategy is the set of all asset holdings at all points in time in all scenarios. The hedging portfolio, which also is referred to as the hedging assets, is a subset of the investment assets. The hedging strategy is the hedging asset holdings at all points in time in all scenarios. There is no attempt to distinguish what is the hedging portfolio and what is the investment portfolio in this section. Nor is the distinction between investment strategy and hedging strategy formally made here. Where necessary to give effect to the intent of this section, the requirements applicable to the hedging portfolio or the hedging strategy are to apply to the overall investment portfolio and investment strategy.

5. This particularly applies to restrictions on the reasonableness or acceptability of the models that make up the stochastic cash-flow model used to perform the projections, since these restrictions are inherently restrictions on the joint modeling of the hedging and non-hedging portfolio. To give effect to these requirements, they must apply to the overall investment strategy and investment portfolio.

B. Modeling Approaches

1. The analysis of the impact of the hedging strategy on cash flows is typically performed using either one of two types of methods as described below. Although a hedging strategy normally would be expected to reduce risk provisions, the nature of the hedging strategy and the costs to implement the strategy may result in an increase in the amount of the stochastic reserve otherwise calculated.

2. The fundamental characteristic of the first type of method, referred to as the “explicit method,” is that hedging positions and their resulting cash flows are included in the stochastic cash-flow model used to determine the scenario reserve, as discussed in Section 3.D, for each scenario.
3. The fundamental characteristic of the second type of method, referred to as the “implicit method,” is that the effectiveness of the current hedging strategy on future cash flows is evaluated, in part or in whole, outside of the stochastic cash-flow model. There are multiple ways that this type of modeling can be implemented. In this case, the reduction to the stochastic reserve otherwise calculated should be commensurate with the degree of effectiveness of the hedging strategy in reducing accumulated deficiencies otherwise calculated.

4. Regardless of the methodology used by the company, the ultimate effect of the current hedging strategy (including currently held hedge positions) on the stochastic reserve needs to recognize all risks, associated costs, imperfections in the hedges and hedging mismatch tolerances associated with the hedging strategy. The risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, annuitization, etc.). Costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. In addition, the reduction to the stochastic reserve attributable to the hedging strategy may need to be limited due to the uncertainty associated with the company’s ability to implement the hedging strategy in a timely and effective manner. The level of operational uncertainty varies indirectly with the amount of time that the new or revised strategy has been in effect or mock tested.

Guidance Note: No hedging strategy is perfect. A given hedging strategy may eliminate or reduce some but not all risks, transform some risks into others, introduce new risks, or have other imperfections. For example, a delta-only hedging strategy does not adequately hedge the risks measured by the “Greeks” other than delta.

5. A safe harbor approach is permitted for those companies whose modeled hedge assets comprise only linear instruments not sensitive to implied volatility. For companies with option-based hedge strategies, electing this approach would require representing the option-based portion of the strategy as a delta-rho two-Greek hedge program. The normally modeled option portfolio would be replaced with a set of linear instruments that have the same first-order Greeks as the original option portfolio.

C. Calculation of Stochastic Reserve (Reported)

1. The company shall calculate CTE70 (best efforts)—the results obtained when the CTE70 is based on incorporating the modeling of hedges (including both currently held and future hedge positions) into the stochastic cash-flow model on a best efforts basis, including all of the factors and assumptions needed to model the hedges (e.g., stochastic implied volatility). The determination of CTE70 (best efforts) may utilize either explicit or implicit modeling techniques.

2. The company shall calculate a CTE70 (adjusted) by recalculating the CTE70 assuming the company has no hedging strategy except those to hedge interest credits and hedge assets held by the company on the valuation date, therefore following the requirements of Section 4.A.4.a and 4.A.4.b.i.

3. Because most models will include at least some approximations or idealistic assumptions, CTE70 (best efforts) may overstate the impact of the hedging strategy. To compensate for potential overstatement of the impact of the hedging strategy, the value for the stochastic reserve is given by:

\[
\text{Stochastic reserve} = \text{CTE70 (best efforts)} + E \times \max[0, \text{CTE70 (adjusted)} - \text{CTE70 (best efforts)}]
\]
4. The company shall specify a value for $E$ (the “error factor”) in the range from 5% to 100% to reflect the company’s view of the potential error resulting from the level of sophistication of the stochastic cash-flow model and its ability to properly reflect the parameters of the hedging strategy (i.e., the Greeks being covered by the strategy), as well as the associated costs, risks and benefits. The greater the ability of the stochastic model to capture all risks and uncertainties, the lower the value of $E$. The value of $E$ may be as low as 5% only if the model used to determine the CTE70 (best efforts) effectively reflects all of the parameters used in the hedging strategy. If certain economic risks are not hedged, yet the model does not generate scenarios that sufficiently capture those risks, $E$ must be in the higher end of the range, reflecting the greater likelihood of error. Likewise, simplistic hedge cash-flow models shall assume a higher likelihood of error.

5. The company shall conduct a formal back-test, based on an analysis of at least the most recent 12 months, to assess how well the model is able to replicate the hedging strategy in a way that supports the determination of the value used for $E$.

6. Such a back-test shall involve one of the following analyses:

a. For companies that model hedge cash flows directly (“explicit method”), replace the stochastic scenarios used in calculating the CTE70 (best efforts) with a single scenario that represents the market path that actually manifested over the selected back-testing period and compare the projected hedge asset gains and losses against the actual hedge asset gains and losses – both realized and unrealized – observed over the same time period. For this calculation, the model assumptions may be replaced with parameters that reflect actual experience during the back-testing period. In order to isolate the comparison between the modeled hedge results and actual hedge results for this calculation, the projected liabilities should accurately reflect the actual liabilities throughout the back-testing period; therefore, adjustments that facilitate this accuracy (e.g. reflecting actual experience instead of model assumptions, including new business, etc.) are permissible.

   To support the choice of a low value of $E$, the company should ascertain that the projected hedge asset gains and losses are within close range of 100% (e.g., 80–125%) of the actual hedge asset gains and losses. The company may also support the choice of a low value of $E$ by achieving a high R-squared (e.g., 0.80 or higher) when using a regression analysis technique.

b. For companies that model hedge cash flows implicitly by quantifying the cost and benefit of hedging using the fair value of the hedged item (an “implicit method” or “cost of reinsurance method”), calculate the delta, rho and vega coverage ratios in each month over the selected back-testing period in the following manner:

   i. Determine the hedge asset gains and losses—both realized and unrealized—incurred over the month attributable to equity, interest rate, and implied volatility movements.

   ii. Determine the change in the fair value of the hedged item over the month attributable to equity, interest rate, and implied volatility movements. The hedged item should be defined in a manner that reflects the proportion of risks hedged (e.g., if a company elects to hedge 50% of a contract’s market risks, it should quantify the fair value of the hedged item as 50% of the fair value of the contract).

   iii. Calculate the delta coverage ratio as the ratio between (i) and (ii) attributable to equity movements.
iv. Calculate the rho coverage ratio as the ratio between (i) and (ii) attributable to interest rate movements.

v. Calculate the vega coverage ratio as the ratio between (i) and (ii) attributable to implied volatility movements.

vi. To support the company’s choice of a low value of E, the company should be able to demonstrate that the delta and rho coverage ratios are both within close range of 100% (e.g., 80–125%) consistently across the back-testing period.

vii. In addition, the company should be able to demonstrate that the vega coverage ratio is within close range of 100% in order to use the prevailing implied volatility levels as of the valuation date in quantifying the fair value of the hedged item for the purpose of calculating CTE70 (best efforts). Otherwise, the company shall quantify the fair value of the hedged item for the purpose of calculating CTE70 (best efforts) in a manner consistent with the realized volatility of the scenarios captured in the CTE (best efforts).

c. Companies that do not model hedge cash flows explicitly, but that also do not use the implicit method as outlined in Section 9.C.6.b above, shall conduct the formal back-test in a manner that allows the company to clearly illustrate the appropriateness of the selected method for reflecting the cost and benefit of hedging, as well as the value used for E.

7. A company that does not have 12 months of experience to date shall set E to a value that reflects the amount of experience available, and the degree and nature of any change to the hedge program. For a material change in strategy, with no history, E should be at least 0.50. However, E may be lower than 0.50 if some reliable experience is available and/or if the change in strategy is a refinement rather than a substantial change in strategy.

Guidance Note: The following examples are provided as guidance for determining the E factor when there has been a change to the hedge program:

- The error factor should be temporarily large (e.g., ≥ 50%) for substantial changes in hedge methodology (e.g., moving from a fair-value based strategy to a stop-loss strategy) where the company has not been able to provide a meaningful simulation of hedge performance based on the new strategy.

- A temporary moderate increase (e.g., 15–30%) in error factor should be used for substantial modifications to hedge programs or modeling where meaningful simulation has not been created (e.g., adding second-order hedging, such as gamma or rate convexity).

- No increase in the error factor may be used for incremental modifications to the hedge strategy (e.g., adding death benefits to a program that previously covered only living benefits, or moving from swaps to Treasury Department futures).

D. Specific Considerations and Requirements

1. As part of the process of choosing a methodology and assumptions for estimating the future effectiveness of the current hedging strategy (including currently held hedge positions) for
purposes of reducing the stochastic reserve, the company should review actual historical hedging effectiveness. The company shall evaluate the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, the mix of business and other items that are likely to result in materially adverse results. This includes an analysis of model assumptions that, when combined with the reliance on the hedging strategy, are likely to result in adverse results relative to those modeled. The parameters and assumptions shall be adjusted (based on testing contingent on the strategy used and other assumptions) to levels that fully reflect the risk based on historical ranges and foreseeable future ranges of the assumptions and parameters. If this is not possible by parameter adjustment, the model shall be modified to reflect them at either anticipated experience or adverse estimates of the parameters.

2. A discontinuous hedging strategy is a hedging strategy where the relationships between the sensitivities to equity markets and interest rates (commonly referred to as the Greeks) associated with the guaranteed contract holder options embedded in the fixed indexed annuities and other in-scope products and these same sensitivities associated with the hedging assets are subject to material discontinuities. This includes, but is not limited to, a hedging strategy where material hedging assets will be obtained when the fixed indexed annuity account balances reach a predetermined level in relationship to the guarantees. Any hedging strategy, including a delta hedging strategy, can be a discontinuous hedging strategy if implementation of the strategy permits material discontinuities between the sensitivities to equity markets and interest rates associated with the guaranteed contract holder options embedded in the fixed indexed annuities and other in-scope products and these same sensitivities associated with the hedging assets. There may be scenarios that are particularly costly to discontinuous hedging strategies, especially where those result in large discontinuous changes in sensitivities (Greeks) associated with the hedging assets. Where discontinuous hedging strategies contribute materially to a reduction in the stochastic reserve, the company must evaluate the interaction of future trigger definitions and the discontinuous hedging strategy, in addition to the items mentioned in the previous paragraph. This includes an analysis of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.

3. A strategy that has a strong dependence on acquiring hedging assets at specific times that depend on specific values of an index or other market indicators may not be implemented as precisely as planned.

4. The combination of elements of the stochastic cash-flow model—including the initial actual market asset prices, prices for trading at future dates, transaction costs and other assumptions—should be analyzed by the company as to whether the stochastic cash-flow model permits hedging strategies that make money in some scenarios without losing a reasonable amount in some other scenarios. This includes, but is not limited to:
   a. Hedging strategies with no initial investment that never lose money in any scenario and in some scenarios make money.
   b. Hedging strategies that, with a given amount of initial money, never make less than accumulation at the one-period risk-free rates in any scenario but make more than this in one or more scenarios.

5. If the stochastic cash-flow model allows for such situations, the company should be satisfied that the results do not materially rely directly or indirectly on the use of such strategies. If the results do materially rely directly or indirectly on the use of such strategies, the strategies may not be used to reduce the stochastic reserve otherwise calculated.
6. In addition to the above, the method used to determine prices of financial instruments for trading in scenarios should be compared to actual initial market prices. In addition to comparisons to initial market prices, there should be testing of the pricing models that are used to determine subsequent prices when scenarios involve trading financial instruments. This testing should consider historical relationships. For example, if a method is used where recent volatility in the scenario is one of the determinants of prices for trading in that scenario, then that model should approximate actual historic prices in similar circumstances in history.
Section 10: Guidance and Requirements for Setting Contract Holder Behavior Prudent Estimate Assumptions

A. General

Contract holder behavior assumptions encompass actions such as lapses, withdrawals, transfers, recurring deposits, benefit utilization, option election, etc. Contract holder behavior is difficult to predict accurately, and variance in behavior assumptions can significantly affect the results. In the absence of relevant and fully credible empirical data, the company should set behavior assumptions as guided by Principle 3 in Section 1.B.

In setting behavior assumptions, the company should examine, but not be limited by, the following considerations:

1. Behavior can vary by product, market, distribution channel, index performance, interest credited (current and guaranteed rates), time/product duration, etc.
2. Options embedded in the product may affect behavior.
3. Utilization of options may be elective or non-elective in nature. Living benefits often are elective, and death benefit options are generally non-elective.
4. Elective contract holder options may be more driven by economic conditions than non-elective options.
5. As the value of a product option increases, there is an increased likelihood that contract holders will behave in a manner that maximizes their financial interest (e.g., lower lapses, higher benefit utilization, etc.).
6. Behavior formulas may have both rational and irrational components (irrational behavior is defined as situations where some contract holders may not always act in their best financial interest). The rational component should be dynamic, but the concept of rationality need not be interpreted in strict financial terms and might change over time in response to observed trends in contract holder behavior based on increased or decreased financial efficiency in exercising their contractual options.
7. Options that are ancillary to the primary product features may not be significant drivers of behavior. Whether an option is ancillary to the primary product features depends on many things, such as:
   a. For what purpose was the product purchased?
   b. Is the option elective or non-elective?
   c. Is the value of the option well-known?
8. External influences may affect behavior.

B. Aggregate vs. Individual Margins

1. Prudent estimate assumptions are developed by applying a margin for uncertainty to the anticipated experience assumption. The issue of whether the level of the margin applied to the anticipated experience assumption is determined in aggregate or independently for each and every behavior assumption is discussed in Principle 3 in Section 1.B.
2. Although this principle discusses the concept of determining the level of margins in aggregate, it notes that the application of this concept shall be guided by evolving practice and expanding knowledge. From a practical standpoint, it may not always be possible to completely apply this concept to determine the level of margins in aggregate for all behavior assumptions.

3. Therefore, the company shall determine prudent estimate assumptions independently for each behavior (e.g., mortality, lapses and benefit utilization), using the requirements and guidance in this section and throughout these requirements, unless the company can demonstrate that an appropriate method was used to determine the level of margin in aggregate for two or more behaviors.

C. Sensitivity Testing

The impact of behavior can vary by product, time period, etc. For any assumption that is not prescribed or stochastically modeled, the qualified actuary to whom responsibility for this group of contracts is assigned shall use sensitivity testing to ensure that the assumption is set at the conservative end of the plausible range. The company shall sensitivity test:

- Surrenders.
- Partial withdrawals.
- Benefit utilization.
- Other behavior assumptions if relevant to the risks in the product.

Sensitivity testing of assumptions is required and shall be more complex than, for example, base lapse assumption plus or minus X% across all contracts. A more appropriate sensitivity test in this example might be to devise parameters in a dynamic lapse formula to reflect more out-of-the-money contracts lapsing and/or more holders of in-the-money contracts persisting and eventually using the guarantee. The company should apply more caution in setting assumptions for behaviors where testing suggests that stochastic modeling results are sensitive to small changes in such assumptions. For such sensitive behaviors, the company shall use higher margins when the underlying experience is less than fully relevant and credible.

The company shall examine the results of sensitivity testing to understand the materiality of prudent estimate assumptions on the modeled reserve. The company shall update the sensitivity tests periodically as appropriate, considering the materiality of the results of the tests. The company may update the tests less frequently when the tests show less sensitivity of the modeled reserve to changes in the assumptions being tested or the experience is not changing rapidly. Providing there is no material impact on the results of the sensitivity testing, the company may perform sensitivity testing:

1. Using samples of the contracts in force rather than performing the entire valuation for each alternative assumption set.

2. Using data from prior periods.

D. Specific Considerations and Requirements

1. Within materiality considerations, the company should consider all relevant forms of contract holder behavior and persistency, including, but not limited to, the following:
a. Mortality (additional guidance and requirements regarding mortality is contained in Section 11).
b. Surrenders.
c. Partial withdrawals (systematic and elective).
d. Account transfers (switching/exchanges).
e. Resets/ratchets of the guaranteed amounts (automatic and elective).
f. Future deposits.
g. Income start date
h. Commutation of benefit (from periodic payment to lump sum)

2. It may be acceptable to ignore certain items that might otherwise be explicitly modeled in an ideal world, particularly if the inclusion of such items reduces the calculated provisions.

For example:

a. The impact of account transfers (intra-contract index “switching”) might be ignored, unless required under the terms of the contract (e.g., automatic asset re-allocation/rebalancing, ) or if the contract provisions incentivize the contract holders to transfer between accounts.
b. Future deposits might be excluded from the model, unless required by the terms of the contracts under consideration and then only in such cases where future premiums can reasonably be anticipated (e.g., with respect to timing and amount).
c. For some non-elective benefits (nursing home benefits for example), a zero incidence rate after the surrender charge has ended, or the cash value has depleted, may be acceptable since use of a non-zero rate could reduce the modeled reserve.

3. However, the company should exercise caution in assuming that current behavior will be indefinitely maintained. For example, it might be appropriate to test the impact of a shifting asset mix and/or consider future deposits to the extent they can reasonably be anticipated and increase the calculated amounts.

4. Normally, the underlying model assumptions would differ according to the attributes of the contract being valued. This would typically mean that contract holder behavior and persistency may be expected to vary according to such characteristics as (this is not an exhaustive list):

a. Gender.
b. Attained age.
c. Issue age.
d. Contract duration.
e. Time to maturity.
f. Tax status.
g. Account value.
h. Interest credited (current and guaranteed).
i. Available indices.
j. Guaranteed benefit amounts.
k. Surrender charges, transfer fees or other contract charges.
l. Distribution channel.

5. Unless there is clear evidence to the contrary, behavior assumptions should be no less conservative than past experience. Margins for contract holder behavior assumptions shall assume, without relevant and credible experience or clear evidence to the contrary, that contract holders’ efficiency will increase over time.

6. In determining contract holder behavior assumptions, the company shall use actual experience data directly applicable to the business segment (i.e., direct data) if it is available. In the absence of direct data, the company should then look to use data from a segment that is similar to the business segment (i.e., other than direct experience), whether or not the segment is directly written by the company. If data from a similar business segment are used, the assumption shall be adjusted to reflect differences between the two segments. Margins shall reflect the data uncertainty associated with using data from a similar but not identical business segment.

7. Where relevant and fully credible empirical data do not exist for a given contract holder behavior assumption, the company shall set the contract holder behavior assumption to reflect the increased uncertainty such that the contract holder behavior assumption is shifted towards the conservative end of the plausible range of expected experience that serves to increase the stochastic reserve. If there are no relevant data, the company shall set the contract holder behavior assumption to reflect the increased uncertainty such that the contract holder behavior assumption is at the conservative end of the range. Such adjustments shall be consistent with the definition of prudent estimate, with the principles described in Section 1.B, and with the guidance and requirements in this section.

8. Ideally, contract holder behavior would be modeled dynamically according to the simulated economic environment and/or other conditions. It is important to note, however, that contract holder behavior should neither assume that all contract holders act with 100% efficiency in a financially rational manner nor assume that contract holders will always act irrationally. These extreme assumptions may be used for modeling efficiency if the result is more conservative.

E. Dynamic Assumptions

1. Consistent with the concept of prudent estimate assumptions described earlier, the liability model should incorporate margins for uncertainty for all risk factors that are not dynamic (i.e., the non-scenario tested assumptions) and are assumed not to vary according to the financial interest of the contract holder.

2. The company should exercise care in using static assumptions when it would be more natural and reasonable to use a dynamic model or other scenario-dependent formulation for behavior. With due regard to considerations of materiality and practicality, the use of
dynamic models is encouraged, but not mandatory. Risk factors that are not scenario tested but could reasonably be expected to vary according to a stochastic process, or future states of the world (especially in response to economic drivers) may require higher margins and/or signal a need for higher margins for certain other assumptions.

3. Risk factors that are modeled dynamically should encompass the plausible range of behavior consistent with the economic scenarios and other variables in the model, including the non-scenario tested assumptions. The company shall test the sensitivity of results to understand the materiality of making alternate assumptions and follow the guidance discussed above on setting assumptions for sensitive behaviors.

F. Consistency with the CTE Level

1. All behaviors (i.e., dynamic, formulaic and non-scenario tested) should be consistent with the scenarios used in the CTE calculations (generally, the top 30% of the loss distribution). To maintain such consistency, it is not necessary to iterate (i.e., successive runs of the model) in order to determine exactly which scenario results are included in the CTE measure. Rather, in light of the products being valued, the company should be mindful of the general characteristics of those scenarios likely to represent the tail of the loss distribution and consequently use prudent estimate assumptions for behavior that are reasonable and appropriate in such scenarios. For fixed annuities, these “valuation” scenarios would typically display one or more of the following attributes:

a. Declining and/or volatile index values, where applicable.
b. Price gaps and/or liquidity constraints.
c. Rapidly changing interest rates or persistently low interest rates.
d. Volatile credit spreads.

2. The behavior assumptions should be logical and consistent both individually and in aggregate, especially in the scenarios that govern the results. In other words, the company should not set behavior assumptions in isolation, but give due consideration to other elements of the model. The interdependence of assumptions (particularly those governing customer behaviors) makes this task difficult and by definition requires professional judgment, but it is important that the model risk factors and assumptions:

a. Remain logically and internally consistent across the scenarios tested.
b. Represent plausible outcomes.
c. Lead to appropriate, but not excessive, asset requirements.

4. The company should remember that the continuum of “plausibility” should not be confined or constrained to the outcomes and events exhibited by historic experience.

5. Companies should attempt to track experience for all assumptions that materially affect their risk profiles by collecting and maintaining the data required to conduct credible and meaningful studies of contract holder behavior.

G. Additional Considerations and Requirements for Assumptions Applicable to Guaranteed Living Benefits
Experience for contracts without guaranteed living benefits may be of limited use in setting a lapse assumption for contracts with in-the-money or at-the-money guaranteed living benefits. Such experience may only be used if it is appropriate (e.g., lapse experience on contracts without a living benefit may have relevance to the early durations of contracts with living benefits) and relevant to the business.

H. Policy Loans

If policy loans are applicable for the block of business, the company shall determine cash flows for each projection interval for policy loan assets by modeling existing loan balances either explicitly or by substituting assets that are a proxy for policy loans (e.g., bonds, cash, etc.) subject to the following:

1. If the company substitutes assets that are a proxy for policy loans, the company must demonstrate that such substitution:
   a. Produces reserves that are no less than those that would be produced by modeling existing loan balances explicitly.
   b. Complies with the contract holder behavior requirements stated in Section 10 above in this section.

2. If the company models policy loans explicitly, the company shall:
   a. Treat policy loan activity as an aspect of contract holder behavior and subject to the requirements above in this section.
   b. Assign loan balances either to exactly match each policy’s utilization or to reflect average utilization over a model segment or sub-segments.
   c. Model policy loan interest in a manner consistent with policy provisions and with the scenario. Include interest paid in cash as a positive policy loan cash flow in that projection interval, but do not include interest added to the loan balance as a policy loan cash flow. (The increased balance will require increased repayment cash flows in future projection intervals.)
   d. Model policy loan principal repayments, including those that occur automatically upon death or surrender. Include policy loan principal repayments as a positive policy loan cash flow, per Section 4.A.1.h.
   e. Model additional policy loan principal. Include additional policy loan principal as a negative policy loan cash flow, per Section 4.A.1.h (but do not include interest added to the loan balance as a negative policy loan cash flow).
   f. Model any investment expenses allocated to policy loans and include them either with policy loan cash flows or insurance expense cash flows.

I. Non-Guaranteed Elements

Consistent with the definition in VM-01, Non-Guaranteed Elements (NGEs) are elements within a contract that affect policy costs or values and not guaranteed or not determined at issue. NGEs consist of elements affecting contract holder costs or values that are both established and subject to change at the discretion of the insurer.
Examples of NGEs specific to fixed annuities include but are not limited to the following: fixed credited rates, index parameters (caps, spreads, participation rates, etc.), rider fees, rider benefit features being subject to change (rollup rates, rollup period, etc.), account value charges, and dividends under participating policies or contracts.

1. Except as noted below in Section 10.J.5, the company shall include NGE in the models to project future cash flows beyond the time the company has authorized their payment or crediting.

2. The projected NGE shall reflect factors that include, but are not limited to, the following (not all of these factors will necessarily be present in all situations):
   a. The nature of contractual guarantees.
   b. The company’s past NGE practices and established NGE policies.
   c. The timing of any change in NGE relative to the date of recognition of a change in experience.
   d. The benefits and risks to the company of continuing to authorize NGE.

3. Projected NGE shall be established based on projected experience consistent with how actual NGE are determined.

4. Projected levels of NGE in the cash-flow model must be consistent with the experience assumptions used in each scenario. Contract holder behavior assumptions in the model must be consistent with the NGE assumed in the model.

5. The company may exclude any portion of an NGE that:
   a. Is not based on some aspect of the policy’s or contract’s experience.
   b. Is authorized by the board of directors and documented in the board minutes, where the documentation includes the amount of the NGE that arises from other sources.

   However, if the board has guaranteed a portion of the NGE into the future, the company must model that amount. In other words, the company cannot exclude from its model any NGE that the board has guaranteed for future years, even if it could have otherwise excluded them, based on this subsection.

6. The liability for contract holder dividends declared but not yet paid that has been established according to statutory accounting principles as of the valuation date is reported separately from the statutory reserve. The contract holder dividends that give rise to this dividend liability as of the valuation date may or may not be included in the cash-flow model at the company’s option.
   a. If the contract holder dividends that give rise to the dividend liability are not included in the cash-flow model, then no adjustment is needed to the resulting aggregate stochastic reserve.
   b. If the contract holder dividends that give rise to the dividend liability are included in the cash-flow model, then the resulting aggregate stochastic reserve should be reduced by the amount of the dividend liability.

7. All projected cash flows associated with NGEs shall reflect margins for adverse deviations and estimation error in prudent estimate assumptions.
Section 11: Guidance and Requirements for Setting Prudent Estimate Mortality Assumptions

A. Overview

1. Intent

The guidance and requirements in this section apply to setting prudent estimate mortality assumptions when determining the stochastic reserve. The intent is for prudent estimate mortality assumptions to be based on facts, circumstances and appropriate actuarial practice, with only a limited role for unsupported actuarial judgment. (Where more than one approach to appropriate actuarial practice exists, the company should select the practice that the company deems most appropriate under the circumstances.)

2. Description

Prudent estimate mortality assumptions shall be determined by first developing expected mortality curves based on either available experience or published tables. Where necessary, margins shall be applied to the experience to reflect data uncertainty. The expected mortality curves shall then be adjusted based on the credibility of the experience used to determine the expected mortality curve. Section 11.B addresses guidance and requirements for determining expected mortality curves, and Section 11.C addresses guidance and requirements for adjusting the expected mortality curves to determine prudent estimate mortality.

Finally, the credibility-adjusted tables shall be adjusted for mortality improvement (where such adjustment is permitted or required) using the guidance and requirements in Section 11.D.

3. Business Segments

For purposes of setting prudent estimate mortality assumptions, the products falling under the scope of these requirements shall be grouped into business segments with different mortality assumptions. The grouping, at a minimum, should differentiate between payout annuities or deferred annuity contracts that contain GLBs, and deferred annuity contracts with no guaranteed benefits or only GMDBs. Where appropriate, the grouping should also differentiate between segments which are known or expected to contain contract holders with sociodemographic, geographic, or health factors reasonably expected to impact the mortality assumptions for the segment (e.g., annuitants drawn from different countries, geographic areas, industry groups, or impaired lives on individually underwritten contracts such as structured settlements). The grouping should also generally follow the pricing, marketing, management and/or reinsurance programs of the company.

Guidance Note: This paragraph contemplates situations where it may be appropriate to differentiate mortality assumptions by segment or even by contract due to varying sociodemographic, geographic, or health factors. Particularly, though not exclusively, in the context of group payout annuity contracts, companies may have credible, contract-specific mortality experience data or relevant pooled data from annuitants drawn from similar industries or geographies that may be used to sub-divide inforce blocks into business segments for purposes of setting prudent estimate mortality assumptions.

For example, a company may sell group PRT contracts both to union plans in the U.S. and to private single-employer plans in another country. While both are “PRT contracts,” it would be appropriate to differentiate them for mortality assumption purposes, similar to...
how payout annuities vs. deferred annuities are distinguished.

**Guidance Note:** Distinct mortality or liability assumptions among different contracts within a group of contracts does not in itself preclude the group of contracts from being aggregated for the purposes of the broader stochastic reserve calculation.

4. Margin for Data Uncertainty

The expected mortality curves that are determined in Section 11.B may need to include a margin for data uncertainty. The margin could be in the form of an increase or a decrease in mortality, depending on the business segment under consideration. The margin shall be applied in a direction (i.e., increase or decrease in mortality) that results in a higher reserve. A sensitivity test may be needed to determine the appropriate direction of the provision for uncertainty to mortality. The test could be a prior year mortality sensitivity analysis of the business segment or an examination of current representative cells of the segment.

For purposes of this section, if mortality must be increased (decreased) to provide for uncertainty, the business segment is referred to as a plus (minus) segment.

It may be necessary, because of a change in the mortality risk profile of the segment, to reclassify a business segment from a plus (minus) segment to a minus (plus) segment to the extent compliance with this section requires such a reclassification. For example, a segment could require reclassification depending on whether it is gross or net of reinsurance.

B. Determination of Expected Mortality Curves

1. Experience Data

In determining expected mortality curves, the company shall use actual experience data directly applicable to the business segment (i.e., direct data) if it is available. In the absence of direct data, the company should then look to use data from a segment that is similar to the business segment (i.e., other than direct experience). See Section 11.B.2. for additional considerations. Finally, if there is no data, the company shall use the applicable table, as required in Section 11.B.3.

2. Data Other Than Direct Experience

Adjustments shall be applied to the data to reflect differences between the business segments, and margins shall be applied to the adjusted expected mortality curves to reflect the data uncertainty associated with using data from a similar but not identical business segment.

To the extent the mortality of a business segment is reinsured, any mortality charges that are consistent with the company’s own pricing and applicable to a substantial portion of the mortality risk also may be a reasonable starting point for the determination of the company’s expected mortality curves.

3. No Data Requirements

i. When little or no experience or information is available on a business segment, the company shall use expected mortality curves that would produce expected deaths no less than:
a. [2021 SOA Deferred Annuity Mortality Table] with [Projection Scale G2] for individual deferred annuities that do not contain guaranteed living benefits

\[ q^*_{x+1} = q^*_{x} (1 - G2_x)^n \]

ii. When little or no experience or information is available on a business segment, the company shall use expected mortality curves that would produce expected deaths no greater than:

a. [The appropriate percentage (\(F_x\)) from Table 11.1 applied to the 2012 IAM Basic Mortality Table] with [Projection Scale G2] for individual payout annuity contracts and deferred annuity contracts with guaranteed living benefits

\[ q^*_{x+1} = q^*_{x} (1 - G2_x)^n \]

b. [1983 Table “a”] for structured settlements or other contracts with impaired mortality

c. [1994 GAR Table] with [Projection Scale AA] for group annuities

\[ q^*_{x+1} = q^*_{x} (1 - AA_x)^n \]

**Table 11.1**

<table>
<thead>
<tr>
<th>Attained Age (x)</th>
<th>(F_x)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;=65</td>
<td>80.0%</td>
</tr>
<tr>
<td>66</td>
<td>81.5%</td>
</tr>
<tr>
<td>67</td>
<td>83.0%</td>
</tr>
<tr>
<td>68</td>
<td>84.5%</td>
</tr>
<tr>
<td>69</td>
<td>86.0%</td>
</tr>
<tr>
<td>70</td>
<td>87.5%</td>
</tr>
<tr>
<td>71</td>
<td>89.0%</td>
</tr>
<tr>
<td>72</td>
<td>90.5%</td>
</tr>
<tr>
<td>73</td>
<td>92.0%</td>
</tr>
<tr>
<td>74</td>
<td>93.5%</td>
</tr>
<tr>
<td>75</td>
<td>95.0%</td>
</tr>
<tr>
<td>76</td>
<td>96.5%</td>
</tr>
<tr>
<td>77</td>
<td>98.0%</td>
</tr>
<tr>
<td>78</td>
<td>99.5%</td>
</tr>
<tr>
<td>79</td>
<td>101.0%</td>
</tr>
<tr>
<td>80</td>
<td>102.5%</td>
</tr>
<tr>
<td>81</td>
<td>104.0%</td>
</tr>
<tr>
<td>82</td>
<td>105.5%</td>
</tr>
<tr>
<td>83</td>
<td>107.0%</td>
</tr>
<tr>
<td>84</td>
<td>108.5%</td>
</tr>
<tr>
<td>85</td>
<td>110.0%</td>
</tr>
</tbody>
</table>
### iii. For a business segment with non-U.S. insureds, an established industry or national mortality table may be used, with approval from the domiciliary commissioner.

#### 4. Additional Considerations Involving Data

The following considerations shall apply to mortality data specific to the business segment for which assumptions are being determined (i.e., direct data discussed in Section 11.B.1 or other than direct data discussed in Section 11.B.2).

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>86</td>
<td>110.0%</td>
</tr>
<tr>
<td>87</td>
<td>110.0%</td>
</tr>
<tr>
<td>88</td>
<td>110.0%</td>
</tr>
<tr>
<td>89</td>
<td>110.0%</td>
</tr>
<tr>
<td>90</td>
<td>110.0%</td>
</tr>
<tr>
<td>91</td>
<td>110.0%</td>
</tr>
<tr>
<td>92</td>
<td>110.0%</td>
</tr>
<tr>
<td>93</td>
<td>110.0%</td>
</tr>
<tr>
<td>94</td>
<td>110.0%</td>
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<tr>
<td>95</td>
<td>110.0%</td>
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<tr>
<td>96</td>
<td>109.0%</td>
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<tr>
<td>97</td>
<td>108.0%</td>
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<tr>
<td>98</td>
<td>107.0%</td>
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<tr>
<td>99</td>
<td>106.0%</td>
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<tr>
<td>100</td>
<td>105.0%</td>
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<tr>
<td>101</td>
<td>104.0%</td>
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<tr>
<td>102</td>
<td>103.0%</td>
</tr>
<tr>
<td>103</td>
<td>102.0%</td>
</tr>
<tr>
<td>104</td>
<td>101.0%</td>
</tr>
<tr>
<td>&gt;=105</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

a. **Underreporting of Deaths**

Mortality data shall be examined for possible underreporting of deaths. Adjustments shall be made to the data if there is any evidence of underreporting. Alternatively, exposure by lives or amounts on contracts for which death benefits were in the money may be used to determine expected mortality curves. Underreporting on such exposures should be minimal; however, this reduced subset of data will have less credibility.

b. **Experience by Contract Duration**

Experience of a plus segment shall be examined to determine if mortality by contract duration increases materially due to selection at issue. In the absence of information, the company shall assume that expected mortality will increase by contract duration for an appropriate select period. As an alternative, if the company determines that mortality is affected by selection, the company could apply margins to the expected mortality in such a way that the actual mortality modeled does not depend on contract duration.

c. **Modification and Relevance of Data**
Even for a large company, the quantity of life exposures and deaths are such that a significant amount of smoothing may be required to determine expected mortality curves from mortality experience. Expected mortality curves, when applied to the recent historic exposures (e.g., three to seven years), should not result in an estimate of aggregate number of deaths less (greater) than the actual number deaths during the exposure period for plus (minus) segments.

In determining expected mortality curves (and the credibility of the underlying data), older data may no longer be relevant. The “age” of the experience data used to determine expected mortality curves should be documented.

d. Other Considerations

In determining expected mortality curves, consideration should be given to factors that include, but are not limited to, trends in mortality experience, trends in exposure, volatility in year-to-year A/E mortality ratios, mortality by lives relative to mortality by amounts, changes in the mix of business and product features that could lead to mortality selection.

C. Adjustment for Credibility to Determine Prudent Estimate Mortality

1. Adjustment for Credibility

The expected mortality curves determined in Section 11.B shall be adjusted based on the credibility of the experience used to determine the curves in order to arrive at prudent estimate mortality. The adjustment for credibility shall result in blending the expected mortality curves with the mortality assumption described in Section 11.B.3. The approach used to adjust the curves shall suitably account for credibility.

Guidance Note: For example, when credibility is zero, an appropriate approach should result in a mortality assumption consistent with 100% of the mortality table used in the blending.

2. Adjustment of Statutory Valuation Mortality for Improvement

For purposes of the adjustment for credibility, the mortality table for a plus segment may be and the mortality table for a minus segment must be adjusted for mortality improvement. Such adjustment shall reflect the mortality improvement scale described in Section 11.B.3 from the effective date of the respective mortality table to the experience weighted average date underlying the data used to develop the expected mortality curves.

3. Credibility Procedure

The credibility procedure used shall:

a. Produce results that are reasonable.

b. Not tend to bias the results in any material way.

c. Be practical to implement.

d. Give consideration to the need to balance responsiveness and stability.

e. Take into account not only the level of aggregate claims but the shape of the mortality curve.
f. Contain criteria for full credibility and partial credibility that have a sound statistical basis and be appropriately applied.

4. Further Adjustment of the Credibility-Adjusted Table for Mortality Improvement

The credibility-adjusted table used for plus segments may be and the credibility adjusted table used for minus segments must be adjusted for mortality improvement using the applicable mortality improvement scale described in Section 11.B.3 from the experience weighted average date underlying the company experience used in the credibility process to the valuation date.

Any adjustment for mortality improvement beyond the valuation date is discussed in Section 11.D.

D. Future Mortality Improvement

The mortality assumption resulting from the requirements of Section 11.C shall be adjusted for mortality improvements beyond the valuation date if such an adjustment would serve to increase the resulting stochastic reserve. If such an adjustment would reduce the stochastic reserve, such assumptions are permitted, but not required. In either case, the assumption must be based on current relevant data with a margin for uncertainty (increasing assumed rates of improvement if that results in a higher reserve or reducing them otherwise).
Section 12: Allocation of Aggregate Reserves to the Contract Level

Section 3.F states that the aggregate reserve shall be allocated to the contracts falling within the scope of these requirements. That allocation should be done for both the pre- and post-reinsurance ceded reserves. Contracts that have passed the stochastic exclusion test as defined in Section 7.B will not be included in the allocation of the aggregate reserve. For the purpose of this section, if a contract does not have a cash surrender value, then the cash surrender value is assumed to be zero.

Contracts for which the Deterministic Certification Option is elected in Section 7.E are intended to use the methodology described in this section to allocate aggregate reserves in excess of the cash surrender value to individual contracts.

The contract-level reserve for each contract shall be the sum of the following:

A. The contract’s cash surrender value.

Drafting Note: The American Academy of Actuaries Annuity Reserves and Capital Work Group is including two potential options for allocating the excess portion of the aggregate reserve over cash surrender value: (1) Use the same approach as VM-21 (2) Allocate based on an actuarial present value calculation.

The Work Group did not reach a consensus between these two approaches, so wording for both is included in the text below. The Work Group recommends field testing both approaches and considering the results in determining future decisions.

Option 1: VM-21 Approach

B. An allocated portion of the excess of the aggregate reserve over the aggregate cash surrender value shall be allocated to each contract based on a measure of the risk of that product relative to its cash surrender value in the context of the company’s in force contracts (assuming zero cash value for contracts that do not contain such). The measure of risk should consider the impact of risk mitigation programs, including hedge programs and reinsurance, that would affect the risk of the product. The specific method of assessing that risk and how it contributes to the company’s aggregate reserve shall be defined by the company. The method should provide for an equitable allocation based on risk analysis.

1. As an example, consider a company with the results of the following three contracts:

Table 12.1: Sample Allocation of Aggregate Reserve

<table>
<thead>
<tr>
<th>Contract (i)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash Surrender Value, C</td>
<td>28</td>
<td>40</td>
<td>52</td>
<td>120</td>
</tr>
<tr>
<td>Risk adjusted measure, R</td>
<td>38</td>
<td>52</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Aggregate Reserve</td>
<td></td>
<td></td>
<td></td>
<td>140</td>
</tr>
<tr>
<td>Allocation Basis for the excess of the Aggregate Reserve over the Cash Surrender Value ( Ai = \text{Max}(Ri-Ci, 0) )</td>
<td>10</td>
<td>12</td>
<td>0</td>
<td>22</td>
</tr>
</tbody>
</table>
2. In this example, the Aggregate Reserve exceeds the aggregate Cash Surrender Value by 20. The 20 is allocated proportionally across the three contracts based on the allocation basis of the larger of (i) zero; and (ii) a risk adjusted measure based on reserve principles. Therefore, contracts 1 and 2 receive 45% (9/22) and 55% (11/22), respectively, of the excess Aggregate Reserve. As Contract 3 presents no risk in excess of its cash surrender value, it does not receive an allocation of the excess Aggregate Reserve.

**Option 2: Actuarial Present Value Approach**

**B.** The excess of the aggregate reserve over the aggregate cash surrender value is allocated to policies based on a calculation of the actuarial present value of projected liability cash flows in excess of the cash surrender value:

1. Discount the liability cash flows at the NAER, pursuant to requirements in Section 4, for the scenario that produces the scenario reserve closest to, but not less than the stochastic reserve defined in Section 3.D.
   a. Groups of contracts that elect the Deterministic Certification Option defined in Section 7.E shall use the NAER in the single scenario used to calculate the reserve to discount liability cash flows.

2. If the actuarial present value is less than the cash surrender value, then the excess actuarial present value to be used for allocating the excess aggregate reserve over the cash value shall be floored at zero.
   a. If all contracts have an excess actuarial present value that is floored at zero, then use the cash surrender value to allocate any excess aggregate reserve over the aggregate cash surrender value.

3. For projecting future liability cash flows, assume the same liability assumptions that were used to calculate the stochastic reserve defined in 3.D.

4. As a hypothetical example, consider a company with the results of the following five contracts:

<table>
<thead>
<tr>
<th>Allocation of the excess of the Aggregate Reserve over the Cash Surrender Value</th>
<th>9.09</th>
<th>10.91</th>
<th>0.00</th>
<th>20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract-level reserve Ci+ Li</td>
<td>37.09</td>
<td>50.91</td>
<td>52.00</td>
<td>140.00</td>
</tr>
</tbody>
</table>
Table 12.1: Hypothetical Sample Allocation of Aggregate Reserve

<table>
<thead>
<tr>
<th>Contract</th>
<th>Example Product Type</th>
<th>CSV* (1)</th>
<th>Scenario APV (2)</th>
<th>Excess (Floored) of the scenario APV over CSV* (3) = Max[(2), 0]</th>
<th>Aggregate Reserve CTE 70 (4)</th>
<th>Excess of Aggregate Reserve over Aggregate CSV* (5) = Max[(4 Total) – (1 Total), 0]</th>
<th>Allocated Excess Reserve (6) = (3) x [(5 Total) / (3 Total)]</th>
<th>Total Contract Level Reserve (7) = (1) + (6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract 1: Indexed Annuity with no GLWB**</td>
<td>95.0</td>
<td>90.0</td>
<td>0.0</td>
<td></td>
<td>0.0</td>
<td></td>
<td>95.0</td>
<td></td>
</tr>
<tr>
<td>Contract 2: Indexed Annuity with low benefit GLWB**</td>
<td>92.0</td>
<td>95.0</td>
<td>3.0</td>
<td></td>
<td>3.6</td>
<td></td>
<td>95.6</td>
<td></td>
</tr>
<tr>
<td>Contract 3: Indexed Annuity with medium benefit GLWB**</td>
<td>90.0</td>
<td>100.0</td>
<td>10.0</td>
<td></td>
<td>12.0</td>
<td></td>
<td>102.0</td>
<td></td>
</tr>
<tr>
<td>Contract 4: Indexed Annuity with high benefit GLWB**</td>
<td>88.0</td>
<td>105.0</td>
<td>17.0</td>
<td></td>
<td>20.4</td>
<td></td>
<td>108.4</td>
<td></td>
</tr>
<tr>
<td>Contract 5: Fixed Life Contingent Payout Annuity</td>
<td>0.0</td>
<td>70.0</td>
<td>70.0</td>
<td></td>
<td>84.0</td>
<td></td>
<td>84.0</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>365.0</td>
<td>100.0</td>
<td>485.0</td>
<td>120.0</td>
<td>120.0</td>
<td>485.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Cash Surrender Value
**Guaranteed Lifetime Withdrawal Benefit

Guidance Note: The actuarial present value (APV) in the section above is separate from the Guarantee Actuarial Present Value (GAPV) referred to in the additional standard projection amount calculation in VM-21. The GAPV is only applicable to guaranteed minimum benefits and uses prescribed liability assumptions. In contrast, the APV in this section applies to the entire contract, irrespective of whether guaranteed benefits are attached, and uses company prudent estimate liability assumptions.
Section 13: Statutory Maximum Valuation Interest Rates for Income Annuity Formulaic Reserves

A. Purpose and Scope

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

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

   **Guidance Note:** For Section 13.A.2.d, Section 13.A.2.e, Section 13.A.2.f and Section 13.A.2.h above, there is no restriction on the type of contract that may give rise to the benefit.

3. Exemptions:
   a. With the permission of the domiciliary commissioner, for the categories of annuity contracts, certificates and/or contract features in scope as outlined in Section 13.A.2.d, Section 13.A.2.e, Section 13.A.2.f, Section 13.A.2.g or Section 13.A.2.h, the company may use the same maximum valuation interest rate used to value the payment stream in accordance with the guidance applicable to the host contract. In order to obtain such
permission, the company must demonstrate that its investment policy and practices are consistent with this approach.

4. The maximum valuation interest rates for the contracts, certificates and contract features within the scope of Section 13 of VM-22 supersede those described in Appendix VM-A and Appendix VM-C, but they do not otherwise change how those appendices are to be interpreted. In particular, Actuarial Guideline IX-B—Clarification of Methods Under Standard Valuation Law for Individual Single Premium Immediate Annuities, Any Deferred Payments Associated Therewith, Some Deferred Annuities and Structured Settlements Contracts (AG-9-B) (see VM-C) provides guidance on valuation interest rates and is, therefore, superseded by these requirements for contracts, certificates and contract features in scope. Likewise, any valuation interest rate references in Actuarial Guideline IX-C—Use of Substandard Annuity Mortality Tables in Valuing Impaired Lives Under Individual Single Premium Immediate Annuities (AG-9-C) (see VM-C) are also superseded by these requirements.

B. Definitions

1. The term “reference period” means the length of time used in assigning the Valuation Rate Bucket for the purpose of determining the statutory maximum valuation interest rate and is determined as follows:

   a. For contracts, certificates or contract features with life contingencies and substantially similar payments, the reference period is the length of time, rounded to the nearest year, from the premium determination date to the earlier of: i) the date of the last non-life-contingent payment under the contract, certificate or contract feature; and ii) the date of the first life-contingent payment under the contract, certificate or contract feature, or

   b. For contracts, certificates or contract features with no life-contingent payments and substantially similar payments, the reference period is the length of time, rounded to the nearest year, from the premium determination date to the date of the last non-life-contingent payment under the contract, certificate or contract feature, or

   c. For contracts, certificates or contract features where the payments are not substantially similar, the actuary should apply prudent judgment and select the Valuation Rate Bucket with Macaulay duration that is a best fit to the Macaulay duration of the payments in question.

   **Guidance Note:** Contracts with installment refunds or similar features should consider the length of the installment period calculated from the premium determination date as the non-life contingent period for the purpose of determining the reference period.

   **Guidance Note:** The determination in Section 13.B.1.c above shall be made based on the materiality of the payments that are not substantially similar relative to the life-contingent payments.

2. The term “jumbo contract” means a contract with an initial consideration equal to or greater than $250 million. Considerations for contracts issued by an insurer to the same contract holder within 90 days shall be combined for purposes of determining whether the contracts meet this threshold.

   **Guidance Note:** If multiple contracts meet this criterion in aggregate, then each contract is a jumbo contract.

3. The term “non-jumbo contract” means a contract that does not meet the definition of a jumbo
contract.

4. The term “premium determination date” means the date as of which the valuation interest rate for the contract, certificate or contract feature being valued is determined.

5. The term “initial age” means the age of the annuitant as of his or her age last birthday relative to the premium determination date. For joint life contracts, certificates or contract features, the “initial age” means the initial age of the younger annuitant. If a contract, certificate or contract feature for an annuitant is being valued on a standard mortality table as an impaired annuitant, “initial age” means the rated age. If a contract, certificate or contract feature is being valued on a substandard mortality basis, “initial age” means an equivalent rated age.

6. The term “Table X spreads” means the prescribed VM-22 Section 13 current market benchmark spreads for the quarter prior to the premium determination date, as published on the Industry tab of the NAIC website. The process used to determine Table X spreads is the same as that specified in VM-20 Appendix 2.D for Table F, except that JP Morgan and Bank of America bond spreads are averaged over the quarter rather than the last business day of the month.

7. The term “expected default cost” means a vector of annual default costs by weighted average life. This is calculated as a weighted average of the VM-20 Table A prescribed annual default costs published on the Industry tab of the NAIC website in effect for the quarter prior to the premium determination date, using the prescribed portfolio credit quality distribution as weights.

8. The term “expected spread” means a vector of spreads by weighted average life. This is calculated as a weighted average of the Table X spreads, using the prescribed portfolio credit quality distribution as weights.

9. The term “prescribed portfolio credit quality distribution” means the following credit rating distribution:
   a. 5% Treasuries
   b. 15% Aa bonds (5% Aa1, 5% Aa2, 5% Aa3)
   c. 40% A bonds (13.33% A1, 13.33% A2, 13.33% A3)*
   d. 40% Baa bonds (13.33% Baa1, 13.33% Baa2, 13.33% Baa3)*

*40%/3 is used unrounded in the calculations.

C. Determination of the Statutory Maximum Valuation Interest Rate

1. Valuation Rate Buckets
   a. For the purpose of determining the statutory maximum valuation interest rate, the contract, certificate or contract feature being valued must be assigned to one of four Valuation Rate Buckets labeled A through D.
   b. If the contract, certificate or contract feature has no life contingencies, the Valuation Rate Bucket is assigned based on the length of the reference period (RP), as follows:

      Table 3-1: Assignment to Valuation Rate Bucket by Reference Period Only
c. If the contract, certificate or contract feature has life contingencies, the Valuation Rate Bucket is assigned based on the length of the RP and the initial age of the annuitant, as follows:

Table 3-2: Assignment to Valuation Rate Bucket by Reference Period and Initial Age

<table>
<thead>
<tr>
<th>Initial Age</th>
<th>RP ≤ 5Y</th>
<th>5Y &lt; RP ≤ 10Y</th>
<th>10Y &lt; RP ≤ 15Y</th>
<th>RP &gt; 15Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>90+</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>80–89</td>
<td>B</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>70–79</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>&lt; 70</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td>D</td>
</tr>
</tbody>
</table>

2. Premium Determination Dates

a. The following table specifies the decision rules for setting the premium determination date for each of the contracts, certificates and contract features listed in Section 1:

Table 3-3: Premium Determination Dates

<table>
<thead>
<tr>
<th>Section</th>
<th>Item Description</th>
<th>Premium determination date</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.2.a</td>
<td>Immediate annuity</td>
<td>Date consideration is determined and committed to by contract holder</td>
</tr>
<tr>
<td>A.2.b</td>
<td>Deferred income annuity</td>
<td>Date consideration is determined and committed to by contract holder</td>
</tr>
<tr>
<td>A.2.c</td>
<td>Structured settlements</td>
<td>Date consideration is determined and committed to by contract holder</td>
</tr>
<tr>
<td>A.2.d and A.2.e</td>
<td>Fixed payout annuities resulting from settlement options or annuitizations from host contracts</td>
<td>Date consideration for benefit is determined and committed to by contract holder</td>
</tr>
<tr>
<td>A.2.f</td>
<td>Supplementary contracts</td>
<td>Date of issue of supplementary contract</td>
</tr>
<tr>
<td>A.2.g</td>
<td>Fixed income payment streams from CDAs, AV becomes 0</td>
<td>Date on which AV becomes 0</td>
</tr>
<tr>
<td>A.2.h</td>
<td>Fixed income payment streams from guaranteed living benefits, AV becomes 0</td>
<td>Date on which AV becomes 0</td>
</tr>
</tbody>
</table>
Guidance Note: For the purposes of the items in the table above, the phrase “date consideration is determined and committed to by the contract holder” should be interpreted by the company in a manner that is consistent with its standard practices. For some products, that interpretation may be the issue date or the date the premium is paid.

b. Immaterial Change in Consideration

If the premium determination date is based on the consideration, and if the consideration changes by an immaterial amount (defined as a change in present value of less than 10% and less than $1 million) subsequent to the original premium determination date, such as due to a data correction, then the original premium determination date shall be retained. In the case of a group annuity contract where a single premium is intended to cover multiple certificates, certificates added to the contract after the premium determination date that do not trigger the company’s right to reprice the contract shall be treated as if they were included in the contract as of the premium determination date.

3. Statutory Maximum Valuation Interest Rate

a. For a given contract, certificate or contract feature, the statutory maximum valuation interest rate is determined based on its assigned Valuation Rate Bucket (Section 13.C.1) and its Premium Determination Date (Section 13.C.2) and whether the contract associated with it is a jumbo contract or a non-jumbo contract.

b. Statutory maximum valuation interest rates for jumbo contracts are determined and published daily by the NAIC on the Industry tab of the NAIC website. For a given premium determination date, the statutory maximum valuation interest rate is the daily statutory maximum valuation interest rate published for that premium determination date.

c. Statutory maximum valuation interest rates for non-jumbo contracts are determined and published quarterly by the NAIC on the Industry tab of the NAIC website by the third business day of the quarter. For a given premium determination date, the statutory maximum valuation interest rate is the quarterly statutory maximum valuation interest rate published for the quarter in which the premium determination date falls.

d. Quarterly Valuation Rate:

For each Valuation Rate Bucket, the quarterly valuation rate is defined as follows:

\[ I_q = R + S - D - E \]

Where:

a. R is the reference rate for that Valuation Rate Bucket (defined in Section 13.C.4);

b. S is the spread rate for that Valuation Rate Bucket (defined in Section 13.C.5);

c. D is the default cost rate for that Valuation Rate Bucket (defined in Section 13.C.6);
and

d. E is the spread deduction defined as 0.25%.

e. Daily Valuation Rate:

For each Valuation Rate Bucket, the daily valuation rate is defined as follows:

\[ I_d = I_q + C_{d-1} - C_q \]

Where:

a. \( I_q \) is the quarterly valuation rate for the calendar quarter preceding the business day immediately preceding the premium determination date;

b. \( C_{d-1} \) is the daily corporate rate (defined in Section 13.C.7) for the business day immediately preceding the premium determination date; and

c. \( C_q \) is the average daily corporate rate (defined in Section 13.C.8) corresponding to the same period used to develop \( I_q \).

For jumbo contracts, the daily statutory maximum valuation interest rate is the daily valuation rate \( (I_d) \) rounded to the nearest one-hundredth of one percent (1/100 of 1%).

4. Reference Rate

Reference rates are updated quarterly as described below:

a. The “quarterly Treasury rate” is the average of the daily Treasury rates for a given maturity over the calendar quarter prior to the premium determination date. The quarterly Treasury rate is downloaded from https://fred.stlouisfed.org, and is rounded to two decimal places.

b. Download the quarterly Treasury rates for two-year, five-year, 10-year and 30-year U.S. Treasuries.

c. The reference rate for each Valuation Rate Bucket is calculated as the weighted average of the quarterly Treasury rates using Table 1 weights (defined in Section 13.C.9) effective for the calendar year in which the premium determination date falls.

5. Spread

The spreads for each Valuation Rate Bucket are updated quarterly as described below:

a. Use the Table X spreads from the NAIC website for WALs two, five, 10 and 30 years only to calculate the expected spread.

b. Calculate the spread for each Valuation Rate Bucket, which is a weighted average of the expected spreads for WALs two, five, 10 and 30 using Table 2 weights (defined in Section 3.1) effective for the calendar year in which the premium determination date falls.

6. Default costs for each Valuation Rate Bucket are updated annually as described below:

a. Use the VM-20 prescribed annual default cost table (Table A) in effect for the quarter prior to the premium determination date for WAL two, WAL five and WAL 10 years only to calculate the expected default cost. Table A is updated and published annually on
b. Calculate the default cost for each Valuation Rate Bucket, which is a weighted average of the expected default costs for WAL two, WAL five and WAL 10, using Table 3 weights (defined in Section 13.C.9) effective for the calendar year in which the premium determination date falls.

7. Daily Corporate Rate

Daily corporate rates for each valuation rate bucket are updated daily as described below:

a. Each day, download the Bank of America Merrill Lynch U.S. corporate effective yields as of the previous business day’s close for each index series shown in the sample below from the St. Louis Federal Reserve website: https://research.stlouisfed.org/fred2/categories/32348. To access a specific series, search the St. Louis Federal Reserve website for the series name by inputting the name into the search box in the upper right corner, or input the following web address: https://research.stlouisfed.org/fred2/series/[replace with series name from the table below].

<table>
<thead>
<tr>
<th>Maturity</th>
<th>Series Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1Y – 3Y</td>
<td>BAMLC1A0C13YEY</td>
</tr>
<tr>
<td>3Y – 5Y</td>
<td>BAMLC2A0C35YEY</td>
</tr>
<tr>
<td>5Y – 7Y</td>
<td>BAMLC3A0C57YEY</td>
</tr>
<tr>
<td>7Y – 10Y</td>
<td>BAMLC4A0C710YEY</td>
</tr>
<tr>
<td>10Y – 15Y</td>
<td>BAMLC7A0C1015YEY</td>
</tr>
<tr>
<td>15Y+</td>
<td>BAMLC8A0C15PYEY</td>
</tr>
</tbody>
</table>

b. Calculate the daily corporate rate for each valuation rate bucket, which is a weighted average of the Bank of America Merrill Lynch U.S. corporate effective yields, using Table 4 weights (defined in Section 13.C.9) effective for the calendar year in which the business date immediately preceding the premium determination date falls.

8. Average Daily Corporate Rate

Average daily corporate rates are updated quarterly as described below:

a. Download the quarterly average Bank of America Merrill Lynch U.S. corporate effective yields for each index series shown in Section 3.G.1 from the St. Louis Federal Reserve website: https://research.stlouisfed.org/fred2/categories/32348. To access a specific series, search the St. Louis Federal Reserve website for the series name by inputting the name into the search box in the upper right corner, or input the following web address: https://research.stlouisfed.org/fred2/series/[replace with series name from Section 13.C.7.a].
b. Calculate the average daily corporate rate for each valuation rate bucket, which is a weighted average of the quarterly average Bank of America Merrill Lynch U.S. corporate effective yields, using Table 4 weights (defined in Section 13.C.9) for the same calendar year as the weight tables (i.e. Tables 1, 2, and 3) used in calculating \( I_q \) in Section 13.C.3.e.

9. Weight Tables 1 through 4

The system for calculating the statutory maximum valuation interest rates relies on a set of four tables of weights that are based on duration and asset/liability cash-flow matching analysis for representative annuities within each valuation rate bucket. A given set of weight tables is applicable to the calculations for every day of the calendar year.

In the fourth quarter of each calendar year, the weights used within each valuation rate bucket for determining the applicable valuation interest rates for the following calendar year will be updated using the process described below. In each of the four tables of weights, the weights in a given row (valuation rate bucket) must add to exactly 100%.

Weight Table 1

The process for determining Table 1 weights is described below:

a. Each valuation rate bucket has a set of representative annuity forms. These annuity forms are as follows:

i. Bucket A:
   a) Single Life Annuity age 91 with 0 and five-year certain periods.
   b) Five-year certain only.

ii. Bucket B:
   a) Single Life Annuity age 80 and 85 with 0, five-year and 10-year certain periods.
   b) 10-year certain only.

iii. Bucket C:
   a) Single Life Annuity age 70 with 0 and 15-year certain periods.
   b) Single Life Annuity age 75 with 0, 10-year and 15-year certain periods.
   c) 15-year certain only.

iv. Bucket D:
   a) Single Life Annuity age 55, 60 and 65 with 0 and 15-year certain periods.
   b) 25-year certain only.

b. Annual cash flows are projected assuming annuity payments are made at the end of each year. These cash flows are averaged for each valuation rate bucket across the annuity forms for that bucket using the statutory valuation mortality table in effect for the following calendar year for individual annuities for males (ANB).
c. The average daily rates in the third quarter for the two-year, five-year, 10-year and 30-year U.S. Treasuries are downloaded from https://fred.stlouisfed.org as input to calculate the present values in Step d.

d. The average cash flows are summed into four time period groups: years 1–3, years 4–7, years 8–15 and years 16–30. (Note: The present value of cash flows beyond year 30 are discounted to the end of year 30 and included in the years 16–30 group. This present value is based on the lower of 3% and the 30-year Treasury rate input in Step c.)

e. The present value of each summed cash-flow group in Step d is then calculated by using the Step 3 U.S. Treasury rates for the midpoint of that group (and using the linearly interpolated U.S. Treasury rate when necessary).

f. The duration-weighted present value of the cash flows is determined by multiplying the present value of the cash-flow groups by the midpoint of the time period for each applicable group.

g. Weightings for each cash-flow time period group within a valuation rate bucket are calculated by dividing the duration weighted present value of the cash flow by the sum of the duration weighted present value of cash flow for each valuation rate bucket.

Weight Tables 2 through 4

Weight Tables 2 through 4 are determined using the following process:

i. Table 2 is identical to Table 1.

ii. Table 3 is based on the same set of underlying weights as Table 1, but the 10-year and 30-year columns are combined since VM-20 default rates are only published for maturities of up to 10 years.

iii. Table 4 is derived from Table 1 as follows:

   a) Column 1 of Table 4 is identical to column 1 of Table 1.
   b) Column 2 of Table 4 is 50% of column 2 of Table 1.
   c) Column 3 of Table 4 is identical to column 2 of Table 4.
   d) Column 4 of Table 4 is 50% of column 3 of Table 1.
   e) Column 5 of Table 4 is identical to column 4 of Table 4.
   f) Column 6 of Table 4 is identical to column 4 of Table 1.

10. Group Annuity Contracts

For a group annuity purchased under a retirement or deferred compensation plan (Section 13.A.2.i), the following apply:

a. The statutory maximum valuation interest rate shall be determined separately for each certificate, considering its premium determination date, the certificate holder’s initial age, the reference period corresponding to its form of payout and whether the contract is a jumbo contract or a non-jumbo contract.

Guidance Note: Under some group annuity contracts, certificates may be purchased on different dates.
b. In the case of a certificate whose form of payout has not been elected by the beneficiary at its premium determination date, the statutory maximum valuation interest rate shall be based on the reference period corresponding to the normal form of payout as defined in the contract or as is evidenced by the underlying pension plan documents or census file. If the normal form of payout cannot be determined, the maximum valuation interest rate shall be based on the reference period corresponding to the annuity form available to the certificate holder that produces the most conservative rate.

Guidance Note: The statutory maximum valuation interest rate will not change when the form of payout is elected.
Valuation Manual Section II. Reserve Requirements

Subsection 2: Annuity Products

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

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

C. Minimum reserve requirements for fixed annuity contracts issued prior to 1/1/2024 are those requirements as found in VM-A and VM-C as applicable, with the exception of the minimum requirements for the valuation interest rate for single premium immediate annuity contracts, and other similar contracts, issued after Dec. 31, 2017, including those fixed payout annuities emanating from host contracts issued on or after Jan. 1, 2017, and on or before Dec. 31, 2017. The maximum valuation interest rate requirements for those contracts and fixed payout annuities are defined in Section 13 of VM-22, Statutory Maximum Valuation Interest Rates for Income Annuity Formulaic Reserves.

D. Minimum reserve requirements for fixed annuity contracts issued on 1/1/2024 and later are those requirements as found in Sections 1 through 12 of VM-22.

E. The below principles may serve as key considerations for assessing whether VM-21 or VM-22 requirements apply:

1. Index-linked or modified guaranteed annuity contracts or riders that satisfy both of the following conditions may be a key consideration for application of VM-22 requirements:
   a. Guarantees the principal amount of purchase payments, net of any partial withdrawals, and interest credited thereto, less any deduction (without regard to its timing) for sales, administrative or other expenses or charges.
   b. Credits a rate of interest under the contract that is at least equal to the minimum rate required to be credited by the standard nonforfeiture law in the jurisdiction in which the contract is issued.

   **Guidance Note:** Paragraph E.1.b is intended to apply prior to the application of any market value adjustments for modified guaranteed annuities where the underlying assets are held in a separate account. If meeting Paragraph E.1.b prior to the application of any market value adjustments and Paragraph E.1.a above, it may be appropriate to value such contracts under VM-22 requirements.

2. Index-linked or modified guaranteed annuity contracts that do not satisfy either of the two conditions listed above in Paragraph E.1.i and E.1.ii may be a key consideration for application of VM-21 requirements.
Subsection 6: Riders and Supplemental Benefits

**Guidance Note:** Policies or contracts with riders and supplemental benefits which are created to simply disguise benefits subject to the Valuation Manual section describing the reserve methodology for the base product to which they are attached, or exploit a perceived loophole, must be reserved in a manner similar to more typical designs with similar riders.

A. If a rider or supplemental benefit is attached to a health insurance product, deposit-type contract, or credit life or disability product, it may be valued with the base contract unless it is required to be separated by regulation or other requirements.

B. For supplemental benefits on life insurance policies or annuity contracts, including Guaranteed Insurability, Accidental Death or Disability Benefits, Convertibility, Nursing Home Benefits or Disability Waiver of Premium Benefits, the supplemental benefit may be valued with the base policy or contract and follow the reserve requirements for the base policy or contract under VM-20, VM-21, VM-22, VM-A, and/or VM-C, as applicable.

C. ULSG and other secondary guarantee riders on a life insurance policy shall be valued with the base policy and follow the reserve requirements for ULSG policies under VM-20, VM-A and/or VM-C, as applicable.

D. Any guaranteed minimum benefits on life insurance policies or annuity contracts not subject to Paragraph C above including, but not limited to, Guaranteed Minimum Accumulation Benefits, Guaranteed Minimum Death Benefits, Guaranteed Minimum Income Benefits, Guaranteed Minimum Withdrawal Benefits, Guaranteed Lifetime Income Benefits, Guaranteed Lifetime Withdrawal Benefits, Guaranteed Payout Annuity Floors, Waiver of Surrender Charges, Return of Premium, Systematic Withdrawal Benefits under Required Minimum Distributions, and all similar guaranteed benefits shall be valued with the base policy or contract and follow the reserve requirements for the base policy or contract under VM-20, VM-21, VM-22, and VM-A and/or VM-C, as applicable.

E. If a rider or supplemental benefit to a life insurance policy or annuity contract that is not addressed in Paragraphs B, C, or D above possesses any of the following attributes, the rider or supplemental benefit shall be valued with the base policy or contract and follow the reserve requirements for the base policy or contract under VM-20, VM-21, VM-22, and VM-A and/or VM-C, as applicable.

   1. The rider or supplemental benefit does not have a separately identified premium or charge.
   2. After issuance, the rider or supplemental benefit premium, charge, value or benefits are determined by referencing the base policy or contract features or performance.
   3. After issuance, the base policy or contract value or benefits are determined by referencing the rider or supplemental benefit features or performance. The deduction of rider or benefit premium or charge from the contract value is not sufficient for a determination by reference.

F. If a term life insurance rider on the named insured[s] on the base life insurance policy does not meet the conditions of Paragraph E above, and either (1) guarantees level or near level premiums until a specified duration followed by a material premium increase; or (2) for a rider for which level or near level premiums are expected for a period followed by a material premium increase, the rider is separated from the base policy and follows the reserve requirements for term policies under VM20, VM-A and/or VM-C, as applicable.
G. For all other riders or supplemental benefits on life insurance policies or annuity contracts not addressed in Paragraphs B through F above, the riders or supplemental benefits may be valued with the base policy or contract and follow the reserve requirements for the base policy or contract under VM-20, VM-21, VM-22, VM-A and/or VM-C, as applicable. For a given rider, the election to include riders or supplemental benefits with the base policy or contract shall be determined at the policy form level, not on a policy-by-policy basis, and shall be treated consistently from year-to-year, unless otherwise approved by the domiciliary commissioner.

H. Any supplemental benefits and riders offered on life insurance policies or annuity contracts that would have a material impact on the reserve if elected later in the contract life, such as joint income benefits, nursing home benefits, or withdrawal provisions on annuity contracts, shall be considered when determining reserves using the following principles:

1. Policyholders with living benefits and annuitization in the same contract will generally use the more valuable of the two benefits.

2. When advantageous, policyholders will commence living benefit payouts if not started yet.
VM-22 Exposure Priorities

- Standard Projection Amount language analogous to that in VM-21 is expected to be added to the next exposure, as either a disclosure item or floor.

- Comments on the current draft are especially welcome with respect to:
  - Reserve Categories (Section 3):
    - Are more or less categories preferable? If more, how should they be determined?
    - Are more changes required other than in Section 3?
    - Definition language including:
      - Is #8 in “Payout Annuity Reserve Category Definition -VM22 list July 21 2021.docx” too broad or narrow?
      - In “Reserve Category Definitions – Principle Based July 21 2021.docx” is valuation date or issue date preferable?
  - Model Segments (Section 3.E)
    - Conceptual
    - Language
  - Allocation (Section 12)
    - Preference between Option 1 (VM-21 Approach) and Option 2 (Actuarial Present Value Approach)
  - VM-21 vs. VM-22 Distinction (VM Section II edits)
    - Wording for conditions regarding whether to treat index-linked and modified guaranteed annuities as VM-21 or VM-22
  - Exclusion Test
    - Deterministic Certification Option (Section 7.E)
    - Keeping longevity shocks as part of the stochastic exclusion test (current wording) or make a separate test from interest rate/equity shocks in the stochastic exclusion test (alternative)
RESERVING CATEGORY DEFINITIONS

OPTION 1:

The Term "Payout Annuity Reserving Category" includes the following categories of contracts, certificates and contract features, whether group or individual, including both life contingent and term certain only contracts, directly written or assumed through reinsurance, with the exception of benefits provided by variable annuities:

1. Immediate annuity contracts;
2. Deferred income annuity contracts;
3. Structured settlements in payout or deferred status;
4. Fixed income payment streams resulting from the exercise of settlement options or annuitizations of host contracts issued;
5. Supplementary contracts, excluding contracts with no scheduled payments (such as retained asset accounts and settlements at interest);
6. Fixed income payment streams attributable to guaranteed living benefits associated with deferred annuity contracts when the contract funds are exhausted; and
7. Certificates emanating from non-variable group annuity contracts specified in Model #820, Section 5.C.2, purchased for the purpose of providing certificate holders fixed income payment streams upon their retirement.

8. Pension Risk Transfer Annuities.
Reserve Category Definitions

The Accumulation Reserve Category contains contracts with supporting assets such that there is greater disintermediation risk and other risks associated with policyholder behavior, than reinvestment and longevity risks as of the valuation date.

The Payout Reserve Category contains contracts with supporting assets such that there is greater reinvestment and longevity risks, than disintermediation risk and other risks associated with policyholder behavior as of the valuation date.

Guidance Note

Reasonable grouping of contracts is allowed. The determination process shall not incorporate the effect on reserves of categorization decisions and shall be documented in the VM-31 Actuarial Report.
The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met July 7, 2021. The following Subgroup members participated: Bruce Sartain, Chair, and Vincent Tsang (IL); Ted Chang, Ahmad Kamil, Elaine Lam, and Thomas Reedy (CA); Lei Rao-Knight (CT); Mike Yanacheak (IA); Nicole Boyd (KS); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello and Amanda Fenwick (NY); Rachel Hemphill and Karen Jiang (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA). Also participating was: John Robinson (MN).

1. Discussed Reserving Categories

Mr. Sartain said the Subgroup has agreed to consider the existing VM-22, Statutory Maximum Valuation Interest Rate for Income Annuities, product descriptions as an alternative to the prescriptive option proposed previously. He said the Subgroup also agreed to consider exploring modifications to the principle-based option for defining reserving categories. He said the Subgroup should determine which approach is preferred or if both approaches should be exposed for public comment.

Mr. Leung discussed the proposed modifications (Attachment One) to the VM-22 product descriptions. He recommended replacing the term “benefits provided by variable annuities” with the term “payment streams arising from variable annuities.” He said the former term would cause supplementary contract payments arising from variable annuity contracts to automatically fall out of the payout reserving category; therefore, he recommended using the latter term. He said the effective date of the VM-22 revisions will make the current references to Dec. 31, 2017, in the descriptions unnecessary. He recommended that fixed income payments from contingent deferred annuities (CDAs) should be treated as variable annuities and should not be included in the scope of VM-22. He noted that pension risk transfer (PRT) business is added. Brian Bayerle (American Council of Life Insurers—ACLI) asked what considerations led to the decision to add PRT business, given that the reserve would also have to be included for active lives. Mr. Leung responded that fixed payment streams from PRT contracts are included only after the payment is determined. Mr. Bayerle said that would require bifurcation of the PRT contract into lives in payout and active lives. Mr. Sartain said that would require bifurcation of the PRT contract into lives in payout and active lives. Mr. Sartain said perhaps a principle-based approach could be used to bifurcate the risks. Mr. Robinson said the Subgroup discussed a similar issue related to payouts under non-variable group annuity contracts. He suggested that the use of the broad reference to “other fixed payment streams such as those under PRT business” might lead to confusion because the term is ambiguous and is not defined in the Valuation Manual. Mr. Sartain suggested removing the ambiguity by removing the reference to anything other than PRT business and providing a definition of PRT business in the Valuation Manual. Ms. Eom suggested that the modification should avoid using the term “fixed payment streams.” She agreed to think about alternative wording.

Mr. Sartain said the principle-based option for reserving categories (Attachment Two) was also modified. He said the concept of supporting assets was brought into the definition to coincide with the reference to disintermediation risk. He said the definition of the payout reserving category was enhanced by adding a reference to longevity risk. He said the accumulation reserving category was improved by adding the risks associated with policyholder behavior. He said the risk category is to be determined based on the risks identified at the time of issue. He noted that the risk category determination under the principle-based approach must be made without consideration of its impact on the reserve amount. Mr. Bayerle said determining at the valuation date lends itself to the possibility of drifting away from the intent over time. Mr. Serbinowski asked if the approach would require that the determination be static after being made at the time of issue. Mr. Sartain said it is intended to be static. Mr. Serbinowski said making the determination on the valuation date would seem to allow the most flexibility to adapt to changing circumstances.

Mr. Sartain said modifications will be made to both approaches for consideration on the next call. He said the modifications will include changing form issue date back to valuation date. He said the goal is to expose the documents and the American Academy of Actuaries’ (Academy’s) revised fixed annuity framework at the July 21 Subgroup meeting. Ms. Hemphill said the Life Actuarial (A) Task Force has adopted a revision to VM-21, Requirements for Principle-Based Reserves for Variable Annuities, that addresses materiality, approximations, and simplifications. She said similar wording should be incorporated into the VM-22 draft for consistency. Chris Conrad (Academy) agreed to consider the change.

Having no further business, the VM-22 (A) Subgroup adjourned.
VM-22:

The Term “Payout Annuity Reserve Category” includes the following categories of contracts, certificates and contract features, whether group or individual, including both life contingent and term certain only contracts, directly written or assumed through reinsurance, with the exception of benefits provided by variable annuities:

1. Immediate annuity contracts issued after Dec. 31, 2017;

2. Deferred income annuity contracts issued after Dec. 31, 2017;

3. Structured settlements in payout or deferred status issued after Dec. 31, 2017;

4. Fixed payout annuities resulting from the exercise of settlement options or annuitizations of host contracts issued after Dec. 31, 2017;

5. Fixed payout annuities resulting from the exercise of settlement options or annuitizations of host contracts issued during 2017, for fixed payouts commencing after Dec. 31, 2018, or, at the option of the company, for fixed payouts commencing after Dec. 31, 2017;

6.5. Supplementary contracts, excluding contracts with no scheduled payments (such as retained asset accounts and settlements at interest), issued after Dec. 31, 2017;

7. Fixed income payment streams attributable to contingent deferred annuities (CDAs) issued after Dec. 31, 2017, once the underlying contract funds are exhausted;

8.6. Fixed income payment streams attributable to guaranteed living benefits associated with deferred annuity contracts issued after Dec. 31, 2017, once the contract funds are exhausted; and

7. Certificates with premium determination dates after Dec. 31, 2017, emanating from non-variable group annuity contracts specified in Model #820, Section 5.C.2, purchased for the purpose of providing certificate holders benefits upon their retirement.

9.8. Other fixed payment streams such as those under Pension Risk Transfer business.

Guidance Note: For Section 1.B.4, Section 1.B.5, Section 1.B.6 and Section 1.B.8 above, there is no restrictions on the type of contract that may give rise to the benefit.
Reserve Category Definitions
The Accumulation Reserve Category contains contracts with supporting assets such that there is greater disintermediation risk and other risks associated with policyholder behavior, than reinvestment and longevity risks at issue.

The Payout Reserve Category contains contracts with supporting assets such that there is greater reinvestment and longevity risks than disintermediation risk and other risks associated with policyholder behavior at issue.

Guidance Note
Reasonable grouping of contracts is allowed. The determination process shall not incorporate the effect on reserves of categorization decisions and shall be documented in the VM-31 Actuarial Report.

Pros of making determination at issue
- Much simpler/easier.
- No reserve discontinuity due to a contract changing categories over time.

Con of making determination at issue date
- Dilutes goal of not allowing for diversification of disintermediation/policyholder risks and reinvestment/longevity risks (e.g. an annuitization of a deferred annuity with no commutation options will be in the Accumulation RC)

Note
If a different reserve methodology is developed for a portion of contracts in the Payout Reserve Category, these definitions may be revisited.
The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met June 30, 2021. The following Subgroup members participated: Bruce Sartain, Chair, and Vincent Tsang (IL); Ted Chang, Ahmad Kamil, Elaine Lam, and Thomas Reedy (CA); Lei Rao-Knight (CT); Nicole Boyd (KS); William Leung (MO); Seong-min Eom (NJ); Bill Carmello and Amanda Fenwick (NY); Rachel Hemphill and Karen Jiang (TX); and Craig Chupp (VA).

1. **Discussed VM-20 Section 5.A Language**

Mr. Sartain said in a previous discussion of Section 5.A of VM-20, Requirements for Principle-Based Reserves for Life Products, Subgroup members shared views that ranged from desiring more than two reserve categories to desiring a single reserve category. He said the Subgroup ultimately voted to have two reserve categories. He suggested proceeding with the development of an exposure that proceeds with the implementation of two reserve categories.

2. **Heard a PRT Drafting Group Update**

Ms. Eom said the Pension Risk Transfer (PRT) Drafting Group was formed to review the appropriateness of the mortality tables currently used for PRT mortality. She said the table used most often is the 1994 Group Annuity Reserving (GAR) table. She said PRT mortality experience differs from the mortality experience generally observed in annuity populations. She noted that some PRT contracts cover populations outside of the U.S. She said the drafting group held regulator-only sessions to discuss marketing and contract information requested from companies in the PRT market. She said the drafting group hopes to recommend an approach that will serve as a guideline during the development of VM-22, Statutory Maximum Valuation Interest Rate for Income Annuities, and it will provide a good linkage to the VM-22 standard projection amount. She said the drafting group is continuing to receive and analyze company data.

3. **Discussed the VM-22 Field Test**

Mr. Sartain said the American Academy of Actuaries (Academy) is spearheading the planning for a VM-22 field test. He said the timing of the field test is contingent upon the timing of the Life Actuarial (A) Task Force economic scenario generator (ESG) field test. Chris Conrad (Academy) discussed the details of the draft of the fixed annuity principle-based reserving (PBR) field test specifications (Attachment Nineteen-A). He said the company participation portion of the field test is scheduled for May through September of 2022. Pat Allison (NAIC) said the NAIC will participate in the selection of a consultant to lead the field test and will pay a portion of the consulting costs. She said the NAIC will work with state insurance regulators to encourage company participation in the field test and will monitor company involvement. She said the NAIC will also review the consolidation of field test results and assist with the presentation of those results. Mr. Conrad said the structure of the VM-22 field test will be like the yearly renewable term (YRT) field test. He said both payout and deferred annuities will be included in the field test.

Having no further business, the VM-22 (A) Subgroup adjourned.

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Annuity Reserves and Capital Work Group Reserves & Capital Field Testing
Description & Specifications

Primary Contacts:
Khloe Greenwood (greenwood@actuary.org)
Steve Jackson (sjackson@actuary.org)

Section I: Field Study Overview

Objectives
1) Measure the impact on actual business of the proposed reserve and capital frameworks relative to the current standards to ensure frameworks are working as intended.
   o Conduct field test to inform decisions related to the proposed fixed annuity principle-based reserving (PBR) methodology
     ▪ Test exclusion testing, allocation, proposed treatment for hedging indexed credit, aggregation, and other methodology elements
2) At a high-level, ensure pillars of framework are met:
   o Appropriate Reflection of Risk—All else equal, greater risk in adverse conditions requires greater statutory reserves/capital, and vice-versa.
   o Comprehensive—The statutory reserve accounts for all material risks covered in the Valuation Manual and inherent in product features and potential management actions associated with the policies or contracts being valued.
   o Consistency Across Products—Statutory reserves between two contracts with similar features and risks are consistent given the same anticipated experience, regardless of product type.
   o Practicality and Appropriateness—Balance principles above with an approach that is practical, auditable, and able to be implemented.

Tentative Timeline: May-September 2022

Structure
• Propose exploring a coordinated effort between Academy, NAIC, and American Council of Life Insurers
• Propose to hire an external consultant who can:
  o Provide companies, collectively and individually, with information on calculations requested
  o Help design field test and communicate with companies
  o Work with Academy Research staff to help aggregate and summarize results
  o Potentially supplement the analysis of the field test results with analysis of factors affecting certain calculations, and/or assessing separate impacts on elements that are less feasible for companies to test

Products Covered (companies can chose which of their products to field test)
• Deferred Annuities
  o Fixed Indexed Annuities (FIAs) with Guaranteed Living Benefits (GLBs)
  o FIAs without GLBs
  o Fixed Deferred Annuities (FDAs) with GLBs (if at least five participating companies to ensure anonymity)
  o FDAs without GLBs (if at least five participating companies to ensure anonymity)

• Payout Annuities
  o Single Premium Immediate Annuities (SPIAs)
  o Pension Risk Transfer (PRT)
  o Deferred Income Annuities (DIAs) (if at least five participating companies to ensure anonymity)

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- Structured Settlement Contracts (SSCs) (if at least five participating companies to ensure anonymity)

- Potential Survey Questions
  - Does your company have “longevity reinsurance,” and is it more closely related to mortality-linked securities or an explicit reinsurance contract for annuities?
  - Does your company have modified guaranteed annuities? If so, would you value them as variable or fixed annuities?

- Population
  - For time = 0, test at least 10 years of inforce non-variable annuity products in scope
    - Participants must provide output by policy duration or issue year to provide a sense of the durational impact
    - At option of the participant, may test for using all past inforce business, but must at least provide output by policy duration or issue year for the most recent 10 issue years

- Time Zero Valuation Date
  - 9/30/2021 (to line up with cash flow testing [CFT])
    - Consider option to allow 12/31/2021 upon requests for such

- Model Type
  - Use a model that can project future cash flows over the contract life for the modeled block
    - Can be based on valuation model or pricing model
  - Encourage use of a model that is able to re-project reserves at future time periods (TBD—may be optional)
    - See Section V in this document for additional requirements on projecting future reserves
    - If unable to project, proxy future durations by considering historical inforce product calculations for similar products at the associated duration
    - Seek feedback from potential participants and consider recommendations from consultant

Section II: Assumption Specifications

- Asset Assumptions
  - Use asset assumptions found in Valuation Manual (VM)-22 draft instructions
  - Investment guardrail for fixed income investment strategy set to 5% Treasury, 15% AA, 40% AAA, 40% BBB, unless company-specific investment strategy would result in a higher reserve
  - Set index-based hedging program error to the maximum of the company assumption and [1%], which is deducted from hedge payoffs relative to index credits
    - All other hedging program error set to [5%] of the difference between “best efforts” run and the “adjusted run” CTE70 amounts. This amount is added to the CTE70 “best efforts” run
  - Include margins on company experience assumptions (see subsection below)

- Liability Assumption & Margin Requirements
  - Prudent estimate assumptions for the VM-22 deterministic reserve
    - Set margins on mortality, policyholder behavior, expenses, hedging, non-guaranteed elements (NGEs), withdrawals, and other assumptions as deemed necessary
    - If a company does not wish to use its own margins, then use margins below:

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- +/-10% mortality on plus/minus segments, +5% maintenance expenses, +/- 10% on lapses (depending on lapse-supportedness), 150% dynamic lapses, 5% shift from no withdrawals to 10-year GLB withdrawals, index hedging error at 5%?

**Metrics / Output**

- Provide following metrics at time zero
  - CTE70, CTE90, CTE98
  - Commissioners’ Annuity Reserve Valuation Method (CARVM) at valuation (VM-22 AG33, AG35, etc.)
  - C3P1 at valuation date

**Aggregation**

- Calculate in the following three buckets, if possible:
  1. Deferred annuities with GLBs (FIAs or FDAs)
  2. Deferred annuities without GLBs (FIAs or FDAs)
  3. Payout annuities (SPIAs, DIAs, SSC, PRT, longevity reinsurance as applicable)
     - Optional: Split out SPIAs and PRT if not managed together
- Provide mapping for which blocks meet aggregation criteria in current VM-22 framework draft

**Section III: Supplemental Testing**

**Exclusion test exercise**

- Time points tested: Year 0, year 10
- Scenarios Tested: 16 VM-20 economic scenarios for each mortality scenario specified below.
- Mortality Scenarios: +/- 5%
- Exclusion Testing Aggregation: For only the exclusion test, test each of the following subcategories and provide mapping for how products would be aggregated in current VM-22 framework draft:
  - Deferred Annuities
    - FIAs with GLBs
    - FIAs without GLBs
    - FDAs with GLBs
  - Payout Annuities
    - Individual and joint life-contingent SPIA/DIAs
    - Individual non-life-contingent SPIA
    - Pension risk transfer contracts (split out as a separate group for deferred benefits as deemed appropriate)
    - Optional to test structured settlements separately or combine into above sections
  - All Other
    - Please provide brief description of product for other in-scope products not specified above for which results are provided
- Indicate whether or not a hedging program exists for each block

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Allocation (TBD based on future discussions of allocation method—which may be optional)
Test out the scenario reserve at time = 0 in our proposed allocation scenario (moderately adverse) and assumptions for a few sample policies:
- Sample policies could include: issue age 55 male and female, issue ages 75 male and female
- If available, test these four sample policies out for both a payout annuity product (no CSV) and a deferred annuity product with/without a GLB 75
- Compare our two proposed allocation bases (GPVAD and VM-21-like approach) to the CSV as an allocation basis for these policies to show the difference in results
- Idea is to look at “high risk” and “low risk” policies, and make sure high-risk policies are receiving a greater % allocation. In addition, products generating greater reserves in excess of CSV should receive more allocation.
- Ask participants what challenges were, drawbacks, what improvements are possible, what are implementation challenges, companies provide feedback.

Hedging Survey Questions
- Identify the type of hedging you do for products in VM-22 scope, for example,
  - hedge only index credits for index products,
    - For index credit hedging, are the hedges static, dynamic, or a blend of the two?
  - hedge GLBs and/or other guaranteed benefits,
  - other hedging (e.g., asset-liability matching (ALM) interest rate risk hedging)
- For the case of only hedging index credits, the proposed approach allows simplified modeling, for example, model a hedge error expense such as X% of index account value (AV) notional annualized
  - What do you view as a prudent best estimate for this hedge error?
- For other hedging the VM-21 approach is proposed, weighted average of best efforts and adjusted CTE70 (see formula below), what do you view as an appropriate error factor:
  - Stochastic reserve = CTE70 (best efforts) + E x max[0, CTE70 (adjusted) − CTE70 (best efforts)]

Standard Projection Amount (TBD)
- To the extent there is a standard projection amount proposed, test proposed assumptions and inputs to ensure the calculation is working as intended and producing reasonable results

Revisit as future developments evolve

Section IV: Projections (TBD—may be optional)

Projection Metrics and Future Valuation Nodes
- Project following metrics at projection years 10 and 20:
  - Account value and cash surrender value
  - CARVM (VM-22, AG33, AG35, etc.)
  - CTE70, CTE90, CTE98, Median (specify whether margins are included)
  - For value at risk (VaR)/CTE runs, if available, provide:
    - Actuarial present value of benefits, expenses, and related amounts less the actuarial present value of premiums and related amounts plus the balance of any separate account assets at each valuation time node
    - Present values are calculated using the discount factors implied by the NAER vector under the path of discount rates specified by the economic scenario

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- For shorter-duration contracts, such as deferred annuities without guarantees and surrender charges < 10 years or annuity certains < 10 years, request projection years 5 and 10lf run-time is hindered, optionally provide only year 10 (year 5 for shorter-duration contracts)

**Population**
- For projections, either create a population using inforce population based on the most recent issue year or use a pricing population (pricing cells) for a single year of issue business based on recent historical inforce business

**Outer Loop Scenario Requirements**
- The outer loop requirements should be based on unmargined PBR experience assumptions
- Use scenario 9 for interest rates and equities from scenario generator for outer loop assumptions
  - Interest rate and equity scenario assumptions will be provided to field testing participants
  - Three sets of 200 scenarios, 600 in total (if including time 0, time 10, time 20), will be provided for field testing participants at each valuation point
- Assume 0.5% mortality improvement and 2% expense inflation
- Assume the company's inforce portfolio mix and reinvestment strategy (ignoring any VM guardrails)
- Use VM prescribed long-term spreads and defaults

**Section V: Sensitivities**
Encourage attribution step analysis from current C3P1 for the new proposed methodology for capital, including quantification of VM-22 reserve updates in interim step (optional):

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>C3 Phase 1</th>
<th>VM-22</th>
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<tr>
<td></td>
<td></td>
<td>Mandatory</td>
<td>Optional</td>
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<td>Baseline [Use new economic scenario generator [ESG] scenarios, CFT model Working reserve = cash surrender value (CSV)]</td>
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<td>2</td>
<td>Add indexed annuities (and remove life). Companies should use identical business for both C3P1 and VM-22.</td>
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<td>Y</td>
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<tr>
<td>2a</td>
<td>CTE 70 Default Costs</td>
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<tr>
<td>3</td>
<td>VM-22 asset mix &amp; net asset earned rate (NAER) discounting</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>4</td>
<td>Working Reserve = 0</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>VM-22 hedging guidance</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>6</td>
<td>Other Deviations from VM-21/C3P2</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>7</td>
<td>Update to PBR Margins</td>
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<td>Y</td>
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<tr>
<td>7a</td>
<td>Remove Mortality Margin</td>
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<td>Y</td>
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</tbody>
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**Note:** C3P1 CTE metrics may be determined on a pre-tax basis and later adjusted for taxes in line with the C3P2 Macro Tax Adjustment.
The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met June 16, 2021. The following Subgroup members participated: Bruce Sartain, Chair, and Vincent Tsang (IL); Ted Chang, Ahmad Kamil, Elaine Lam, and Thomas Reedy (CA); Lei Rao-Knight (CT); Mike Yanacheak (IA); Nicole Boyd (KS); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello and Amanda Fenwick (NY); Rachel Hemphill and Karen Jiang (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA). Also participating was: John Robinson (MN).

1. **Discussed Reserve Category Definitions**

Mr. Sartain said two options for reserve category definitions were discussed by a small drafting group. He said one option is prescriptive and the other is principle-based. He said Mr. Leung has proposed a third option, which uses the VM-22, Statutory Maximum Valuation Interest Rate for Income Annuities, product descriptions. Mr. Chupp presented the prescriptive option (Attachment Twenty-A), which recommends a list of definitive characteristics a fixed annuity must meet to be considered for the payout reserve category and suggests that any fixed annuity that does not fit into the payout category be assigned to the accumulation category. He said consideration was given to defining the accumulation category in accordance with the deferred annuity definition in *Statement of Statutory Accounting Principles (SSAP) No. 50—Classifications of Insurance and Managed Care Contracts* and categorizing fixed annuities that are unable to meet the definition as payout annuities. He said that direction was not chosen because the SSAP definition seemed applicable only to traditional deferred annuities and would not capture current products such as annuities with guaranteed minimum withdrawal benefits (GMWBs). He said the drafting group considered using the VM-22 product descriptions, but it decided to go in this other direction; although, the Subgroup may ultimately decide to expose the VM-22 product descriptions. Mr. Carmello suggested that the reference to guaranteed payments in payout category criteria 1.b. be changed to certain payments to differentiate it from life contingent payments, which are also guaranteed. Mr. Robinson suggested changing the word “and” in criteria 1.a. to the word “or.” He also suggested that criteria 1.a. be worded to include both level and non-level payments that are predetermined.

Mr. Serbinowski suggested consideration of the principle-based risk categories approach. Mr. Sartain said the principle-based option (Attachment Twenty-B) is designed to avoid risk offsets between disintermediation and reinvestment risks. He said the approach leaves the company to decide how to measure the disintermediation risk and reinvestment risk and how policies are to be grouped. He stressed that documentation of the company’s risk measurement and grouping decisions should be required. Ben Slutsker (American Academy of Actuaries—Academy) said information on how companies currently treat disintermediation risk and reinvestment risk within their risk management programs may be helpful in establishing the principle-based risk categories approach. He said the general feedback from the Academy on the prescriptive approach mirrors the concerns of some Subgroup members. He said the Academy prefers the principle-based approach. He said if the Subgroup prefers a prescriptive approach, more consideration should be given to the VM-22 product description option, as that is more like the VM-20, Requirements for Principle-Based Reserves for Life Products, approach. Mr. Sartain said based on the feedback from the Subgroup and the Academy, the prescriptive approach may be eliminated from consideration. Ms. Ahrens said the risk category discussions seem to have excluded consideration of the mortality risk inherent in fixed annuity products. Mr. Slutsker responded that the Academy fixed annuity framework considers longevity risk as part of exclusion testing.

Having no further business, the VM-22 (A) Subgroup adjourned.
Proposed Definition of Payout Annuity Category:

The “Payout Annuity Category” shall only consist of annuities which meet all of the criteria in 1 through 3 below:

1. The annuity must include only one or more combinations of the types of payment streams listed in 1.a and 1.b, below:
   a. Life contingent payments of a fixed amount, certain payments of a total fixed amount, and certain payments for a fixed period.
   b. If acceleration of payments is permitted, the amount of each acceleration shall be no more than six months of payments or a present value of remaining guaranteed payments.

2. The actual payment start date may change by no more than five years from the original payment start date that was established when the contract was issued.

3. The amount of any elective withdrawal or cash out option available prior to the payment start date shall be no more than the sum of the premiums paid.
Reserve Category Definitions

The Accumulation Reserve Category contains contracts with greater disintermediation risk than reinvestment risk as of the valuation date.

The Payout Reserve Category contains contracts with greater reinvestment risk than disintermediation risk as of the valuation date.

Guidance Note: Contracts with a material cash surrender value, a reasonable expectation of a future material cash surrender value, or with material withdrawal or acceleration options, should be in the Accumulation Reserve Category. Reasonable grouping of contracts is allowed. Appropriate documentation within the VM-31 Actuarial Report of the determination process is a required component of this principle-based approach.
The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met May 26, 2021. The following Subgroup members participated: Bruce Sartain, Chair, and Vincent Tsang (IL); Ted Chang, Ahmad Kamil, Elaine Lam and Thomas Reedy (CA); Lei Rao-Knight (CT); Mike Yanacheak (IA); Nicole Boyd (KS); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello and Amanda Fenwick (NY); Rachel Hemphill and Karen Jiang (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. **Discussed Materiality Standards**

Ms. Hemphill said VM-20, Requirements for Principle-Based Reserves for Life Products, has a section that specifically requires materiality standards and a section that specifically authorizes the use of simplifications and approximation. She said VM-21, Requirements for Principle-Based Reserves for Variable Annuities, does not discuss those items. She said that an amendment proposal that adds materiality standards and allows simplifications and approximations to VM-21 has been submitted to the Life Actuarial (A) Task Force. She said the VM-22, Statutory Maximum Valuation Interest Rate for Income Annuities, revisions should mirror those requirements. Ben Slutsker (American Academy of Actuaries—Academy) suggested that might be a topic more for the Subgroup that the Academy could react to if desired. Cindy Barnard (Pacific Life) asked if materiality should be addressed at the Valuation Manual level, instead of addressing it separately in VM-20, VM-21, and VM-22. Mr. Sartain said that will be added to the issues list and could be discussed after amendment proposal 2020-09 is decided on for VM-21.

2. **Discussed Aggregation Language**

Mr. Sartain said Subgroup discussions have yielded three options for addressing aggregation in VM-22. The first option is to carry over the language from VM-20 Section 5.A verbatim. The second option is to modify the VM-20 language for VM-22 products. The third option is to remove the language from the fixed annuity framework recommendation. Ms. Hemphill discussed the draft document (Attachment Twenty-One-A) with the details of the original language and two options with revised language. She said the drafting group that worked on the language was split over option one and option two. Mr. Sartain said that the guidance note seems to define additional reserve categories. He asked if consideration was given to incorporating the guidance note into the body of option one. Mr. Carmello agreed that the guidance note should be worked into the body and that essentially, the Subgroup is talking about reserve categories. Mr. Slutsker said the Academy believes that both options obstruct the objective of principle-based reserving (PBR). He said the reserves should be tied to the anticipated economics of the policy and have an explicit margin added for conservatism. He said the option one approach results in a margin that is unintuitive instead of explicit. He said the prescriptive approach in the options may result in attempts to develop workarounds. He said the Academy prefers the original language. Mr. Serbinowski agreed, saying the options may discourage companies from appropriately managing economic risks. Ms. Hemphill agreed that a single risk category would be the best solution but said that the original language adds no value to the reserve determination process. She recommended removing the original language. Mr. Sartain raised the possibility of revoting to determine the number of reserve categories for VM-22.

Having no further business, the VM-22 (A) Subgroup adjourned.
May 26, 2021
VM-22 Subgroup

1. Subgroup aggregation language in VM-20 (5)(A) – two draft revisions (Texas, Nebraska, NY)

   a. Existing language
      In determining the stochastic reserve, the company shall determine the number and composition of subgroups for aggregations purposes in a manner that is consistent with how the company manages risks across products with significantly different risk profiles, and that reflects the likelihood of any change in risk offsets that could arise from the distributional shifts between product type due to, for example, differing policyholder behavior. If a company is managing the risks of two or more products with significantly different risk profiles as part of an integrated risk management process, then the products may be combined into the same subgroup for aggregation purposes.

   b. Option 1
      In determining the stochastic reserve, the company shall determine the number and composition of subgroups for aggregations purposes. Products with significantly different risk profiles shall not be combined into the same subgroup for aggregation purposes.

      **Guidance Note:** For example, multi-year guarantee annuities may not be aggregated with annuities with one-year resets, annuities without GMxBs may not be aggregated with annuities with significant GMxBs, and fixed annuities may not be aggregated with indexed annuities.

   c. Option 2
      In determining the stochastic reserve, the company shall determine the number and composition of subgroups for aggregation purposes in a manner that identifies distinct subgroups of contracts, reflecting how contracts were priced, marketed, and managed. This will typically result in different subgroups for distinct product types. Other criteria that may be considered include, but are not limited to: marketing methods, target market, presence of GMxBs, to the extent that such criteria materially affect how contracts are priced, marketed, and managed. Whichever criteria are used, each grouping should be large enough to be material.

      **Guidance Note:** For example, multi-year guarantee annuities may not be aggregated with annuities with one-year resets, annuities without GMxBs may not be aggregated with annuities with significant GMxBs, and fixed annuities may not be aggregated with indexed annuities, when such groups of annuities are each of a material size.
The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met May 12, 2021. The following Subgroup members participated: Bruce Sartain, Chair, and Vincent Tsang (IL); Ted Chang, Ahmad Kamil, Elaine Lam and Thomas Reedy (CA); Lei Rao-Knight (CT); Mike Yanacheak (IA); Nicole Boyd (KS); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello and Amanda Fenwick (NY); Rachel Hemphill and Karen Jiang (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. **Discussed the Definition of Reserve Categories**

Mr. Chupp said a drafting group is proposing definitions for the two reserve categories voted on by the VM-22 (A) Subgroup for non-variable annuities. The proposal defines a payout annuity category and a yet to be named category covering all products that do not meet the payout annuity definition. He said the payout annuity category definition has two requirements: 1) the policy must have fixed payment streams that are affected only by death; and 2) the policyholder is not permitted to deposit additional funds or withdraw funds. He said the definition allows a deferred policy to be moved to the payout annuity category at the commencement of annuitization, assuming the policy meets the two payout category requirements. He noted that the Subgroup could also consider options that would either lock in the definition of the contract at the time of issue or allow a principle-based approach for defining the contract.

Cindy Barnard (Pacific Life) asked if the payout annuity definition includes deferred income annuities (DIAs) that allow for additional premiums after issue. Mr. Carmello said those products should be considered payout annuities and that the distinguishing feature should be whether there is a disintermediation issue. Mr. Leung said the intent of the drafting group was to develop a strict definition that the Subgroup could adjust as needed to reflect optionality. Ben Slutsker (American Academy of Actuaries—Academy) said the Academy view is that some level of materiality should be considered when attempting to reflect optionality.

Ms. Barnard said asked if a pension risk transfer (PRT) contract without a fixed annuitization date fits into the deferred or payout category. Mr. Chupp responded that if the payout amount is scheduled, and there is no account value, the contract would be considered a payout annuity. Ms. Barnard asked if a cash refund annuity with a cash withdrawal option would be considered a payout annuity. Mr. Leung said the drafting group definition is intended to exclude hardship withdrawals. He said that the Subgroup could expand the definition if needed.

Mr. Yanacheak said differentiating categories based on disintermediation risk makes sense. He said it is difficult to determine whether disintermediation risk should be the lone differentiation criterion without seeing the reserve methodology. He said an essential aspect of the reserving category decision is whether a policy moving from one category to the other can make that transition smoothly. He suggested that the Subgroup should be sure to consider the treatment for contingent deferred annuities (CDAs) when discussing product optionality.

2. **Discussed the Deviations from VM-21 Document**

Mr. Slutsker said the Academy’s preliminary framework recommendation is based on VM-21, Requirements for Principle-Based Reserves for Variable Annuities, with revisions to address the fixed annuity framework. He said the fixed annuity principle-based reserving (PBR) deviations from the VM-21 document (Attachment Twenty-Two-A), provided in response to a Subgroup member request, delineate the VM-21 requirements that the Academy proposes to change to appropriately reserve for fixed annuities.

Having no further business, the VM-22 (A) Subgroup adjourned.
March 15, 2021

Honorable Bruce Sartain, Chair
Valuation Manual (VM)-22 (A) Subgroup
National Association of Insurance Commissioners (NAIC)

Dear Mr. Sartain,

The American Academy of Actuaries\(^1\) Annuity Reserves Work Group (ARWG) presented a fixed annuity principle-based reserving (PBR) framework proposal on the October 21, 2020, NAIC VM-22 Subgroup call. The work group subsequently received a request from you to provide a summary of the differences between the proposal and current framework for VM-21 (variable annuity PBR). Furthermore, it was asked whether each deviation from VM-21 could be classified as either a change that would be specific to fixed annuity PBR or a change that the ARWG would recommend making to VM-21 and VM-20 (life PBR) as well for future versions of the NAIC Valuation Manual. The ARWG (now, Annuity Reserves and Capital Work Group [ARCWG]) worked with the chairpersons of the Academy’s Life Reserves Work Group (LRWG) and Variable Annuity Reserves and Capital Work Group (VARCWG) to come up with the following grid.

We ask for the VM-22 Subgroup’s consideration to include this grid as a supplement to the exposed ARWG Preliminary Framework (October 2020) on fixed annuity PBR, which may provide more clarity to regulators and interested parties in their consideration of the Framework.

Please let us know if you have any follow-up inquiries in response to this document. Again, we appreciate the opportunity to present the fixed annuity framework and all of the efforts made by the NAIC VM-22 Subgroup to focus on this topic.

Sincerely,

Ben Slutsker
Chairperson, Annuity Reserves and Capital Work Group
American Academy of Actuaries

CC: Reggie Mazyck, NAIC

\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
## Fixed Annuity PBR Deviations from VM-21

**Description:** This grid summarizes deviations between the proposed ARWG fixed annuity PBR framework and the current VM-21 requirements. The remaining framework elements not listed in this grid are generally proposed to be the same as the current VM-21 requirements. A description and rationale for the proposed deviations are provided, along with a suggestion for whether each item should be explored for possible updates to VM-20 and VM-21 going forward as well.

<table>
<thead>
<tr>
<th>#</th>
<th>Element</th>
<th>Description of how Proposed deviates from current VM-21 requirements</th>
<th>Rationale for Proposed compared to current VM-21</th>
<th>Suggest to consider applying update to VM-20?</th>
<th>Suggest to consider applying update to VM-20?</th>
<th>Rationale for whether to update VM-20/21?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reinvestment Assumption</td>
<td>Limits on general account reinvestment mix for new money; recommend changing from 50% AA/50% A to the current VM-22 reinvestment mix</td>
<td>Thought is to set more in line with the current industry mix</td>
<td>Yes</td>
<td>Yes</td>
<td>General accounts on VAs should be same as fixed annuities; also consider for VM-20</td>
</tr>
<tr>
<td>2</td>
<td>Index Credit Hedge Method</td>
<td>Model a best efforts CTE70 amount with breakage expense to reflect index credit hedge error, rather than requiring an adjusted CTE70</td>
<td>Hedging program largely specific to fixed index annuities rather than variable annuities¹</td>
<td>No</td>
<td>No</td>
<td>Less relevant for VAs and there is already a separate treatment established for life requirements²</td>
</tr>
<tr>
<td>3</td>
<td>Index Credit Hedge Error</td>
<td>Minimum hedging error for hedging programs that specifically support products with index-based credits (not other hedging programs)</td>
<td>Hedging program largely specific to fixed index annuities rather than Variable Annuities¹</td>
<td>No</td>
<td>No</td>
<td>Less relevant for VAs and there is already a separate treatment established for life requirements²</td>
</tr>
<tr>
<td>4</td>
<td>Model Hedges Regardless of CDHS</td>
<td>Require seasoned hedging programs to be modeled in future cash flows, regardless of whether or not considered a CDHS</td>
<td>Would prevent only including hedging if reducing reserves</td>
<td>Yes</td>
<td>Yes</td>
<td>Applicable to both life and variable annuity reserve requirements as well</td>
</tr>
<tr>
<td>5</td>
<td>Borrowing Cost Safe Harbor</td>
<td>Safe harbor to use negative new money reinvestment rates as the cap on negative net asset earned rate when borrowing in later years</td>
<td>Assets may run out in later years, leading to an inappropriately large discount rate</td>
<td>Yes</td>
<td>Yes</td>
<td>Same issue that prompted safe harbor proposal also exists in VM-20/VM-21</td>
</tr>
<tr>
<td>6</td>
<td>Exclusion Test</td>
<td>Exclusion testing option to use prior CARVM requirements, including AGs, using an approach that measures the level of risk inherent within contracts</td>
<td>Propose exclusion test instead of Alternative Methodology for assessing PBR applicability</td>
<td>No</td>
<td>No</td>
<td>VM-21 has alternative methodology; VM-20 has exclusion test</td>
</tr>
<tr>
<td>7</td>
<td>Policy Allocation</td>
<td>Propose different policy allocation method that allocates aggregate reserves in excess of cash surrender value to each contract</td>
<td>Differences in how tax reserve deductibility between variable and non-variable contracts</td>
<td>No</td>
<td>No</td>
<td>VM-20/VM-21 already have allocation methods that are appropriate given tax requirements</td>
</tr>
<tr>
<td>8</td>
<td>Policy loans</td>
<td>Include guidance and considerations for how to model policy loans explicitly and through asset approximations based on VM-20</td>
<td>Loans exist on VAs, but no clear advantage if not included</td>
<td>No</td>
<td>No</td>
<td>No clear advantages in current VM-21 wording; VM-20 already has this wording</td>
</tr>
<tr>
<td>9</td>
<td>Non-Guaranteed Elements (NGEs)</td>
<td>Include guidance around non-guaranteed elements based on VM-20</td>
<td>NGEs less prevalent on VAs; use of actuarial judgement</td>
<td>Maybe</td>
<td>No</td>
<td>NGEs less prevalent on VAs; VM-20 already has this wording</td>
</tr>
<tr>
<td>10</td>
<td>Supplemental Benefits</td>
<td>Provide more guidance around when PBR addresses riders and supplemental benefits (possibly in VM Section II)</td>
<td>Supplemental benefits &amp; riders treatment clarified on whether to value with the base policy</td>
<td>Maybe</td>
<td>No</td>
<td>Supplemental benefits &amp; riders also exist on VA contracts; life reserve requirements already address</td>
</tr>
<tr>
<td>11</td>
<td>Aggregation Principles</td>
<td>Propose allowing aggregation across various fixed annuity contracts, but clarify a list of principles under which aggregation is appropriate or not</td>
<td>Given the variety of fixed annuities: (index, deferred, payout), there is a need to outline principles</td>
<td>No</td>
<td>Maybe</td>
<td>Less contract variety for VAs than fixed annuities; may be relevant to life</td>
</tr>
<tr>
<td>12</td>
<td>Product Scope</td>
<td>Fixed annuity PBR would apply to only non-variable annuity contracts</td>
<td>Scope of products to focus on non-variable annuity contracts</td>
<td>No</td>
<td>No</td>
<td>Scope of products is different; ARWG/ARCWG still reviewing hybrid VA/fixed contracts</td>
</tr>
</tbody>
</table>

**Note:**

1. The ARWG fixed annuity framework proposes to only set this treatment for programs supporting index credits. There is a separate treatment proposed for future hedging programs that follow guaranteed living benefits and other liabilities, which is to follow the methodology laid out in VM-21 requirements for future hedging programs.

2. For index universal life (IUL), VM-20 also requires a deterministic reserve (subject to exclusion testing). In 2020, VM-20 was amended to set the crediting rate in the deterministic reserve based on the methodology outlined in AG63. No deterministic reserve, this treatment is not applicable to VM-22. In addition, VM-20 only requires hedging to be included in future cash flows if the program is a CDHS. VM-20 also prohibits exclusion testing for blocks with CDHS programs.
The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met May 5, 2021. The following Subgroup members participated: Bruce Sartain, Chair, and Vincent Tsang (IL); Ted Chang, Ahmad Kamil, Elaine Lam and Thomas Reedy (CA); Lei Rao-Knight (CT); Nicole Boyd (KS); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello and Amanda Fenwick (NY); Rachel Hemphill and Karen Jiang (TX); and Craig Chupp (VA).

1. Discussed the Academy ARCWG Preliminary Framework

Chris Conrad (American Academy of Actuaries—Academy) said in its Preliminary Framework recommendation from the Subgroup’s April 21 minutes, the Academy Annuities Reserve and Capital Work Group (ARCWG) has proposed that the fixed annuity hedging requirements be consistent with VM-21, Requirements for Principle-Based Reserves for Variable Annuities, with the exception that: 1) all future hedging programs tied directly to contracts should be modeled, regardless of whether the hedging program is considered a clearly defined hedging strategy (CDHS); and 2) indexed credits should be allowed to be modeled under an alternative methodology that reflects the hedge breakage expense in the 70% conditional tail expectation (CTE70) best efforts by reducing hedge payoffs relative to modeled index credits through the use of an effectiveness multiple. He said an adjusted CTE70 run will not be required. He said the ARCWG supports the exceptions because hedging programs on indexed credits typically have lower basis risk and are more effective.

Ms. Hemphill said the Texas Department of Insurance (TDI) comment letter from the Subgroup’s April 21 minutes points out that the CDHS concept is necessary in cases where reserves or total asset requirement (TAR) is materially reduced. She said the CDHS requirements, which are documentation requirements, demonstrate that the hedging program is robust and therefore reliable. Mr. Sartain said requiring a CDHS if the modeling decreases the reserve seems to be a reasonable principle-based approach. Brian Bayerle (American Council of Life Insurers—ACLI) said there are other considerations around the modeling of hedges, such as the overhead related to running scenarios. He suggested a survey to understand the landscape of the existing hedge programs and why some of those programs may not conform to CDHS requirements. Mr. Sartain said the issue is broader than what the Subgroup is addressing, and it should be resolved at the Task Force level.

Ms. Hemphill asked how the variability in company expense levels will be reflected in the proposed modeling approach. Ben Slutsker (Academy) said the expenses are included in the cash flows. He said the hedge breakage expense can be viewed as a risk charge. Ms. Hemphill asked if the modeling approach truly reflects both the company’s typical back-testing error and modeling error. Mr. Slutsker confirmed that the total error is being reflected. He said a field test would be helpful in determining a minimum hedge breakage expense. Ms. Hemphill said the hedge modeling approach adopted for fixed annuities should also be considered for VM-20, Requirements for Principle-Based Reserves for Life Products. Mr. Bayerle said the ACLI believes that any modeling simplification should be optional.

Mr. Conrad said the ARCWG believes the hedging cost scope and documentation should be consistent with VM-21.

Having no further business, the VM-22 (A) Subgroup adjourned.
The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met April 28, 2021. The following Subgroup members participated: Bruce Sartain, Chair, and Vincent Tsang (IL); Ted Chang, Ahmad Kamil, Elaine Lam and Thomas Reedy (CA); Lei Rao-Knight (CT); Nicole Boyd (KS); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello and Amanda Fenwick (NY); Rachel Hemphill and Karen Jiang (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. Discussed the Academy ARCWG Preliminary Framework

Chris Conrad (American Academy of Actuaries—Academy) said in its Preliminary Framework recommendation from the Subgroup’s April 21 minutes, the Academy Annuities Reserve and Capital Work Group (ARCWG) has proposed that VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities, should use the same mortality methodology as VM-21, Requirements for Principle-Based Reserves for Variable Annuities. He said the methodology includes using prudent estimate mortality, with mortality improvement reflected using the G-2 scale. Ms. Hemphill said the Texas Department of Insurance (TDI) comment letter from the Subgroup’s April 21 minutes questioned the use of the term “unsupported judgment,” asked what mortality basis is appropriate for international lives, and asked how many years of mortality improvement will be used. Mr. Sartain said either the Pension Risk Transfer (PRT) Mortality Drafting Group or the Standard Projection Amount (SPA) Drafting Group can pursue the issue of the mortality basis for international lives. Mr. Conrad reiterated that the ARCWG’s current approach is to be consistent with VM-21 on the issues of mortality basis and mortality improvement. Ms. Hemphill said there may be other resources more appropriate than VM-21. She said VM-20, Requirements for Principle-Based Reserves for Life Products, Section 9.C.3.b provides flexibility to identify appropriate tables on a case-by-case basis. Paul S. Graham (American Council of Life Insurers—ACLI) said the mortality-related comments in the ACLI comment letter from the Subgroup’s April 21 minutes aligns with the TDI comments.

Mr. Conrad said the ARCWG policyholder behavior recommendations are also consistent with VM-21. Ms. Hemphill said VM-20 and VM-21 take different approaches to margin setting. She suggested re-evaluating the two approaches to determine a “best” version that could then be used for VM-20, VM-21 and VM-22. She noted that reporting requirements should include showing the impact of margins and actual-to-expected ratios. Mr. Sartain said he will add the comments to an issues list, but he does not believe the drafting group is responsible for harmonizing the VM-20, VM-21 and VM-22.

Mr. Conrad said the ARCWG non-guaranteed elements recommendation is for VM-22 to be consistent with VM-20. Ms. Hemphill suggested that VM-22 should explicitly indicate that company policies and past actions should be reflected in the development of non-guaranteed elements. She said this issue should be added to the issues list.

Mr. Conrad said the ARCWG recommends that policy loans assumptions should be consistent with VM-20, while expenses and account transfers should be consistent with VM-21. He said joint payouts and supplemental benefits should be reserved for using reasonable methods. Ms. Hemphill said whatever reasonable methods are developed for VM-22 should also be applied to VM-21. Mr. Conrad said the ARCWG recommends that the treatment of reinsurance should follow the VM-21 requirements.

Ms. Hemphill said the ARCWG approach to reflecting risk in moderately adverse conditions is fundamentally different from the principle-based reserving (PBR) for economic scenarios. She said the treatment of tail risks in stochastic modeling should ensure that the risks that are deeper in the tail are being appropriately considered.

Having no further business, the VM-22 (A) Subgroup adjourned.

Draft: 5/17/21

Valuation Manual (VM)-22 (A) Subgroup
Virtual Meeting
April 28, 2021

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6-581
Attachment Twenty-Four
Life Actuarial (A) Task Force
8/12/21
Valuation Manual (VM)-22 (A) Subgroup  
Virtual Meeting  
April 21, 2021

The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met April 21, 2021. The following Subgroup members participated: Bruce Sartain, Chair, and Vincent Tsang (IL); Ted Chang, Ahmad Kamil, Elaine Lam and Thomas Reedy (CA); Lei Rao-Knight (CT); Mike Yanacheak (IA); Nicole Boyd (KS); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Anna Krylova (NM); Bill Carmello and Amanda Fenwick (NY); Rachel Hemphill and Karen Jiang (TX); and Craig Chupp (VA).

1. Tabled a Motion to Retain the VM-20 Integrated Risk Management Language

Mr. Sartain recapped the March 17 Subgroup discussion on whether to retain the language in Section 5A of VM-20, Requirements for Principle-Based Reserves for Life Products, that allows for the aggregation of products with significantly different risk profiles if the products are managed as part of an integrated risk management process. He said the Subgroup discussed that reviews of VM-20 principle-based reserving (PBR) actuarial reports indicate that most companies feel they have integrated risk management processes and have used full aggregation within reserve categories. He recalled that Subgroup members differed on whether the Section 5A language is currently able to address their aggregation concerns or if language improvement is required. Ms. Hemphill, Mr. Carmello and Ms. Ahrens volunteered to work on improvements to the Section 5A integrated risk management process language.

Mr. Sartain said a previous straw vote to decide whether the standard projection amount (SPA) should be a floor or disclosure item was taken during the March 17 discussion. Ms. Ahrens said given that the uncertainty of how widely the stochastic results may vary makes it difficult to consider a standard projection or floor, it is too early to decide. She suggested deferring the SPA decision until after the field test, while proceeding with the decision to have two reserve categories. Mr. Leung said it will be difficult to determine the SPA without understanding critical policyholder behaviors. He said the Subgroup should consider retaining the cash value floor. Mr. Sartain noted that an SPA drafting group is working on defining policyholder behavior characteristics. Mr. Carmello said he favors using the Commissioners Annuity Reserve Valuation Method (CARVM) as the floor. The Subgroup agreed to wait until the field test is complete before determining the purpose and use of the SPA.

Mr. Sartain discussed the straw vote that resulted in the Subgroup deciding to use two reserving categories: one category for payout annuities and another for deferred annuities. He said more thought must be given to assigning specific products to the two risk categories. He said products like deferred income annuities (DIAs) and deferred annuities with a guaranteed minimum withdrawal benefit (GMWB) that have been exercised but still have remaining cash value are not easily categorized. Mr. Carmello said the risk category distinction should be based on whether the product has a cash value. He acknowledged that multiple categories may be required for deferred annuities, including a separate category for equity-indexed annuities. Ben Slutsker (American Academy of Actuaries—Academy) said DIAs are similar to single premium immediate annuities (SPIAs) with the payments commencing at a set date in the future. He said DIAs have no account value, but they might have a return of premium or hardship return option available during the deferral period. He said those options are infrequently elected. Mr. Sartain said the DIA seems to fit into the payout annuity category. Mr. Chang asked where structured settlements would fit. Mr. Slutsker said there are a variety of structured settlement products, so the response requires some thought. Mr. Leung said the product list in VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities, might be a good starting point for determining which products fit into the reserve categories. Mr. Slutsker said using that approach still leaves questions of how the products should be treated during any transition periods. Mr. Leung and Mr. Chupp volunteered to develop definitions for payout annuities.

Having no further business, the VM-22 (A) Subgroup adjourned.
Future Mortality Improvement Recommendation (VM-20)

Mortality Improvements Life Work Group (MILWG) of the Academy Life Experience Committee and SOA Preferred Mortality Project Oversight Group (“Joint Committee”)

Individual Life Insurance
Future Mortality Improvement (FMI) for VM-20 Products

GOAL: To allow a prudent level of future mortality improvement (FMI) for VM-20 products beginning with the 2022 valuation manual

- FMI scale will be developed, updated and made available to practitioners annually
- Updates will be limited to a threshold of materiality for making a change
- Two versions of the scale will be published: Basic ("Best Estimate") and Loaded ("with margin")
- Period of scale application: 20 years
- Varies by gender and attained age
Topics for Presentation

- FMI scale methodology—review and example rates for 2020
- Recommended FMI scale impact on reserves
- Margin recommendation
- Next steps/future considerations

FMI Scale Development—Methodology Review

- Best estimate FMI grades from the historical basis to a long-term MI rate (“LTMIR”) at 10 years
- Remains level from 10 to 15 years
- Grades to no additional improvement at 20 years
- Separate exercise for initial published scale to consider COVID-19 impacts
Example Best Estimate FMI Rates
Unsmoothed—Male—2020 Valuation

Example Best Estimate FMI Rates
Unsmoothed—Female—2020 Valuation
2020 Smoothed Best Estimate FMI Rates

Male Smoothed—Best Estimate MI Rates

Female Smoothed—Best Estimate MI Rates

Reserve Impact Estimates

- Universal Life with Secondary Guarantees (ULSG) focus—long-duration product, larger potential for reserve reduction
  - Model office and assumptions same as used in the YRT representative model analysis
  - Lifetime shadow account secondary guarantee
  - No reinsurance in the model
- Combined model office

<table>
<thead>
<tr>
<th>Component</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue ages</td>
<td>Decennial issue ages 30 – 70</td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Risk classes</td>
<td>Preferred non-tobacco</td>
</tr>
<tr>
<td></td>
<td>Standard non-tobacco</td>
</tr>
<tr>
<td></td>
<td>Standard tobacco</td>
</tr>
<tr>
<td>Face bands</td>
<td>Low ($250,000)</td>
</tr>
<tr>
<td></td>
<td>High ($1,000,000)</td>
</tr>
</tbody>
</table>
Reserve Impact Estimates
Future Mortality Improvement Assumption Model Implementation

- The 2021 and prior versions of VM-20 prohibited including FMI in the calculation of deterministic and stochastic reserves, while allowing the mortality assumption to be improved up to the valuation date using a historical mortality improvement (HMI) assumption developed by the MILWG.

- An “exact” approach to including FMI in the calculation of deterministic and stochastic reserves would utilize the MILWG’s HMI assumption to bring the mortality table up to the valuation date and then apply the separate FMI assumptions beyond the valuation date.

A modeling simplification was employed that utilized the new MILWG FMI assumption as both HMI and FMI in the deterministic reserve projection.

This simplification allows for the impact of including FMI in current and future deterministic reserve calculations to be quantified.
Reserve Impact Estimates
ULSG Model Office Results

- Baseline reserves—no FMI
- Best estimate—reserves with FMI at best estimate level
- Margin 25%—FMI at best estimate level with 25% reduction across all gender/ages
- Margin 35%—FMI at best estimate level with 35% reduction across all gender/ages

Reserve Impact Estimates
Model Office—Deterministic Reserve Projection Illustration

Deterministic Reserve Projection

Baseline
- 2020 Valuation
  - No FMI included in Deterministic Reserve
- 2024 Valuation
  - No FMI included in Deterministic Reserve

Best Estimate - FMI
- 2020 Valuation
  - Remaining FMI (19 years) included in Deterministic Reserve
  - HMI applied from the beginning of 2021 to year-end 2024
- 2024 Valuation
  - Remaining FMI (15 years) included in Deterministic Reserve
  - HMI applied from the beginning of 2021 to year-end 2024
**ULSG FMI—Reserve Impact Estimates**

**Model Office Results—Percent Change From Baseline Reserve Level**

The blue and black curves were produced based on the pattern of the change in reserve from the Baseline and Best Estimate FMI runs.

**ULSG FMI—Reserve Impact Estimates**

**Full Model Office Results—Percent Change From Baseline Reserve Level**

Reserve Impact by Gender

- Best Estimate: Full Population
- Females Only
- Males Only
ULSG FMI—Reserve Impact Estimates
Model Office Results—Percent Change From Baseline Reserve Level

Reserve Impact by Smoker Status

ULSG FMI—Reserve Impact Estimates
Single Cell Results—Percent Change From Baseline Reserve Level
Margin Recommendation

MARGIN ON THE INCREMENTAL MORTALITY IMPROVEMENT SCALE

- Margin will be included for all companies
  - Companies may use a more conservative MI scale but not less conservative
  - Margin will take the form of a flat % reduction in the best estimate MI scale
    - Recommendation for 25% flat reduction

Considerations in Margin Recommendation

- 25% reduction in best estimate scale is a material cushion to reserve impact

- Conservatism in best estimate MI scale
  - Not explicitly included
  - Methodology has some conservatism—i.e., limiting cumulative improvements to 20 years

- Ability to change best estimate MI scale each year
  - No lock in of assumptions under VM-20
  - Corrections can be made if trends change
Next Steps

CONTINUED CONSIDERATIONS

- Consideration of COVID-19 impacts when we reach 2020 historical data inclusion
  - Shock
  - Potential longer-term impacts
  - Baseline company experience—potential differences in how companies reflect COVID-19 impacts
  - COVID-19 impact different for population vs. insured population
- Threshold of materiality for making a change in a given year

Future Considerations

OTHER ISSUES DISCUSSED

- Impacts of opioid epidemic
- Socioeconomic differences (between general and insured population)
- Obesity impacts
- Mental health impacts
- Slowdown in cardiovascular mortality improvement
- Smoker status
Questions?

Contact Information

Marianne Purushotham, FSA, MAAA
Corporate Vice President, Research Data Services
LLGlobal
mpurushotham@limra.com

Khloe Greenwood
Life Policy Analyst
American Academy of Actuaries
greenwood@actuary.org
## APPENDIX:
YRT Representative Model Liability Assumptions

**Model design and assumptions**

**LIABILITY ASSUMPTIONS (ULSG)**
The assumptions used in the analysis are below, including assumed PBR margins

<table>
<thead>
<tr>
<th>Assumption</th>
<th>Anticipated experience assumption</th>
<th>Prudent estimate assumption (e.g. margin)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality</strong></td>
<td>2015 VBT gender distinct, smoker distinct ANB</td>
<td>Prescribed margins applied to company mortality</td>
</tr>
<tr>
<td></td>
<td>Relative Risk varies by risk class</td>
<td>Industry table: 2015 VBT with prescribed margins and mortality improvement scale</td>
</tr>
<tr>
<td></td>
<td>A/E factors vary by high/low band</td>
<td>Grading and margins assumes 100% Limited Fluctuation method credibility</td>
</tr>
<tr>
<td></td>
<td>Future mortality improvement of .50%</td>
<td></td>
</tr>
<tr>
<td><strong>Lapse</strong></td>
<td>3% annual lapse rate</td>
<td>2% annual lapse rate</td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
<td>$100 per policy (annual)</td>
<td>105% margin on expenses</td>
</tr>
<tr>
<td></td>
<td>2.5% premium tax</td>
<td>2.5% inflation</td>
</tr>
<tr>
<td></td>
<td>2% inflation</td>
<td></td>
</tr>
</tbody>
</table>
Economic Scenario Generator (ESG) Update

Scott O’Neal, FSA, MAAA – NAIC Life Examination Actuary
Dan Finn, FCAS, ASA – Managing Director at Conning

8/12/2021

Agenda

1. Activities of the ESG Drafting Group
2. Key goals for a new GEMS ESG Treasury model calibration
3. Treasury model targeting impacts and tradeoffs
4. Next Steps
Background

The NAIC’s ESG Drafting Group is working to develop ESG recommendations to the Life Actuarial (A) Task Force and Life RBC (E) Working Group and is comprised of:
• Regulators,
• NAIC staff,
• Conning staff, and
• Subject-matter experts.

The subject-matter experts include representatives from the American Academy of Actuaries and the American Council of Life Insurers, life insurance industry professionals, and academics.

Activities of the ESG Drafting Group

• The group’s immediate focus is to develop a set of recommendations for the GEMS Treasury model and an associated set of scenarios for consideration by LATF and the LRBC WG.
• The development of scenarios for eventual use in statutory reserve and capital requirements is an iterative process and multiple recalibrations of the GEMS ESG are expected before a recommendation for field testing is delivered. The group is currently reviewing a new calibration of the Treasury model and expects to make changes.
• Meetings of the group are focused on reviewing scenario output. A SharePoint site has been set up for the group to handle more technical discussions and share additional analysis of the scenario sets.
Key Goals for a New Treasury Model ESG Calibration

All targets are at end of Year 30, unless specified otherwise

1. Make sure there are enough low-for-long scenarios
2. Make sure there are enough high-for-long scenarios
3. Reduce frequency and severity of negative Yields at the shorter tenors relative to the “Revised Baseline” scenarios that were previously exposed February 24th, 2021
4. Reduce short and long inversion frequencies relative to the Revised Baseline
5. Reduce frequency of other Yield curve shapes (i.e. bowls and humps) relative to the Revised Baseline
6. Ensure that 30-Year Yield can stay below December 2020 levels (i.e. 1.65%)
7. Avoid generating a substantial probability of negative Yields for longer tenors (i.e. 10+ years)
8. Increase probability of 10%+ Yields for all tenors relative to the Revised Baseline
9. Avoid generating substantial probability of Yields over 25%
10. Adjust 20-Year Yield target (MRP) to be based on the median rather than the mean to be consistent with the AIRG target
11. Adjust Term Premiums to align with MRP methodology

ESG Targeting Impacts and Tradeoffs

<table>
<thead>
<tr>
<th>Nature of Target</th>
<th>Low for Long</th>
<th>High for Long</th>
<th>Negative Yields – Frequency and Magnitude</th>
<th>Inversion Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Reversion Speed</td>
<td>Slower = Higher Probability</td>
<td>Slower = Higher Probability</td>
<td>Slower = Higher Probability</td>
<td>Slower = Higher Probability</td>
</tr>
<tr>
<td>Volatility</td>
<td>Higher = Higher Probability</td>
<td>Higher = Higher Probability</td>
<td>Higher = Higher Probability</td>
<td>Higher = Higher Probability</td>
</tr>
<tr>
<td>Shift Parameter</td>
<td>Higher = Lower Probability</td>
<td>Higher = Lower Probability</td>
<td>Higher = Lower Probability</td>
<td>Minimal</td>
</tr>
<tr>
<td>Shape Parameters</td>
<td>Steeper = Lower Probability</td>
<td>Steeper = Lower Probability</td>
<td>Steeper = Higher Prob. for Short Yields, Lower for Long Yields</td>
<td>Steeper = Lower Probability</td>
</tr>
<tr>
<td>Mean Reversion Parameter (MRP)</td>
<td>Minimal*</td>
<td>Minimal*</td>
<td>Higher = Lower Probability</td>
<td>Minimal</td>
</tr>
<tr>
<td>Term Premiums</td>
<td>Minimal**</td>
<td>Minimal**</td>
<td>Larger = Higher Probability</td>
<td>Larger = Lower Probability</td>
</tr>
</tbody>
</table>

* Assumes that “Low” and “High” are defined relative to the MRP. For example, in these slides, we’ve taken “Low” as being below MRP – 2.0% (i.e. 1.5%)
** Assumes that the “Low” and “High” calculations are based on the 20-Year Yield
**Next Steps**

1. The ESG Drafting Group will continue to review scenario output from additional calibrations of the GEMS Treasury model.

2. Once the group has settled on a set of recommendations for the Treasury model and associated set of scenarios, the recommendations will be brought to a joint open meeting of the Life Actuarial (A) Task Force and Life RBC (E) Working Group.
2021 GRET Recommendation

Tony Phipps, FSA, MAAA
Chair SOA Committee on Life Insurance Expenses
August 12, 2021

Presentation Disclaimer

The material and information contained in this presentation is for general information only. It does not replace independent professional judgment and should not be used as the basis for making any business, legal or other decisions. The Society of Actuaries assumes no responsibility for the content, accuracy or completeness of the information presented.
GRET Agenda

- Methodology
- Recommendation
- Comparison to Prior Years
- Information on Companies in Study

Methodology

- Select data points provided by NAIC from company Annual Statement submissions
- SOA surveyed companies to determine Distribution Channels
- SOA analyzed data to derive unit expense factors by those Distribution Channels
Additional Comments on Methodology

• Allocated expenses to acquisition and maintenance categories using the same seeds as has been previously used
  • Acquisition/Policy: $200.00
  • Acquisition/Face Amount: $1.10
  • Acquisition/Premium: 50%
  • Maintenance/Policy: $60.00

Recommendation

<table>
<thead>
<tr>
<th>Description</th>
<th>Acquisition per Policy</th>
<th>Acquisition per Unit</th>
<th>Acquisition per Premium</th>
<th>Maintenance per Policy</th>
<th>Company Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>$183.00</td>
<td>$1.00</td>
<td>46%</td>
<td>$55.00</td>
<td>142</td>
</tr>
<tr>
<td>Career</td>
<td>$212.00</td>
<td>1.20</td>
<td>53%</td>
<td>64.00</td>
<td>77</td>
</tr>
<tr>
<td>Direct Marketing</td>
<td>$200.00</td>
<td>1.10</td>
<td>50%</td>
<td>60.00</td>
<td>23</td>
</tr>
<tr>
<td>Niche Marketing</td>
<td>$151.00</td>
<td>0.90</td>
<td>37%</td>
<td>45.00</td>
<td>24</td>
</tr>
<tr>
<td>Other*</td>
<td>$139.00</td>
<td>0.80</td>
<td>35%</td>
<td>42.00</td>
<td>109</td>
</tr>
</tbody>
</table>

* Includes companies that did not respond to this or prior year surveys

<table>
<thead>
<tr>
<th>Description</th>
<th>Acquisition per Policy</th>
<th>Acquisition per Unit</th>
<th>Acquisition per Premium</th>
<th>Maintenance per Policy</th>
<th>Company Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>$166.00</td>
<td>$0.90</td>
<td>42%</td>
<td>$50.00</td>
<td>121</td>
</tr>
<tr>
<td>Career</td>
<td>$214.00</td>
<td>1.20</td>
<td>54%</td>
<td>64.00</td>
<td>63</td>
</tr>
<tr>
<td>Direct Marketing</td>
<td>$195.00</td>
<td>1.10</td>
<td>49%</td>
<td>59.00</td>
<td>15</td>
</tr>
<tr>
<td>Niche Marketing</td>
<td>$137.00</td>
<td>0.80</td>
<td>34%</td>
<td>41.00</td>
<td>26</td>
</tr>
<tr>
<td>Other*</td>
<td>$126.00</td>
<td>0.70</td>
<td>32%</td>
<td>38.00</td>
<td>67</td>
</tr>
</tbody>
</table>

* Includes companies that did not respond to this or prior year surveys
### Comparison to Prior Years

#### Acquisition per Policy

<table>
<thead>
<tr>
<th>Description</th>
<th>2022 Percentage Change</th>
<th>2021 Percentage Change</th>
<th>2020 Percentage Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>10%</td>
<td>-1%</td>
<td>0%</td>
</tr>
<tr>
<td>Career</td>
<td>1%</td>
<td>0%</td>
<td>214%</td>
</tr>
<tr>
<td>Direct Marketing</td>
<td>3%</td>
<td>-10%</td>
<td>217%</td>
</tr>
<tr>
<td>Niche Marketing</td>
<td>10%</td>
<td>10%</td>
<td>125%</td>
</tr>
<tr>
<td>Other*</td>
<td>10%</td>
<td>-10%</td>
<td>140%</td>
</tr>
</tbody>
</table>

* Includes companies that did not respond to this or prior year surveys.

#### Acquisition per Unit

<table>
<thead>
<tr>
<th>Description</th>
<th>2022 Percentage Change</th>
<th>2021 Percentage Change</th>
<th>2020 Percentage Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>11%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Career</td>
<td>0%</td>
<td>0%</td>
<td>120%</td>
</tr>
<tr>
<td>Direct Marketing</td>
<td>0%</td>
<td>-8%</td>
<td>120%</td>
</tr>
<tr>
<td>Niche Marketing</td>
<td>13%</td>
<td>14%</td>
<td>0.70%</td>
</tr>
<tr>
<td>Other*</td>
<td>14%</td>
<td>-13%</td>
<td>0.80%</td>
</tr>
</tbody>
</table>

* Includes companies that did not respond to this or prior year surveys.

#### Acquisition Per Premium

<table>
<thead>
<tr>
<th>Description</th>
<th>2022 Percentage Change</th>
<th>2021 Percentage Change</th>
<th>2020 Percentage Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>46%</td>
<td>42%</td>
<td>42%</td>
</tr>
<tr>
<td>Career</td>
<td>53%</td>
<td>54%</td>
<td>54%</td>
</tr>
<tr>
<td>Direct Marketing</td>
<td>50%</td>
<td>49%</td>
<td>54%</td>
</tr>
<tr>
<td>Niche Marketing</td>
<td>37%</td>
<td>34%</td>
<td>32%</td>
</tr>
<tr>
<td>Other*</td>
<td>35%</td>
<td>32%</td>
<td>35%</td>
</tr>
</tbody>
</table>

* Includes companies that did not respond to this or prior year surveys.

#### Maintenance Per Policy

<table>
<thead>
<tr>
<th>Description</th>
<th>2022 Percentage Change</th>
<th>2021 Percentage Change</th>
<th>2020 Percentage Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>10%</td>
<td>0%</td>
<td>550%</td>
</tr>
<tr>
<td>Career</td>
<td>0%</td>
<td>0%</td>
<td>64%</td>
</tr>
<tr>
<td>Direct Marketing</td>
<td>2%</td>
<td>-9%</td>
<td>65%</td>
</tr>
<tr>
<td>Niche Marketing</td>
<td>10%</td>
<td>8%</td>
<td>38%</td>
</tr>
<tr>
<td>Other*</td>
<td>11%</td>
<td>-10%</td>
<td>42%</td>
</tr>
</tbody>
</table>

* Includes companies that did not respond to this or prior year surveys.
Information on Companies in Study

- The following percentages of companies responded that GRET factors are used for individual life sales illustration purposes:
  - 2021 Survey: 31%
  - 2020 Survey: 29%
  - 2019 Survey: 26%
  - 2018 Survey: 28%
  - 2017 Survey: 30%
  - 2016 Survey: 26%

- We believe variation is a result of the mix of respondents and the limited number of responses

- Included 375 companies in this year’s study
  - Increase of 83 companies from last year’s study.
  - Much of this increase is due to companies that were not included in the 2021 calculations due outliers in the 2018 data.

- There were a total of 771 companies originally in the data received from the NAIC in this year’s data extraction versus 776 in last year
  - Total ordinary policies issued for these 771 companies remained essentially flat (30K more policies out of a total of 10.1M) over the prior year
  - Face amount issued increased by 2.6% over the prior year
Questions
TO:     Reggie Mazyck, NAIC
FROM:   Pete Miller, Experience Study Actuary, Society of Actuaries (SOA)
         Tony Phipps, Chair, SOA Committee on Life Insurance Company Expenses
DATE:   August 4, 2021
RE:     2022 Generally Recognized Expense Table (GRET) – SOA Analysis

Dear Mr. Mazyck:

As in previous years, the Society of Actuaries expresses its thanks to NAIC staff for their assistance and responsiveness in providing Annual Statement expense and unit data for the 2022 GRET analysis for use with individual life insurance sales illustrations. The analysis is based on expense and expense related information reported on companies’ 2019 and 2020 Annual Statements. This project has been completed to assist the Life Actuarial Task Force (LATF) in its consideration of potential revisions to the GRET that could become effective for calendar year 2022. This memo describes the analysis and resultant findings.

NAIC staff provided Annual Statement data for life insurance companies for calendar years 2019 and 2020. This included data from 776 companies in 2019 and 771 companies in 2020. This decrease resumes the trend of small decreases from year to year. Of the total companies, 375 were in both years and passed the outlier exclusion tests and were included as a base for the GRET factors (292 companies passed similar tests last year).

APPROACH USED
The methodology for calculating the recommended GRET factors based on this data is similar to that followed the last several years. The methodology was last altered in 2015. The changes made at that time can be found in the recommendation letter sent to LATF on July 30, 20151.

To calculate updated GRET factors, the average of the factors from the two most recent years (2019 and 2020 for those companies with data available for both years) of Annual Statement data was used. For each company an actual-to-expected ratio was calculated. Companies with ratios that fell outside predetermined parameters were excluded. This process was completed three times to stabilize the average rates. The boundaries of the exclusions have been modified from time to time; however, there were no adjustments made this year. Unit expense seed factors (the seeds for all distribution channel categories are the same), as shown in Appendix B, were used to compute total expected expenses. Thus, these seed factors were used to implicitly allocate expenses between acquisition and maintenance expenses, as well as among the three acquisition expense factors (on a direct of ceded reinsurance basis).

Companies were categorized by their reported distribution channel (four categories were used as described in Appendix A included below). There remain a significant number of companies for which no distribution channel was provided, as no responses to the annual surveys have been received from those companies. The characteristics of these companies vary significantly, including companies not currently writing new business or whose major line of business is not individual life insurance. Any advice or assistance from LATF in future

1 https://www.soa.org/Files/Research/Projects/research-2016-gret-recommendation.pdf
years to increase the response rate to the surveys of companies that submit Annual Statements in order to reduce the number of companies in the “Other” category would be most welcomed. The intention is to continue surveying the companies in future years to enable enhancement of this multiple distribution channel information.

Companies were excluded from the analysis if in either 2019 or 2020 (1) their actual to expected ratios were considered outliers, often due to low business volume, (2) the average first year and single premium per policy were more than $40,000, (3) they are known reinsurance companies or (4) their data were not included in the data supplied by the NAIC. To derive the overall GRET factors, the unweighted average of the remaining companies’ actual-to-expected ratios for each respective category was calculated. The resulting factors were rounded, as shown in Table 1.

THE RECOMMENDATION
The above methodology results in the proposed 2022 GRET values shown in Table 1. To facilitate comparisons, the current 2021 GRET factors are shown in Table 2. Further characteristics of the type of companies represented in each category are included in the last two columns in Table 1, including the average premium per policy issued and the average face amount ($000s) per policy issued.

To facilitate comparisons, the current 2021 GRET factors are shown in Table 2. Further characteristics of the type of companies represented in each category are included in the last two columns in Table 1, including the average premium per policy issued and the average face amount ($000s) per policy issued.

**TABLE 1**
PROPOSED 2022 GRET FACTORS, BASED ON AVERAGE OF 2019/2020 DATA

<table>
<thead>
<tr>
<th>Description</th>
<th>Acquisition per Policy</th>
<th>Acquisition per Unit</th>
<th>Acquisition per Premium</th>
<th>Maintenance per Policy</th>
<th>Companies Included</th>
<th>Average Premium Per Policy Issued During Year</th>
<th>Average Face Amt (000) Per Policy Issued During Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>$183</td>
<td>$1.00</td>
<td>46%</td>
<td>$55</td>
<td>142</td>
<td>3,252</td>
<td>194</td>
</tr>
<tr>
<td>Career</td>
<td>212</td>
<td>1.20</td>
<td>53%</td>
<td>64</td>
<td>77</td>
<td>2,327</td>
<td>197</td>
</tr>
<tr>
<td>Direct Marketing</td>
<td>200</td>
<td>1.10</td>
<td>50%</td>
<td>60</td>
<td>23</td>
<td>875</td>
<td>72</td>
</tr>
<tr>
<td>Niche Marketing</td>
<td>151</td>
<td>0.90</td>
<td>37%</td>
<td>45</td>
<td>24</td>
<td>517</td>
<td>13</td>
</tr>
<tr>
<td>Other*</td>
<td>139</td>
<td>0.80</td>
<td>35%</td>
<td>42</td>
<td>109</td>
<td>786</td>
<td>70</td>
</tr>
</tbody>
</table>

* Includes companies that did not respond to this or prior year surveys 375

**TABLE 2**
CURRENT 2021 GRET FACTORS, BASED ON AVERAGE OF 2017/2019 DATA

<table>
<thead>
<tr>
<th>Description</th>
<th>Acquisition per Policy</th>
<th>Acquisition per Unit</th>
<th>Acquisition per Premium</th>
<th>Maintenance per Policy</th>
<th>Companies Included</th>
<th>Average Premium Per Policy Issued During Year</th>
<th>Average Face Amt (000) Per Policy Issued During Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>$166</td>
<td>$0.90</td>
<td>42%</td>
<td>$50</td>
<td>121</td>
<td>2,916</td>
<td>194</td>
</tr>
<tr>
<td>Career</td>
<td>214</td>
<td>1.20</td>
<td>54%</td>
<td>64</td>
<td>63</td>
<td>2,517</td>
<td>195</td>
</tr>
<tr>
<td>Direct Marketing</td>
<td>195</td>
<td>1.10</td>
<td>49%</td>
<td>59</td>
<td>15</td>
<td>2,933</td>
<td>119</td>
</tr>
<tr>
<td>Niche Marketing</td>
<td>137</td>
<td>0.80</td>
<td>34%</td>
<td>41</td>
<td>26</td>
<td>590</td>
<td>11</td>
</tr>
<tr>
<td>Other*</td>
<td>126</td>
<td>0.70</td>
<td>32%</td>
<td>38</td>
<td>67</td>
<td>836</td>
<td>29</td>
</tr>
</tbody>
</table>

* Includes companies that did not respond to this or prior year surveys 292
In previous recommendations, an effort was made to reduce volatility in the GRET factors from year-to-year by limiting the change in GRET factors between years to about ten percent of the prior value. The changes from the 2021 GRET were reviewed to ensure that a significant change was not made in this year’s GRET recommendation.

The Independent, Niche Marketing and Other distribution channel categories experienced a change greater than ten percent so the factors for this line were capped at the ten percent level (the Acquisition per unit factor changed somewhat more than 10% because of rounding) from the corresponding 2021 GRET values. The volatility occurred due to incorrect NAIC data for 2018 for some companies, which caused their actual to expected ratios to be considered outliers and they were not included in the calculation. This resulted in lower final 2021 GRET factors and subsequently the same for the 2022 recommendation. Over the next one to three years, the ten percent cap will allow this difference to be graded in so calculated GRET will be used for the final recommended GRET factors.

**USAGE OF THE GRET**

This year’s survey, responded to by companies’ Annual Statement correspondent, included a question regarding whether the 2021 GRET table was used in its illustrations by the company. Last year, 29% of the responders indicated their company used the GRET for sales illustration purposes, with similar percentage results by size of company; this contrasted with about 28% in 2019. This year, 31% of responding companies indicated that they used the GRET in 2020 for sales illustration purposes. The range was from 11% for Direct Marketing to 43% for Independent. Based on the information received over the last several years, the variation in GRET usage appears to be in large part due to the relatively small sample size and different responders to the surveys.

We hope LATF finds this information helpful and sufficient for consideration of a potential update to the GRET. If you require further analysis or have questions, please contact Pete Miller at 847-706-3566.

Kindest personal regards,

Pete Miller, ASA, MAAA
Experience Study Actuary
Society of Actuaries

Tony Phipps, FSA, MAAA
Chair, SOA Committee on
Life Insurance Company Expenses

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APPENDIX A -- DISTRIBUTION CHANNELS

The following is a description of distribution channels used in the development of recommended 2022 GRET values:

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

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

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

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

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

The expense seeds used in the 2014 and prior GRETs were differentiated between branch office and all other categories, due to the results of a relatively old study that had indicated that branch office acquisition cost expressed on a per Face Amount basis was about double that of other distribution channels. Due to the elimination of the branch office category in the 2015 GRET, non-differentiated unit expense seeds have been used in the current and immediately prior studies.

The unit expense seeds used in the 2022 GRET and the 2021 GRET recommendations were based on the average of the 2006 through 2010 Annual SOA expense studies. These studies differentiated unit expenses by type of individual life insurance policy (term and permanent coverages). As neither the GRET nor the Annual Statement data provided differentiates between these two types of coverage, the unit expense seed was derived by judgment based this information. The following shows the averages derived from the Annual SOA studies and the seeds used in this study. Beginning with the 2020 Annual Statement submission this information will become more readily available.

2006-2010 (AVERAGE) CLICE STUDIES:

<table>
<thead>
<tr>
<th></th>
<th>Acquisition/ Policy</th>
<th>Acquisition/ Face Amount (000)</th>
<th>Acquisition/ Premium</th>
<th>Maintenance/ Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Term</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weighted Average</td>
<td>$149</td>
<td>$0.62</td>
<td>38%</td>
<td>$58</td>
</tr>
<tr>
<td>Unweighted Average</td>
<td>$237</td>
<td>$0.80</td>
<td>57%</td>
<td>$76</td>
</tr>
<tr>
<td>Median</td>
<td>$196</td>
<td>$0.59</td>
<td>38%</td>
<td>$64</td>
</tr>
<tr>
<td><strong>Permanent</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weighted Average</td>
<td>$167</td>
<td>$1.43</td>
<td>42%</td>
<td>$56</td>
</tr>
<tr>
<td>Unweighted Average</td>
<td>$303</td>
<td>$1.57</td>
<td>49%</td>
<td>$70</td>
</tr>
<tr>
<td>Median</td>
<td>$158</td>
<td>$1.30</td>
<td>41%</td>
<td>$67</td>
</tr>
</tbody>
</table>

CURRENT UNIT EXPENSE SEEDS:

<table>
<thead>
<tr>
<th></th>
<th>Acquisition/ Policy</th>
<th>Acquisition/ Face Amount (000)</th>
<th>Acquisition/ Premium</th>
<th>Maintenance/ Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>All distribution channels</td>
<td>$200</td>
<td>$1.10</td>
<td>50%</td>
<td>$60</td>
</tr>
</tbody>
</table>
Update on the Transition from LIBOR

Pat Allison, FSA, MAAA
August 12, 2021

Agenda

- Background
- Key Dates
- Company Actions Needed
- Applicable Valuation Manual Language
- Future LATF Actions Needed
Background

- LIBOR is a widely used benchmark for short-term interest rates. Approximately $200 trillion of financial contracts reference USD LIBOR.

- USD LIBOR is currently published for 7 tenors (overnight, 1-week, 1-month, 2-month, 3-month, 6-month, and 12-months), but this will be ceasing.

- The 3-month and 6-month USD LIBOR tenors are specifically cited in the Valuation Manual.

- The Alternative Reference Rates Committee (ARRC) is a group of private-market participants formed in 2014 by the Federal Reserve Board and the NY Fed. It seeks to ensure a successful transition from USD LIBOR to its recommended alternative, the Secured Overnight Financing Rate (SOFR).

Background (continued)

Some cited advantages of SOFR*:

- As an overnight secured rate, SOFR better reflects the way financial institutions fund themselves today.

- SOFR is fully based on actual transactions and does not rely on judgment.

- SOFR references multiple segments of the US Treasury repurchase agreement market. The transactions underlying SOFR regularly are around $1 trillion in daily volumes. This protects against the risk of manipulation.

- SOFR's underlying market is resilient and robust.

- SOFR is a true “risk-free” rate suitable as a reflection of interest rates overall.

- SOFR is produced by the public sector using a transparent methodology.

*Source: Government Finance Officers Association - Guide for Municipal Issuers
Key Dates

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/26/21</td>
<td>Interdealer trading conventions changed to trade SOFR linear swaps in place of USD LIBOR.</td>
</tr>
<tr>
<td>7/29/21</td>
<td>The ARRC formally recommended CME Group’s forward-looking SOFR Term Rates. CME Term SOFR rates are now published daily in 1-month, 3-month, and 6-month tenors.</td>
</tr>
<tr>
<td>1/1/22</td>
<td>1-week and 2-month USD LIBOR will no longer be published (the Valuation Manual does not reference these).</td>
</tr>
<tr>
<td>7/1/23</td>
<td>All other USD LIBOR tenors (i.e. overnight, 1-, 3-, 6-, and 12-month) will no longer be published.</td>
</tr>
</tbody>
</table>

Company Actions Needed

- Insurance companies will need to take inventory of existing products and processes that use LIBOR, which may include:
  - Investments (e.g., floating rate debt, where the interest rate is reset periodically based on LIBOR; derivatives linked to LIBOR)
  - Contracts with policyholders (e.g., annuities with credited rate equal to LIBOR plus a margin)
  - Reinsurance treaties
  - IT feeds
- Take action where required to move toward SOFR or another rate (e.g. for annuity contracts with policyholders, file for approval with the IIPRC and notify owner)
Applicable Valuation Manual Language


  Interest rate swap spreads over Treasuries shall be prescribed by the NAIC for use throughout the cash-flow model wherever appropriate for transactions and operations including, but not limited to, purchase, sale, settlement, cash flows of derivative positions and reset of floating rate investments. A current and long term swap spread curve shall be prescribed for year one and years four and after, respectively, with yearly grading in between. The three-month and six-month points on the swap spread curves shall be the market-observable values for these tenors. Currently, this shall be the corresponding London Interbank Offered Rate (LIBOR) spreads over Treasuries. **When the NAIC determines LIBOR is no longer effective, the NAIC shall recommend a replacement to the Life Actuarial (A) Task Force which shall be effective upon adoption by the Task Force.**

  Note: The bolded language above accommodates a single replacement for LIBOR (e.g., SOFR).

Applicable Valuation Manual Language (continued)

- VM-20 Appendix 2, Sections G.1-3 relating to Long-Term Benchmark Swap Spreads

  1. **Extract daily swap spread data over the prescribed observation period (rolling 15-year period)** ending on the last business day of the quarter. For Bank of America data, convert the daily swap rate for each maturity to a swap spread by subtracting the corresponding maturity Treasury yield from the swap rate. For JP Morgan, the daily swap spread is provided for each maturity.

  2. Average the daily Bank of America swap spread data with the daily JP Morgan swap spread data by maturity over the prescribed observation (rolling 15-year period).

  3. Calculate the 85% conditional mean for each of the 32 maturity categories (three-month, six-month, one-year, two-year, ... 30-year) using the same business trading days as were used in the 85% conditional mean for long-term bonds spreads.

  Note: We will not have 15 years of data for LIBOR’s replacement.
Future LATF Actions Needed

- Identify the replacement for LIBOR.
  - The ARRC has recommended SOFR as LIBOR’s replacement, but there are competing alternatives (e.g. Bloomberg’s Short-Term Bank Yield Index).
- Adopt the replacement for LIBOR when the NAIC determines that LIBOR is no longer effective. This will enable the NAIC to begin publishing the 3-month and 6-month rates.
- Amend the *Valuation Manual* to specifically identify the replacement for 3-month and 6-month USD LIBOR.
- Determine whether the process for calculating Long-Term Benchmark Swap Spreads needs to be changed, given that there is no 15-year history for LIBOR’s replacement.

Questions?
Update on Mortality Experience Data Collection

Pat Allison, FSA, MAAA
Angela McNabb, ASA, MAAA
August 12, 2021

Agenda

• Data Collection Timeline
• Project Status
• Early Observations
• Resources Available on the NAIC Website
## 2021 Experience Data Collection Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/27/21</td>
<td>NAIC finished hosting a series of company training webinars.</td>
</tr>
<tr>
<td>6/7/21</td>
<td>NAIC notified companies that they could begin submitting data for the 2018 and 2019 observation years.</td>
</tr>
<tr>
<td>9/30/21</td>
<td>Deadline to submit data using the Regulatory Data Collection (RDC) tool. Automatic feedback on form and format data exceptions will be provided by RDC upon submission. Additional feedback will be provided within 30 days based on actuarial review.</td>
</tr>
<tr>
<td>12/31/21</td>
<td>Deadline for companies to make corrections</td>
</tr>
<tr>
<td>5/31/22</td>
<td>NAIC to submit aggregate experience data to SOA</td>
</tr>
</tbody>
</table>

## Project Status

- As of 8/2/2021, 115 companies, representing 90% of industry claims, are subject to the Mortality Experience Data Collection. Of these companies:
  - 85 have participated in either the KS or NY mortality experience data calls
  - 77 are subject to Life PBR
- The NAIC has received 3 full submissions and 1 partial submission
Early Observations

- Training sessions were very well attended (recordings and slides are available on the NAIC website).
- Companies have been actively communicating with the NAIC regarding out-of-scope business, exemption requests, and miscellaneous questions.
- Some submissions have been incomplete. They need to include data for the 2018 and 2019 observation years, VM-51 questionnaires, control totals, and a reconciliation.
- A communication was sent to companies regarding common questions and issues.

Resources

The following resources are on the NAIC website

https://content.naic.org/pbr_data.htm

VM-50 / VM-51

Experience Reporting
For Questions Please Contact: experience_reporting@naic.org

- Mortality Data Collection Training Series - Recordings, PowerPoint slides, Summaries from Q&A
- Instructions and Guides
  - Instructions, Questionnaires, and File Formats (extracted from the Valuation Manual)
  - Company Administrator Guide
  - RDC Rate File Submission Instructions
- Templates
  - Control Totals Template
  - Reconciliation Template
  - VM-51 Appendix 1/2/3 Questionnaire Template
  - VM-51 Mortality Experience Data Collection FAQ
- VM-51 Reporting when Business is Administered by Third-parties
- VM-51 Data Validations
- A VM-51 data dictionary will be posted shortly
Society of Actuaries
Research Update to LATF

R. DALE HALL, FSA, MAAA, CERA, CFA
Managing Director of Research
August 12, 2021

Presentation Disclaimer

The material and information contained in this presentation is for general information only. It does not replace independent professional judgment and should not be used as the basis for making any business, legal or other decisions. The Society of Actuaries assumes no responsibility for the content, accuracy or completeness of the information presented.
Group Life COVID-19 Mortality Survey

Survey Overview

• Purpose is to gather high-level view of U.S. Group Term Life Insurance mortality results during the COVID-19 pandemic
• 20 of the top 21 U.S. Group Term Life insurers focused on employer groups participated in the survey (about 90% of industry)
  • Includes over 1.8 million claims and over $83 billion in earned premium
• Survey compares mortality results during pandemic to 2017-2019 baseline period
• July report contains data through Q1 2021 and is an update to the December 2020 report, which included data through August 2020
Survey Highlights

• Group Life claim incidence were higher for the April 2020 – March 2021 period:
  • 17.3% on Reported basis
  • 19.6% on Incurred basis
• 13% of reported claims from April 2020 – March 2021 had a cause of death of COVID-19
• Blue Collar group experienced the smallest excess mortality of the collar groups studied
  • Spread between Blue and White/Grey has narrowed since the previous update

Survey Highlights

• Mortality patterns by region changed over the course of the pandemic.
  Regions with highest excess mortality by quarter:
  • Q2 2020: Northeast (42.6%)
  • Q3 2020: Southeast (25.3%)
  • Q4 2020: Midwest (33.8%)
  • Q1 2021: Southeast (32.3%)
• Group Life survey data excess mortality was generally 80% - 110% of U.S. population data
  • December report indicated a 50% - 70% range
  • West region showed the largest spread between Group Life and U.S. population data
Individual Life COVID-19 Claims Analysis

Overview and Data

• The previous report published in March included data from 2015 – June, 2020
  • Analysis was by cause of death, but not a true experience study
• This experience study included data from 2015 – September, 2020
  • 2020 deaths compared with 2015 – 2019, by quarter
  • The data included exposures: this is similar to a more traditional experience study than the March study
  • Results largely in line with COVID-19 experience from other studies, with some interesting observations
• 31 Contributing companies with 2.8 million deaths
Methodology

• Generally follows a standard Actual to Expected study, but:
  • The baseline is based on VBT-2015, which is an amount-based table
  • When analyzed based on amount, even with 2.8 million deaths, ratios were very volatile
  • Numerators based on counts, which gave stable, solid results
  • Report discusses “relative mortality ratios” instead of “Actual to Expected” because of this technical disconnect

Methodology Contd.

• 2015 – 2019 experience was extrapolated to 2020 by quarter, and compared against 2020 actuals
• Overall 5-year trends were clearly identifiable
Methodology Contd.

• The results were also shown as excess mortality charts, by quarter:

![Excess Mortality Charts](chart.png)

All fully underwritten business, by quarter

Actual to Expected Relative Mortality Ratios: By Sex and Attained Age

![Actual to Expected Mortality Ratios](chart2.png)
Actual to Expected Relative Mortality Ratios: By Preferred Class

Actual to Expected Relative Mortality Ratios: By Face Amount
Actual to Expected Relative Mortality Ratios: By Underwriting Type

![Bar chart showing actual to expected relative mortality ratios by underwriting type.](chart)

Actual to Expected Relative Mortality Ratios: By Geographic Region

<table>
<thead>
<tr>
<th>Code</th>
<th>Name</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Northeast</td>
<td>96%</td>
<td>103%</td>
<td>94%</td>
<td>123%</td>
<td>137%</td>
<td>100%</td>
<td>99%</td>
<td>95%</td>
<td>105%</td>
</tr>
<tr>
<td>2</td>
<td>NY-NJ</td>
<td>98%</td>
<td>98%</td>
<td>112%</td>
<td>244%</td>
<td>126%</td>
<td>102%</td>
<td>96%</td>
<td>96%</td>
<td>93%</td>
</tr>
<tr>
<td>3</td>
<td>Mid-Atlantic</td>
<td>98%</td>
<td>98%</td>
<td>103%</td>
<td>123%</td>
<td>115%</td>
<td>99%</td>
<td>106%</td>
<td>99%</td>
<td>102%</td>
</tr>
<tr>
<td>4</td>
<td>Southeast</td>
<td>95%</td>
<td>99%</td>
<td>103%</td>
<td>102%</td>
<td>103%</td>
<td>102%</td>
<td>102%</td>
<td>118%</td>
<td>119%</td>
</tr>
<tr>
<td>5</td>
<td>North Central</td>
<td>96%</td>
<td>94%</td>
<td>99%</td>
<td>118%</td>
<td>105%</td>
<td>106%</td>
<td>103%</td>
<td>106%</td>
<td>102%</td>
</tr>
<tr>
<td>6</td>
<td>Texas and surrounding states</td>
<td>93%</td>
<td>94%</td>
<td>101%</td>
<td>108%</td>
<td>102%</td>
<td>103%</td>
<td>121%</td>
<td>113%</td>
<td>110%</td>
</tr>
<tr>
<td>7</td>
<td>Plains</td>
<td>100%</td>
<td>90%</td>
<td>95%</td>
<td>99%</td>
<td>103%</td>
<td>104%</td>
<td>108%</td>
<td>108%</td>
<td>101%</td>
</tr>
<tr>
<td>8</td>
<td>Northern Plains</td>
<td>104%</td>
<td>96%</td>
<td>95%</td>
<td>114%</td>
<td>103%</td>
<td>100%</td>
<td>95%</td>
<td>96%</td>
<td>110%</td>
</tr>
<tr>
<td>9</td>
<td>California+</td>
<td>94%</td>
<td>98%</td>
<td>96%</td>
<td>108%</td>
<td>102%</td>
<td>102%</td>
<td>118%</td>
<td>114%</td>
<td>105%</td>
</tr>
<tr>
<td>10</td>
<td>Washington+</td>
<td>98%</td>
<td>100%</td>
<td>101%</td>
<td>99%</td>
<td>92%</td>
<td>106%</td>
<td>106%</td>
<td>101%</td>
<td>109%</td>
</tr>
</tbody>
</table>
US Population Mortality

2020 Overall U.S. Population Historical Mortality Rates

- 2020 Mortality Rate = 830.5/100,000 (0.8%)
- 83.6 deaths/100,000 due to COVID
- ★16.1% increase over 2019
- ★2020 highest rate since 2003
- ★Without COVID, increase over 2019 = 4.4%

CDC WONDER; CDC Rapid Release.
Actual/Expected (A/E) in 2020 U.S. Population

- Compares actual deaths to an expected baseline
- Actual/Expected or A/E's
- Differs from CDC analysis – by sex and age group

★ Ages <5 had lower mortality than expected
★ Ages 35-54 highest A/Es for all CODs
★ Ages 15-24 had highest A/Es if COVID excluded

<table>
<thead>
<tr>
<th>Age</th>
<th>Female Total</th>
<th>Excl. COVID</th>
<th>Male Total</th>
<th>Excl. COVID</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1</td>
<td>96.2%</td>
<td>96.0%</td>
<td>93.8%</td>
<td>93.4%</td>
</tr>
<tr>
<td>1-4</td>
<td>91.5%</td>
<td>90.6%</td>
<td>96.9%</td>
<td>96.1%</td>
</tr>
<tr>
<td>5-14</td>
<td>95.8%</td>
<td>94.3%</td>
<td>107.1%</td>
<td>105.7%</td>
</tr>
<tr>
<td>15-24</td>
<td>119.0%</td>
<td>115.4%</td>
<td>125.3%</td>
<td>123.2%</td>
</tr>
<tr>
<td>25-34</td>
<td>118.7%</td>
<td>112.4%</td>
<td>122.5%</td>
<td>117.9%</td>
</tr>
<tr>
<td>35-44</td>
<td>124.0%</td>
<td>114.6%</td>
<td>128.9%</td>
<td>118.8%</td>
</tr>
<tr>
<td>45-54</td>
<td>122.8%</td>
<td>110.2%</td>
<td>128.7%</td>
<td>112.9%</td>
</tr>
<tr>
<td>55-64</td>
<td>116.4%</td>
<td>102.6%</td>
<td>121.2%</td>
<td>105.3%</td>
</tr>
<tr>
<td>65-74</td>
<td>120.4%</td>
<td>103.9%</td>
<td>122.8%</td>
<td>103.7%</td>
</tr>
<tr>
<td>75-84</td>
<td>121.2%</td>
<td>103.5%</td>
<td>123.5%</td>
<td>102.7%</td>
</tr>
<tr>
<td>&gt; 84</td>
<td>119.5%</td>
<td>102.5%</td>
<td>119.4%</td>
<td>100.4%</td>
</tr>
<tr>
<td>All Ages</td>
<td>119.7%</td>
<td>103.7%</td>
<td>122.3%</td>
<td>104.8%</td>
</tr>
</tbody>
</table>

2020 U.S. Population Mortality Rates by Cause of Death

★ Heart COD – largest increase in 20 years. Only other increase was in 2015 = 0.9%.
★ Cancer continued its steady improvement.
★ Diabetes, liver, hypertension, Parkinson’s had large increases
★ ‘Other’ includes accidents, drug overdoses (O.D.), suicides, and assaults

<table>
<thead>
<tr>
<th>COD</th>
<th>2019 Age-Adjusted Mortality Rate</th>
<th>2020 Age-Adjusted Mortality Rate</th>
<th>Change in Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidents</td>
<td>161.5</td>
<td>167.0</td>
<td>3.4%</td>
</tr>
<tr>
<td>Drug O.D.</td>
<td>146.2</td>
<td>143.7</td>
<td>-1.7%</td>
</tr>
<tr>
<td>Suicides</td>
<td>0.0</td>
<td>83.6</td>
<td>-∞</td>
</tr>
<tr>
<td>Assaults</td>
<td>37.0</td>
<td>36.2</td>
<td>4.3%</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>38.2</td>
<td>36.2</td>
<td>-5.2%</td>
</tr>
<tr>
<td>Alzheimer’s</td>
<td>29.8</td>
<td>32.2</td>
<td>8.1%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>21.6</td>
<td>24.5</td>
<td>13.9%</td>
</tr>
<tr>
<td>Liver</td>
<td>11.3</td>
<td>13.2</td>
<td>16.8%</td>
</tr>
<tr>
<td>Influenza/pneumonia</td>
<td>12.3</td>
<td>13.0</td>
<td>5.7%</td>
</tr>
<tr>
<td>Kidney</td>
<td>12.7</td>
<td>12.7</td>
<td>0.0%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>8.9</td>
<td>10.0</td>
<td>12.4%</td>
</tr>
<tr>
<td>Parkinson’s</td>
<td>8.8</td>
<td>9.8</td>
<td>11.4%</td>
</tr>
<tr>
<td>Septicemia</td>
<td>9.5</td>
<td>9.7</td>
<td>2.1%</td>
</tr>
<tr>
<td>Pneumonitis</td>
<td>4.7</td>
<td>4.4</td>
<td>-6.4%</td>
</tr>
<tr>
<td>HIV</td>
<td>1.4</td>
<td>1.4</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other</td>
<td>372.8</td>
<td>397.4</td>
<td>6.6%</td>
</tr>
<tr>
<td>Total</td>
<td>715.2</td>
<td>830.5</td>
<td>16.1%</td>
</tr>
</tbody>
</table>
Additional SOA Life Research

SOA Experience Studies

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Objective</th>
<th>Expected Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008 Variable Annuity Guaranteed Living Benefit Utilization Study</td>
<td>Examine the utilization of guaranteed living benefit options on variable annuity contracts under a joint SOA/UMMA project.</td>
<td>Complete. On SOA web site.</td>
</tr>
<tr>
<td>GBST for 2011</td>
<td>Develop the Generally Recognized Expense Table (GBST) for 2022</td>
<td>2017/07/11</td>
</tr>
<tr>
<td>2010-2017 Post-Level Term Mortality and Lapse - Machine Learning Report</td>
<td>A report regarding the ML machine learning analysis that was done; this report will supplement the above report.</td>
<td>2017/07/11</td>
</tr>
<tr>
<td>Mortality Improvement Survey</td>
<td>Complete a survey to learn how companies are reacting to the slowdown in the level of mortality improvement within the general population.</td>
<td>2017/10/30</td>
</tr>
<tr>
<td>2016-17 Indexed Annuity Study</td>
<td>Complete a mortality study assessing the impact of indexed annuity contracts on deferred annuity contracts and release a report with the findings and a database with the experience data.</td>
<td>2017/10/30</td>
</tr>
<tr>
<td>COVID-19 Individual Life Mortality Study - Experience Study Report - 2020</td>
<td>Complete a mortality study assessing the impact of COVID-19 on individual life insurance.</td>
<td>2017/10/30</td>
</tr>
<tr>
<td>2011-2015 Indexed Annuity Mortality Study</td>
<td>Complete a mortality study assessing the impact of indexed annuity contracts on deferred annuity contracts and release a report with the findings and a database with the experience data.</td>
<td>2017/10/30</td>
</tr>
</tbody>
</table>

### SOA Practice Research & Data Driven In-house Research

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Objective</th>
<th>Expected Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Model Evaluation</td>
<td>Review existing literature on GLMs, discuss actuarial standards for using complex models outside of actuary’s initial expertise, develop case studies for demonstrating methods of evaluating the valuation of complex insurance</td>
<td>Complete. On SOA web site.</td>
</tr>
<tr>
<td>Consistent Mortality Framework Model</td>
<td>Develop a consistent mortality framework model to enable mortality improvement projects across variety of mortality actuaries</td>
<td>Complete. On SOA web site.</td>
</tr>
<tr>
<td>Deep Learning for Liability-Driven Investments</td>
<td>Explore the possibility of using deep learning and reinforcement learning techniques to improve investment decision-making for pension funds and life insurance companies.</td>
<td>Complete. On SOA web site.</td>
</tr>
<tr>
<td>InsurTech White Paper</td>
<td>Write a white paper covering the insurTech landscape in the US and discuss how actuaries will be impacted.</td>
<td>Complete. On SOA web site.</td>
</tr>
<tr>
<td>Managing Investment Risks of Insurance/Annuity Contractual Designs</td>
<td>Develop a framework for quantifying and analyzing various forms of contractual designs and their risk management techniques.</td>
<td>Complete. On SOA web site.</td>
</tr>
<tr>
<td>PRAXIS Analytics for Early Detection of Insurer Insolvency</td>
<td>Develop market-based insolvency prediction model to detect financially distressed insurers at an early stage.</td>
<td>7/25/2021</td>
</tr>
<tr>
<td>Human Mortality Database - 2015 Projects</td>
<td>Enhances the Human Mortality Database by focusing on state level mortality tables and expanding cause of death mortality tables for non-countries.</td>
<td>7/25/2021</td>
</tr>
<tr>
<td>2020 Emerging Risks Survey</td>
<td>Tracks the trends and thoughts of risk managers on emerging risks across time.</td>
<td>8/26/2021</td>
</tr>
<tr>
<td>Mortality Improvement Trends Analysis</td>
<td>Identify how mortality improvement varies by insurer.</td>
<td>8/26/2021</td>
</tr>
<tr>
<td>Obesity Trends and Mortality and Longevity Impacts</td>
<td>Develop an estimate of the impact of obesity in mortality and morbidity costs in the US and Canada.</td>
<td>10/21/2021</td>
</tr>
</tbody>
</table>

---

### Ethical and Responsible Use of Data and Predictive Models Certificate Program

- Session runs October 2021 – February 2022
- Self-directed E-learning & virtual instructor-led sessions
- Participant discussion community
- Seven modules with self-tests
- Final ‘take home’ assessment for certificate

Register at SOA.org/ERUcert
Life Practice Council Update

Laura Hanson, MAAA, FSA
Vice President

Agenda

- Webinars and Events
- Recent Activities
- Ongoing Efforts
- Academy Officer Candidates
Webinars and Events

- Recent
  - The Impacts of COVID-19 on the Life Insurance Industry (May 25)
  - Spring 2021 Life Policy Update (May 5)
  - Virtual PBR Boot Camp (June 7-9)

Webinars and Events (continued)

- Upcoming
  - Summer 2021 Life Policy Update (August-TBD)
  - PBR Regulatory Webinar (September-TBD)
  - Academy Annual Meeting and Public Policy Forum (November 4-5)
Recent Activities

- Submitted draft VM-22 Framework
- Published annual FAQ on the Academy Interest Rate Generator in conjunction with the Society of Actuaries
- Submitted comments to the NAIC on:
  - Various Amendment Proposal Forms (LATF)
  - C-1 bond factors and C-2 longevity factors (Life Risk-Based Capital [LRBC] Working Group)
  - Exposed 2021 committee charges (Special Committee on Race and Insurance)

Ongoing Activities

- Provide input on Economic Scenario Generator transition
- Develop VM-22 and C-3 field study for non-variable annuities
- Publish VM-21 Practice Note Addendum
- Provide commentary on mortality improvement discussions
- Recommend C-2 mortality factors
Ongoing Activities (continued)

- Propose VM-51 data elements
- Publish Life Illustrations Practice Note Addendum
- Publish FAQs on changes to tax reserve calculations and reporting under the federal Tax Cuts and Jobs Act

Ongoing Activities (continued)

- Provide public policy analysis on:
  - The use of annuities in retirement plans, including changes as a result of the federal SECURE* Act
  - The use of data and algorithms in risk classification and underwriting
  - Efforts to promote diversity and inclusion in the actuarial profession and in life insurance products

* Setting Every Community Up for Retirement Enhancement
Academy Officer Candidates

- Slate of Incoming Vice Presidents*
  - Ben Slutsker, Life
  - Seong-min Eom, Risk Management and Financial Reporting

* Academy vice presidents serve two-year terms. Per the Academy’s bylaws, the officer slate will be voted on by the Board at its annual meeting in October. Terms for all new Board members will begin in November at the completion of the Academy’s Annual Meeting.

Thank You

- Questions?
- For more information, please contact the Academy’s life policy analyst, Khloe Greenwood, at greenwood@actuary.org.
HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

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The Health Insurance and Managed Care (B) Committee met in Columbus, OH, Aug. 16, 2021. The following Committee members participated: Jon Godfread, Chair (ND); Jessica K. Altman, Vice Chair (PA); Lori K. Wing-Heier (AK); Michael Conway (CO); Dean L. Cameron (ID); Kathleen A. Birrane (MD); Anita G. Fox (MI); Grace Arnold (MN); Russell Toal (NM); Glen Mulready (OK); Andrew R. Stolli (OR); Jonathan T. Pike (UT); Mike Kreidler (WA); and James A. Dodrill represented by Ellen Potter (WV). Also participating were: Alan McClain (AR); David Altmaier (FL); Doug Ommen (IA); Mike Chaney (MS); Troy Downing (MT); Eric Dunning (NE); Barbara D. Richardson (NV); Elizabeth Kelleher Dwyer (RI); Carter Lawrence (TN); Doug Slape (TX); Don Beatty (VA); and Tregenza A. Roach (VI).

1. **Adopted its June 22 and Spring National Meeting Minutes**

The Committee met June 22 to adopt the [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM Model).

Director Cameron made a motion, seconded by Commissioner Mulready, to adopt the Committee’s June 22 (Attachment One) and April 12 (see *NAIC Proceedings – Spring 2021, Health Insurance and Managed Care (B) Committee*) minutes. The motion passed unanimously.

2. **Adopted its Subgroup, Working Group, and Task Force Reports**

Commissioner Pike made a motion, seconded by Commissioner Kreidler, to adopt the following reports: 1) the Consumer Information (B) Subgroup, including its July 1 minutes (Attachment Two) minutes; 2) the Health Innovations (B) Working Group, including its July 27 minutes (Attachment Three); and 3) the Senior Issues (B) Task Force.

3. **Heard a Discussion from the Biden Administration on the Implementation and Enforcement of the NSA Provider Requirements**

Jeff Wu (Center for Consumer Information and Insurance Oversight—CCIIO) discussed the Biden Administration’s current and future efforts related to the implementation and enforcement of the federal No Surprises Act (NSA) provider requirements. He focused his remarks on how the federal agencies charged with implementing the NSA can work together to address any implementation and enforcement issues. He said the CCIIO recognizes that the states are in different positions as far as enforcement when the NSA becomes effective Jan. 1, 2022.

Mr. Wu discussed the major provisions in the interim final rule (IFR) issued July 1 with an effective date of Sept. 13. The IFR was issued jointly by the U.S. Department of Labor (DOL), the U.S. Department of Health and Human Services (HHS), the U.S. Department of the Treasury (Treasury Department), and the U.S. Office of Personnel Management (OPM). He said the IFR focused on the NSA’s consumer protection provisions, such as calculating patient cost-sharing, outlining notice and consent waiver provisions, and establishing a consolidated complaints process.

Mr. Wu said the states have primary enforcement authority with respect to insured plans, including the provider provisions. He said the federal Centers for Medicare & Medicaid Services (CMS) will only enforce these provisions if a state does not or cannot substantially enforce them. However, he explained that even under those circumstances, the CMS would seek to enter into a collaborative enforcement agreement with the state. He said the CMS has sent each state a written survey in its effort to assess which states plan to enforce the NSA’s provisions and their ability to do so. He said following the survey response deadline, the CMS plans to hold meetings with each state concerning their survey responses, including which state agency will enforce the NSA provisions, particularly provisions in the NSA concerning providers. Following these conversations, he said the CMS will send a final determination letter to the state’s governor outlining an NSA enforcement scheme.

Director Cameron asked if the CMS plans to send a copy of the letter sent to state governors to state insurance regulators. Mr. Wu confirmed the CMS’s intention to do so. Director Cameron asked for additional clarification on the collaborative enforcement agreements. Mr. Wu said each such agreement would be specific and tailored to a state’s circumstances as to the role the CMS will take, given that the states are the primary enforcers. However, he noted that the CMS recognizes that the
NSA includes a different set of stakeholders, which generally are not subject to state insurance regulation and over which state insurance regulators have no enforcement authority. He said the CMS also recognizes that some states may have resource issues that could affect their direct enforcement capacities. He said given this, there will most likely be different approaches and different collaborative models. He emphasized that the CMS prefers that the states be the primary enforcers of the NSA requirements.

Commissioner Altman asked about the CMS’s plans to educate the consumers and providers on the NSA’s provisions and the possibility of partnering with the states on such education campaigns. Mr. Wu said the CMS is currently thinking about ways to educate stakeholders on the NSA’s provisions. He said the CMS would be very interested in partnering with states in NSA awareness education campaigns. He said he believes that given the nature of the NSA, engaging consumers in such campaigns may be more challenging because consumers most likely will not be paying attention until they need to pay attention, such as after receiving a surprise bill. Commissioner Conway said Colorado has an existing comprehensive state law on surprise bills. He said he is concerned about aligning Colorado’s law and the NSA with respect to enforcement and Employee Retirement Income Security Act of 1974 (ERISA) plans. He asked if the CMS has contemplated or is contemplating the use of collaborative enforcement agreements with the states to address this issue. He said this issue is complex, particularly with respect to self-insured ERISA plans. He said the CMS anticipates additional federal rulemaking to address these types of jurisdictional issues, but the CMS wants to work with the states.

Commissioner Godfried also noted similar complexities regarding enforcement related to air ambulances and the interplay of the NSA and the Airline Deregulation Act (ADA). Mr. Wu agreed. He said the CMS is hoping to address this in future federal rulemaking.

Mr. Wu said the public comment deadline on the IFR ends Sept. 7. He said the federal agencies charged with implementing the NSA plan to issue additional federal rules on the independent dispute resolution (IDR) process. He said he believes that the IDR process in the IFR tries to strike the right balance, but the CMS is certainly aware of trying not to have an overly burdensome and costly administrative process. He said additional federal rulemaking will concern: 1) air ambulance services; 2) direct and indirect compensation to agents and brokers; 3) accuracy of provider directories; and 4) gag clauses.

Heard a Panel Discussion of NSA Provider Compliance and Enforcement Issues

Molly Smith (American Hospital Association—AHA) presented on “No Surprises Act: Provider Compliance and Enforcement Issues.” She said hospitals and health systems strongly support patient protections against surprise medical bills, and they will work diligently to comply with the NSA as of its Jan. 1, 2022, effective date. However, she noted that the NSA is a large comprehensive piece of legislation with several different independent policies. Given this, stakeholders will need time to implement its various components and need adequate and comprehensive guidance from both federal and state governments to assist in this effort. Ms. Smith said oversight will be critical; but, to date, the role of the federal government and the states remains unclear on several key NSA provisions. She discussed the AHA’s primary NSA implementation issues, including issues related to: 1) its scope and application; 2) notice/consent and disclosure documents and policies; and 3) training. She also discussed what the AHA believes are priority areas for oversight and enforcement for both providers and plans and insurers. She discussed from a provider perspective specific NSA oversight and enforcement challenges, such as the complexity of the rules and timeline and standards for implementation. She made several recommendations for Committee members to consider moving forward with NSA implementation, including: 1) clear articulation of which components of the NSA will be overseen by the federal government and which by the states; 2) development of a crosswalk between the federal and state laws and clear assessment of which states meet the standards for compliance on relevant provisions; and 3) development of a data submission process with standards for the states to report complaints and outcomes to the federal government for tracking and oversight.

Emily Carroll (American Medical Association—AMA) discussed the challenges and opportunities the NSA provides from the AMA’s perspective. She highlighted potential issues with the IDR process, including its timelines. In addition, like Ms. Smith’s comments, Ms. Carroll also discussed and urged more clarity on: 1) the scope of federal law and the interaction between federal and state laws; and 2) which laws apply for patients and providers. With respect to the NSA’s notice and consent and disclosure requirements, she urged federal and state insurance regulators to ensure that meaningful information is provided to consumers and noted the need for standard automated transactions. Ms. Carroll also discussed NSA enforcement.

Melanie de Leon (Federation of State Medical Boards—FSMB) presented on “The No Surprises Act: A Process for Collaboration in Compliance.” She described the FSMB, including its role and functions, which is to support state medical boards through education, assessment, research, and advocacy as well as promoting regulator best practices across the states. She discussed how the NSA presents an opportunity for collaboration between stakeholders in complying with its requirements. In focusing on this, Ms. de Leon highlighted Washington’s balance billing law. She discussed how Washington is enforcing its
law with a goal of giving providers and facilities a chance to correct or cure any violations. She also discussed how the Washington Department of Insurance (DOI) has established a partnership with state agencies with provider oversight to share information regarding any violations of the Washington law. The Washington DOI has signed a memorandum of understanding (MOU) regarding data sharing to assist in this partnership effort. Ms. de Leon noted that, to date, the Washington DOI has not received any complaints involving provider violations.

5. Received an Update on the Special (EX) Committee on Race and Insurance Workstream Five’s Work

Commissioner Altman, co-chair of the Special (EX) Committee on Race and Insurance Workstream Five, provided an update to the Committee on Workstream Five’s work to date. She said since the Workstream last updated the Committee at the Spring National Meeting, the Workstream met July 8 and June 10. She said during its June 10 meeting, the Workstream heard responses from a panel of industry representatives and a panel of consumer representatives on several key questions related to data collection. Those questions asked about the benefits of insurer collection of disaggregated demographic data, the risks of collecting such data and regulatory barriers to the collection of such data. She said the Workstream also asked the panelists to discuss what role state insurance regulators should have in collecting this type of data and whether there is a specific deliverable the NAIC should work towards in addressing this issue.

Commissioner Altman said Workstream Five’s July 8 meeting focused on issues related to provider networks, provider directories, and cultural competency. The Workstream asked panelists representing consumers, industry, and providers to respond to several key questions related to these issues, including: 1) whether there are ways state insurance regulators can incentivize more diverse, inclusive, and culturally competent provider networks; and 2) how provider directories can be used as a tool to connect patients to culturally competent providers. The Workstream also asked if there are specific deliverables the NAIC should work towards to address these issues.

Commissioner Altman said following these meetings, the Workstream prepared and distributed a draft data collection best practices document reflecting the discussion during the June 10 meeting for a public comment period ending Aug. 19. She said the Workstream plans to discuss any comments on the draft document during its Aug. 26 meeting.

Commissioner Altman said in looking ahead, the Workstream plans to continue meeting at least once a month to work on best practices documents and collect additional information on issues it identified in its report to the Special (EX) Committee on Race and Insurance. She said the Workstream anticipates finishing work on the data collection best practices document before the Fall National Meeting; and sometime in the Fall, the Workstream plans to begin work on a similar best practices document on provider network, provider directory, and cultural competency issues. She said during its November meeting, the Workstream plans to focus on health equity and COVID-19.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.
1. **Adopted Revised Regulatory Framework (B) Task Force Charges**

Commissioner Godfread said that during its June 15 meeting, the Regulatory Framework (B) Task Force adopted a new 2021 charge for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup to develop a white paper. He said the proposed charge was included in the Committee’s meeting materials. He asked if anyone had any questions about the charge. There were no questions.

Superintendent Toal made a motion, seconded by Commissioner Conway, to adopt the Regulatory Framework (B) Task Force’s revised 2021 charges, adding a new charge for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup to develop a white paper. The motion passed unanimously.

2. **Adopted the PBM Model**

Commissioner Godfread said that during the Committee’s meeting at the Spring National Meeting, the Committee deferred adoption of the proposed [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM model) in order to have more time to discuss it, particularly to discuss concerns expressed about the proposed drafting note for Section 8—Regulations. He explained that the proposed drafting note provides options to the states to add additional provisions to the pharmacy benefit manager (PBM) model regarding certain pharmacy benefit manager (PBM) business practices.

Commissioner Godfread explained his thoughts regarding the proposed PBM model and whether state departments of insurance (DOIs) are the appropriate state agency to regulate PBMs. He said North Dakota has such concerns, but North Dakota also recognizes that some states may have different thoughts on the issue. He requested comments. Commissioner Birrane acknowledged Commissioner Godfread’s concerns, but she noted that Maryland has enacted extensive legislation related to PBMs and that her concerns with the proposed PBM model related to the proposed Section 8 drafting note. She expressed concern about the approach taken in the drafting note and its impact on the uniform adoption of the PBM model, which is a key goal of NAIC models. Commissioner Birrane suggested that because of the newly adopted charge for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup to develop a white paper that would explore the PBM business practices in the drafting note, including current and emerging state laws on these practices, the white paper would be the better approach to take rather than the drafting note.

Commissioner Conway also acknowledged Commissioner Godfread’s comments on whether state DOIs are the appropriate state agency to regulate PBMs. He noted, however, that many states have already moved forward with having the state DOI be responsible for regulating PBMs. He also explained that in discussing the proposed PBM model with other NAIC members, some members expressed support for moving forward with a NAIC model regulating PBMs in order to have an NAIC model to support their ongoing efforts on this issue. Commissioner Conway noted Commissioner Birrane’s comments regarding the Section 8 drafting note and its possible deletion, particularly given the adoption of the white paper charge.

Commissioner Conway made a motion, seconded by Commissioner Birrane, to adopt the PBM model without the Section 8 drafting note. Commissioner Godfread asked if there was any discussion.

Carl Schmid (HIV+Hepatitis Policy Institute) said the NAIC consumer representatives submitted a comment letter to the Committee expressing support for adoption of the white paper charge for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup and support for adoption of the PBM model. He said the NAIC consumer representatives support moving forward.
with the PBM model with the Section 8 drafting note because it provides examples to those states that would like to move beyond PBM licensure or registration to include other provisions regulating PBM business practices. He acknowledged the concerns that some have raised related to the Section 8 drafting note and reiterated the NAIC consumer representatives’ support for moving forward with the PBM model.

The Committee discussed the background related to the Section 8 drafting note, including noting that the drafting note was a compromise between those states that wanted to add substantive provisions to the PBM model concerning some of these PBM business practices and those states that did not want to move beyond PBM licensure and registration. The Committee also discussed the importance of moving forward with the PBM model because it does set out structure for PBM licensure and registration for those states that wish to move forward with having that authority in the state DOI. The Committee also noted the importance of the work the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup will be doing in support of the PBM model with respect to the development of the white paper.

The motion to adopt the PBM model without the Section 8 drafting note (Attachment One-A) passed based on those Committee members present and voting.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

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[STATE] PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION MODEL ACT

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Section 1. Short Title

This Act shall be known and may be cited as the [State] Pharmacy Benefit Manager Licensure and Regulation Act.

Section 2. Purpose

A. This Act establishes the standards and criteria for the licensure and regulation of pharmacy benefit managers providing claims processing services or other prescription drug or device services for health benefit plans.

B. The purpose of this Act is to:

1. Promote, preserve, and protect the public health, safety and welfare through effective regulation and licensure of pharmacy benefit managers;

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

3. Provide for powers and duties of the commissioner; and

4. Prescribe penalties and fines for violations of this Act.

Section 3. Definitions

For purposes of this Act:

A. “Claims processing services” means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include:

1. Receiving payments for pharmacist services;

2. Making payments to pharmacists or pharmacies for pharmacist services; or

3. Both paragraphs (1) and (2).
B. “Commissioner” means the insurance commissioner of this state.

**Drafting Note:** Use the title of the chief insurance regulatory official wherever the term “commissioner” appears.

C. “Covered person” means a member, policyholder, subscriber, enrollee, beneficiary, dependent or other individual participating in a health benefit plan.

D. “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of [physical, mental or behavioral] health care services.

E. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health insurance company, a health maintenance organization, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

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

F. “Other prescription drug or device services” means services other than claims processing services, provided directly or indirectly, whether in connection with or separate from claims processing services, including, but not limited to:

1. Negotiating rebates, discounts or other financial incentives and arrangements with drug companies;
2. Disbursing or distributing rebates;
3. Managing or participating in incentive programs or arrangements for pharmacist services;
4. Negotiating or entering into contractual arrangements with pharmacists or pharmacies, or both;
5. Developing and maintaining formularies;
6. Designing prescription benefit programs; or
7. Advertising or promoting services.

G. “Pharmacist” means an individual licensed as a pharmacist by the [state] Board of Pharmacy.

H. “Pharmacist services” means products, goods, and services or any combination of products, goods and services, provided as a part of the practice of pharmacy.

I. “Pharmacy” means the place licensed by the [state] Board of Pharmacy in which drugs, chemicals, medicines, prescriptions and poisons are compounded, dispensed or sold at retail.

J. (1) “Pharmacy benefit manager” means a person, business or entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefit manager, that provides claims processing services or other prescription drug or device services, or both, to covered persons who are residents of this state, for health benefit plans.

(2) “Pharmacy benefit manager” does not include:
(a) A health care facility licensed in this state;

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

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

(d) A health carrier to the extent that it performs any claims processing and other prescription drug or device services exclusively for its enrollees.

Section 4. Applicability

A. This Act shall apply to a contract or health benefit plan issued, renewed, recredentialed, amended or extended on or after the effective date of this Act, including any health carrier that performs claims processing or other prescription drug or device services through a third party.

Drafting Note: States may want to consider adding language to Subsection A above or Section 10—Effective Date providing additional time for pharmacy benefit managers to come into compliance with the requirements of this Act.

B. As a condition of licensure, any contract in existence on the date the pharmacy benefit manager receives its license to do business in this state shall comply with the requirements of this Act.

C. Nothing in this Act is intended or shall be construed to conflict with existing relevant federal law.

Section 5. Licensing Requirement

A. A person may not establish or operate as a pharmacy benefit manager in this state for health benefit plans without first obtaining a license from the commissioner under this Act.

B. The commissioner may adopt regulations establishing the licensing application, financial and reporting requirements for pharmacy benefit managers under this Act.

Drafting Note: States that are restricted in their rulemaking to only what is prescribed in statute may want to consider including in this section specific financial standards required for a person or organization to obtain a license to operate as a pharmacy benefit manager in this state.

C. A person applying for a pharmacy benefit manager license shall submit an application for licensure in the form and manner prescribed by the commissioner.

Drafting Note: States may want to consider reviewing their third party administrator statute if a state wishes to specify what documents must be provided to the commissioner to obtain a pharmacy benefit manager license in the state.

D. A person submitting an application for a pharmacy benefit manager license shall include with the application a non-refundable application fee of $[X].

E. The commissioner may refuse to issue or renew a license if the commissioner determines that the applicant or any individual responsible for the conduct of affairs of the applicant is not competent, trustworthy, financially responsible or of good personal and business reputation or has been found to have violated the insurance laws of this state or any other jurisdiction, or has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction.

F. (1) Unless surrendered, suspended or revoked by the commissioner, a license issued under this section shall remain valid as long as the pharmacy benefit manager continues to do business in this state and remains in compliance with the provisions of this act and any applicable rules and regulations,
including the payment of an annual license renewal fee of $[X] and completion of a renewal application on a form prescribed by the commissioner.

(2) Such renewal fee and application shall be received by the commissioner on or before [x] days prior to the anniversary of the effective date of the pharmacy benefit manager’s initial or most recent license.

Section 6. Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices

A. In any participation contracts between a pharmacy benefit manager and pharmacists or pharmacies providing prescription drug coverage for health benefit plans, no pharmacy or pharmacist may be prohibited, restricted or penalized in any way from disclosing to any covered person any healthcare information that the pharmacy or pharmacist deems appropriate regarding:

(1) The nature of treatment, risks or alternative thereto;
(2) The availability of alternate therapies, consultations, or tests;
(3) The decision of utilization reviewers or similar persons to authorize or deny services;
(4) The process that is used to authorize or deny healthcare services or benefits; or
(5) Information on financial incentives and structures used by the insurer.

B. A pharmacy benefit manager may not prohibit a pharmacy or pharmacist from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the covered person if a more affordable alternative is available.

C. A pharmacy benefit manager contract with a participating pharmacist or pharmacy may not prohibit, restrict, or limit disclosure of information to the commissioner, law enforcement or state and federal governmental officials, provided that:

(1) The recipient of the information represents it has the authority, to the extent provided by state or federal law, to maintain proprietary information as confidential; and
(2) Prior to disclosure of information designated as confidential the pharmacist or pharmacy:
   (a) Marks as confidential any document in which the information appears; or
   (b) Requests confidential treatment for any oral communication of the information.

D. A pharmacy benefit manager may not terminate the contract of or penalize a pharmacist or pharmacy due to pharmacist or pharmacy:

(1) Disclosing information about pharmacy benefit manager practices, except for information determined to be a trade secret, as determined by state law or the commissioner; or
(2) Sharing any portion of the pharmacy benefit manager contract with the commissioner pursuant to a complaint or a query regarding whether the contract is in compliance with this Act.

E. (1) A pharmacy benefit manager may not require a covered person purchasing a covered prescription drug to pay an amount greater than the lesser of the covered person’s cost-sharing amount under the terms of the health benefit plan or the amount the covered person would pay for the drug if the covered person were paying the cash price.
Any amount paid by a covered person under paragraph (1) of this subsection shall be attributable toward any deductible or, to the extent consistent with section 2707 of the Public Health Service Act, the annual out-of-pocket maximums under the covered person’s health benefit plan.

Section 7. Enforcement

A. The commissioner shall enforce compliance with the requirements of this Act.

B. (1) The commissioner may examine or audit the books and records of a pharmacy benefit manager providing claims processing services or other prescription drug or device services for a health benefit plan to determine compliance with this Act.

Drafting Note: States may want to consider including a reference to the cost of examinations in the Model Law on Examinations (#390).

Drafting Note: States may want to consider incorporating their existing market conduct examination statutes into this Act rather than relying on the examination authority provided under this section.

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

(a) Considered proprietary and confidential;

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

(c) Not subject to subpoena; and

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

C. The commissioner may use any document or information provided pursuant to Section 6C of this Act or Section 6D of this Act in the performance of the commissioner’s duties to determine compliance with this Act.

D. The commissioner may impose a penalty on a pharmacy benefit manager or the health carrier with which it is contracted, or both, for a violation of this Act. The penalty may not exceed [insert appropriate state penalty] per entity for each violation of this Act.

Drafting Note: If an appeals process is not otherwise provided, a state should consider adding such a provision to this section.

Section 8. Regulations

The commissioner may adopt regulations regulating pharmacy benefit managers that are not inconsistent with this Act.

Section 9. Severability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of this Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 10. Effective Date

This Act shall be effective [insert date]. A person doing business in this state as a pharmacy benefit manager on or before the effective date of this Act shall have [six (6)] months following [insert date that the Act is effective] to come into compliance with the requirements of this Act.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met July 1, 2021. The following Subgroup members participated: Mary Kwei, Chair (MD); Debra Judy, Vice Chair, and Tara Smith (CO); William Rodgers (AL); Randy Pipal (ID); Michelle Baldock, Ryan Gillespie, and Sara Stanberry (IL); Alex Peck and Jennifer Groth (IN); Brenda Johnson (KS); Sherry Ingalls and Judith Watters (ME); Camille Anderson-Weddle, Carrie Couch, Amy Hoyt, Jessica Schrimpf, and Michelle Vickers (MO); Kathy Shortt (NC); Laura Arp and Barbara Peterson (NE); Mike Rhoads and Rebecca Ross (OK); Katie Dzurec, Elizabeth Hart, and Lars Thorne (PA); Gretchen Brodkorb, Candy Holbrook, and Jill Kruger (SD); Heidi Clausen and Tanji J. Northrup (UT); and Jennifer Stegall (WI). Also participating was: Jana Jarret (OH).

1. **Adopted its May 25 and April 1 Minutes**

   The Subgroup met May 25 and April 1. During its May 25 meeting, the Subgroup discussed a plan to complete several short consumer guides on the claims process. During its April 1 meeting, the Subgroup took the following action: 1) discussed potential topics for the Subgroup to address in 2021, such as the federal American Rescue Plan Act (ARPA), the claims process, and the federal No Surprises Act (NSA); and 2) discussed potential products for the Subgroup to develop in 2021, such as a series of briefs on claims, updating the Frequently Asked Questions (FAQ) on Health Care Reform document, and developing new products related to the NSA.

   Mr. Rhoads made a motion, seconded by Ms. Dzurec, to adopt the Subgroup’s May 25 (Attachment Two-A) and April 1 (see NAIC Proceedings – Spring 2021, Health Insurance and Managed Care (B) Committee, Attachment One) minutes. The motion passed unanimously.

2. **Discussed Briefs on the Claims Process**

   Ms. Kwei brought up the draft guides to the claims process: 1) appeals (Attachment Two-B); 2) codes and claims (Attachment Two-C); 3) explanation of benefits (EOBs) (Attachment Two-D); 4) filing health care claims (Attachment Two-E); and 5) medical necessity (Attachment Two-F). She asked members and interested parties to send detailed wording changes by email.

   Ms. Kwei asked for comments on the guide to filing claims. Kris Hathaway (AHIP) said her organization would send detailed wording changes. She also said the claims guide references explanations of benefits, but it did not explain what an EOB is. She suggested linking to the separate guide on EOBs. Harry Ting (Health Care Consumer Advocate) suggested the guide include a recommendation for consumers not to pay a bill from a provider before their health insurer has processed a claim. He also suggested a recommendation for consumers to tell their providers about all insurance plans they are enrolled in to facilitate coordination of benefits.

   Ms. Kwei brought up the guide on understanding EOBs. Mr. Ting said that consumers with more than one insurance plan should expect separate EOBs from each of their plans. Ms. Hathaway questioned whether the guide should reference surprise billing. Ms. Kwei said the group plans a separate guide on surprise billing. Ms. Judy asked about the reference to alternate addresses to send an EOB in case sending one to the policyholder would put an individual in danger. She said the language could also reference confidential services even without a threat of danger.

   Ms. Kwei asked for comments on the guide on understanding claims denials. Ms. Watters said that consumers must receive information on how to appeal in their denial letter, but the sample letter in the draft is a helpful resource for consumers.

   Ms. Kwei brought up the guide on medical necessity. Mr. Ting questioned whether the guide provides more detail than consumers are looking for. Ms. Watters said the content is challenging and hard to make consumer friendly. Ms. Kwei said providers’ offices could use the document in addition to consumers. Bonnie Burns (California Health Advocates—CHA) said the guide should refer consumers to the provisions in their plan documents rather than list complex definitions directly. Ms. Arp clarified the difference between consumer and provider appeals, saying that consumer appeals come with additional rights. She said she approves of the current language. Ms. Dzurec said that it would not be a bad thing if content from the documents overlapped and that complex medical necessity terms could be useful for some consumers. Ms. Jarret and Ms. Kruger said the guide should point out that medical necessity does not guarantee coverage of a service. Brenda J. Cude
(University of Georgia) asked about the difficult language in the medical necessity definition. Ms. Arp said the details are important for some cases and suggested referencing denials based on medical decision-making. Ms. Cude asked whether the language comes from plan language or state law.

Ms. Kwei asked for comments on the guide to claims codes. Ms. Hathaway said AHIP has suggested changes and examples to add in this guide.

Ms. Kwei said the Subgroup has held off on drafting a guide on balance billing while it awaits rules from the federal government under the NSA. She asked whether the Subgroup should continue to wait. Ms. Hathaway said that since rules are expected soon, the Subgroup should wait until its next meeting. Others agreed.

Ms. Kwei asked for comments on the overall structure of the guides. Ms. Judy and Ms. Cude supported the use of a question and answer (Q&A) format. Ms. Kwei asked whether the guides should be formatted or in plain text. Subgroup members said their states would want to add branding, so plain versions are preferred.

The Subgroup agreed to provide further edits within two weeks.

Ms. Shortt said she missed the early part of the meeting and asked about changes to the guide on medical necessity. She said the definitions were taken almost directly from the North Carolina statute. Ms. Kwei said some readers would appreciate more general descriptions, but others will want to know precisely what the statute says. Ms. Watters suggested more general language that then directs readers to each state's laws. The Subgroup discussed whether to use general language with pointers to other sources. Eric Ellsworth (Consumers' Checkbook) said that health insurers should be encouraged to post their definitions of medical necessity on their websites. Ms. Shortt, Ms. Arp, and Ms. Cude agreed to collaborate on updates to the medical necessity guide.

Ms. Kwei said the Subgroup plans to conduct an e-vote on the final documents once edits have been made.

Having no further business, the Consumer Information (B) Subgroup adjourned.
Consumer Information (B) Subgroup
Virtual Meeting
May 25, 2021

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met May 25, 2021. The following Subgroup members participated: Mary Kwei, Chair, and Paul Meyer (MD); William Rodgers and Anthony L. Williams (AL); Michele Mackenzie, Kathy McGill and Randy Pipal (ID); Michelle Baldock and Ryan Gillespie (IL); Alex Peck (IN); LeAnn Crow, Brenda Johnson and Tate Flott (KS); Judith Watters (ME); Helen Bassett, Galen Benshoof and Candace Gergen (MN); Camille Anderson-Weddle, Carrie Couch, Amy Hoyt, Jessica Schrimpf and Michelle Vickers (MO); Kathy Shortt (NC); Laura Arp and Martin Swanson (NE); Kurt Cagle and Mike Rhoads (OK); Katie Dzurec and Elizabeth Hart (PA); Gretchen Brodkorb, Lisa Harmon and Jill Kruger (SD); David Combs, Bill Huddleston, Jennifer Ramcharan and Vickie Trice (TN); Tanji J. Northrup, Shelley Wiseman and Jaakob Sundberg (UT); and Barbara Belling, Eric Corman, Diane Dambach, Darcy Paskey, Jennifer Stegall, Jody Ullman and Julie Walsh (WI). Also participating was: Jana Jarrett (OH).

1. Discussed Briefs on the Claims Process

Ms. Kwei noted that the Subgroup had finalized its addendum to the Frequent Asked Questions about Health Care Reform (FAQ) document, and she said the Subgroup would return to the FAQ document prior to the beginning of Open Enrollment in the fall. She said the Subgroup would next turn to consumer guides on the claims process, as had been discussed on previous calls.

Ms. Kwei asked for input from Subgroup members and interested parties on how the guides should be written. Bonnie Burns (California Health Advocates—CHA) asked whether the guides would take the form of a FAQ document. Ms. Kwei responded that she is open to suggestions; although, she said she envisioned a series of separate, stand-alone guides that were brief, hopefully 1–2 pages. She mentioned that one of the most popular documents Maryland makes available to consumers is a short one on in- versus out-of-network claims issues, with definitions, explanations and FAQ. Ms. Shortt said North Carolina provides consumers with a six-page toolkit on medical necessity denials that helps consumers through their own appeals. Ms. Jarrett suggested that the documents be thought of as tip sheets or infographics rather than guides. Harry Ting (Healthcare Consumer Advocate) said an existing brochure from Colorado is a useful model for appeals, as well as a sample letter Pennsylvania provides. Eric Ellsworth (Consumers Checkbook) said consumers need examples of what can be challenged through appeals and what cannot.

Ms. Kwei listed the topics that had been proposed and discussed on past calls, including filing claims; understanding explanations of benefits (EOBs); how to appeal a denial; medical necessity; balance billing; and CPT codes. Ms. Burns said the issues with current procedural terminology (CPT) codes should be covered in the guide to denied claims. She noted that individuals covered by Medicare and Medicaid have different issues with appeals, and there are a good deal of existing documents for the Medicare population. She asked whether EOBs are similar enough across insurers and different types of insurance (TOIs) that one guide could help with all of them. Ms. Kwei said EOBs are not standardized, but they all follow a general template. Ms. Dzurec said denial codes may not fully explain the reason a claim was denied; she said medical necessity may be implicated without being mentioned. She said those who appeal should start with the TOI, because the regulatory agency and potential helpers differ. She said after that determination, there is some baseline content that the Subgroup can develop, then work with sister agencies to determine what is helpful for those covered by other TOIs.

Joe Touschner (NAIC) asked whether the guides are intended for enrollees in state-regulated plans or for consumers with any type of coverage. Ms. Kwei said there is often a distinction made between public plans and commercial plans, and commercial plans include self-funded plans and others not regulated by the state. She said the focus should be on the plans states regulate; although, a guide on how to read an EOB should be applicable for non-state regulated plans, as well. Mr. Ting said a guide should have content for any consumer, regardless of their coverage source, even if it does not go into detail. Mr. Ellsworth said consumers want an answer to their question, not to understand how the health care system works. He suggested organizing around a specific situation a consumer is in. He said FAQ can offer smaller bits of information that are easier to read and better able to be formatted on a mobile-friendly web page.

Ms. Kwei asked about existing documents that can serve as models for the guides. Ms. Dzurec said Pennsylvania could share the script for its YouTube videos. The Subgroup discussed the benefits of both digital and paper-based materials.
Ms. Burns said consumers are interested in getting answers to their questions; i.e., what it is, what they are looking at, why it happened, what they can do about it, and where they can get help.

Ms. Shortt explained that North Carolina has a unit that helps consumers file appeals with their insurers, and it provides sample appeal letters, as well as brochures, that explain how to reach the department.

Ms. Watters suggested producing a document that is broad to increase literacy, rather than a specific how-to in constructing an appeal.

Ms. Kwei asked for an individual to take the lead on each of the topics, with others assisting. Subgroup members volunteered for each of the topics, except balance billing. Ms. Kwei suggested that the balance billing guide should wait until more is known about federal regulations under the No Surprises Act. Kris Hathaway (America’s Health Insurance Plans—AHIP) said her organization would soon complete a consumer-facing one-pager on the No Surprises Act and would share it with the Subgroup. Ms. Kwei said each topic should be covered in one to two pages; for some, a graphic may be the best way to explain it.

Ms. Burns asked if in- and out-of-network concepts should be included. Ms. Kwei said those concepts could be included in the other topics.

The Subgroup agreed that draft guides for each topic should be completed by the end of June.

Ms. Hathaway offered to review the guides for consistency with health plan operations.

2. Discussed Other Matters

Ms. Kwei said some questions have been raised regarding how the Subgroup can better reach consumers with its materials. She said the various sources of coverage, different insurance regulators, and variety of consumer situations all create challenges to having general materials. She said the Subgroup generally relies on states to fill in the specifics where they can. She said the Subgroup is open to suggestions on how it can better fulfill its charges, which center around developing resources for state insurance regulators and others who assist consumers.

Mr. Ting said consumer representatives are concerned that many consumers do not look for information online from insurance departments. He said departments should get the information out to consumers, rather than wait for consumers to come to the departments. He suggested a survey to identify best practices among the states. He said some examples are distributing guidance on choosing plans to consumers who disenroll from Medicaid or file unemployment claims. Ms. Arp said search optimization is important to ensure that insurance department materials come up when consumers search for information on claim denials or other issues. Ms. Dzurec suggested working with communications staff to think about how to better optimize for searches and otherwise break down silos between drafters and communications work.

Having no further business, the Consumer Information (B) Subgroup adjourned.
HOW TO APPEAL DENIED CLAIMS

...If Your Health Plan Says “NO”

You have the right to appeal your health plan’s denial of benefits for covered services that you and your health care provider (doctor, hospital, etc.) believe are medically necessary.

There are two kinds of appeals—internal appeal and external review

Things to Keep in Mind

Medicare & Medicaid
If you are enrolled in Medicare or Medicaid, there are different rules for appeals.
- For Medicare, call 1-800-MEDICARE to ask for information on free assistance.
- For Medicaid, contact your state’s Medicaid agency for assistance.

Keep Records
Keep detailed records, including bills from your provider, notices from your health plan, copies of denial letters, appeal requests and medical information related to your case.

Take Detailed Notes & Establish Response Deadlines
Write down the date/time of all calls, names of people with whom you spoke, details of all conversations and any established deadlines for expected responses or information from your insurance company.

Filing an Internal Appeal
By filing an internal appeal, you are requesting your health plan to review the denial decision in a fair and complete way. You have up to six months (180 days) after finding out your claim was denied to file an internal appeal.

⇒ If the denial is for a medical reason, ask your health care provider to contact your health plan to request reconsideration of your claim based on additional information that your provider can supply. If your life, health, or ability to function could be jeopardized, you can request that the appeal be reviewed on an expedited basis.

⇒ Ask your health plan how to file an internal appeal by contacting the customer service number provided on your insurance card/materials, or

⇒ Write a letter to your health plan requesting an internal appeal. Make sure to include your name, claim number, and health insurance ID number. You should include any additional information, such as a letter from your provider, that helps support your claim. (See reverse side for sample letter.)

Upon receiving your request, your health plan has a specific amount of time to review and issue a decision on the internal appeal.

Filing an External Review
If your health plan does not change its decision as a result of the internal appeal, an external review can be requested. An external review is performed by an independent review organization. You must ask for an external appeal within a specific amount of time after receiving the decision of your internal appeal.

⇒ Your internal appeal notice should provide information on requesting an external review.

⇒ Your state’s insurance regulatory agency is usually in charge of the external review process.

⇒ New information can be submitted to support your position.

⇒ The external reviewer will provide you and your health plan with written notice of its decision within a specific amount of time after receiving the review assignment.

⇒ If the external review results in a reversal of your health plan’s decision to deny, the company must approve benefits for the covered services.

If you have questions or think your health plan is doing something wrong, contact your state insurance regulatory agency. A directory of all state insurance regulatory agencies is

When you use medical services, you or your provider file a claim to your health plan. Most of the time, the health plan will pay the claim, either directly to the provider or to you if you have already paid for your medical care.

Sometimes your health plan will say “no” to a claim, if full or in part, for benefits or services you believe should have been covered. Here are the steps you can take....
Health Care Bills: Codes and Claims

Most of the time, your health care provider will submit claims to your health insurance plan for you, and you don’t need to know how information is entered on the claim. However, sometimes you may have to submit a claim yourself, or your plan may deny a claim. When that happens, you will want to know more about claims and the billing codes used on them.

Why would I need to worry about codes?

When you see a provider who does not participate in your health plan’s network, you might have to file a claim with the plan yourself. Filing a claim means asking the plan to pay its portion of the health care provider’s bill. In order to process the claim, your health plan will need to know the proper codes. You will need to get an invoice from your provider that includes the codes to submit with your claim.

Your health plan may also deny a claim. When you contact your health plan, you might be told that the wrong code was used. Knowing how codes are used can help you get your bill paid.

How are codes used on a claim?

Information is entered on claims using codes. These codes are used as a way to describe the service you received. There are diagnosis codes, which may also be called the ICD-10 codes. Diagnosis codes describe the reason that you received treatment. There are procedure codes, which may be called the CPT codes. These codes describe the treatment you received. There are also codes used by facilities and hospitals to describe the services or supplies they provided.

All of these codes make it possible to send the insurance company detailed information in a condensed way. There are standard references that define the codes, often with very specific details. When a code is used, it gives a summary of a detailed diagnosis or service, using a few numbers.

Why would the health plan deny a claim based on the code?

A health plan may deny a claim if the code does not match the services that were performed or the services the plan expected based on the diagnosis. The definitions of codes can be detailed, and if the medical records don’t record each detail of a code definition, the claim may be denied for an incorrect code. There may be another code that describes the services better.

When you see a doctor for what are called evaluation and management services, there are different levels of codes. Most visits to your family physician are evaluation and management services. The doctor asks about your medical history, examines you, and makes a decision about how to treat you. The level of the service depends on how complex these steps are and how long they take. There are five levels of these services. If the doctor’s office bills for a higher level than was provided, the claim may be denied.

There are other reasons that a claim may be denied based on the code that was used. You can call your health plan to ask questions, and also ask the provider’s billing office to check the code. You can also file an appeal of a denied claim.
Health Care Bills: Explanation of Benefits

After your visit to your doctor or another health care provider, you'll receive information about your claim in the form of an Explanation of Benefits, or EOB. The EOB is not a bill. It is an explanation generated as part of the claims process and shows you the payment breakdown for the services received.

**What does the EOB tell me?**

Essentially, the EOB will tell you how much your provider charged, how much the health plan paid, and how much you are responsible for or owe your provider. Your EOB comes from your health plan and is separate from the bill your provider may send. Make sure to compare “owed” amounts listed on the EOB with the bill from your provider’s office or the co-pay you already paid.

**What does the EOB look like?**

This document may be mailed to you or be made available electronically in your member portal.

Not all EOBs look alike, but here are a few things to look for on your EOB:

- Information about the person receiving the services, including the ID number and the member name sometimes identified as “patient” – if it’s your insurance, the EOB will usually include the notation “self” when referring to the patient, if the insurance is through your spouse or your parent, then their name will be included on the EOB;
- A list of the services received, which should include the dates of service and may include billing codes – if the billing codes are not provided on the EOB, there should be notes about how to get the codes if you would like to review them;
• Information about the provider or facility – this may be the name of a specific doctor, nurse practitioner, psychologist, physical therapist, etc., or it may be the name of a laboratory, hospital, or other office;
• The amount billed by the provider or facility;
• The “allowed” amount is the amount the health plan designates for each service – when you go to an in-network provider, the health plan will pay that provider all or a portion of a negotiated rate for the services provided. Do not be surprised if the allowed amount is lower than the provider/facility billed amount;
• The amount the health plan paid for each service.
• Any amount you owe to the provider – this amount may include the copay you paid in the office at the time of your visit;
• Information about denials, additional details, or other notes – you may see codes in line with each service, and the codes should be defined below the table listing the services.

How else is an EOB helpful?

The EOB is also an important tool for tracking how much you have spent on out-of-pocket health care costs. It will tell you how far along you are in meeting your deductible and your out-of-pocket limit for the year. If you’ve reached your out-of-pocket limit and you are asked to pay for services, you should contact your health plan right away.

Finally, your EOB has instructions for filing a grievance or appeal if coverage for your services is denied or only partially covered.

Who receives the EOB?

Usually, the EOB goes to the primary person listed on the health plan documents. If an employer provides the health plan, the employee is usually the person who receives EOBs, including the EOBs for a spouse and dependents. If disclosure of the information on an EOB would place you in danger, you may ask the health plan to send your EOBs to an alternate address.
Health Care Bills: Filing Health Insurance Claims

When you have a medical procedure or visit, you usually pay your health care provider (doctor, hospital, therapist, etc.) a co-pay to cover your portion of the provider’s bill. You expect your health plan to pay the rest of the bill. To ask the health plan to pay its share, the provider will file a claim with your health plan.

However, there are some cases when you might have to file a claim yourself. This could happen when you go to an out-of-network provider, when the provider does not accept your insurance, or when you are traveling.

If you need to file your own health insurance claim, here’s what you need to know:

**How do I file a claim with my health plan?**

Look at your health insurance card for the correct website or phone number to use.

There will likely be a link on the health plan’s website to file a claim. The plan will have a form to complete for filing a claim and information on how to submit the claim. If you cannot find this information on the website, call the number on your insurance card and the customer support representative can inform you how to file a claim.

**What will I need?**

You will need the itemized bill from your health care provider. This will include the date of service, a list of procedures or services completed, and the provider’s charge for each service. It will also include a description of each service or the code for each procedure.

You will also need information such as your social security number, your insurance ID number, your employment status (if the reason for medical care was due to an accident or illness at work), and whether to send payment directly to the provider or to you.

**When do I file the claim?**

File the claim as soon as it is possible after the procedure or service is completed. Many health plans have a time limit for how long you have to file a claim, such as within 90 days of the service.

**Where do I submit the claim?**

While each health plan will inform you where to send the information, often it is to the address on the back of your health insurance card.

**What happens after you file the claim?**

After you file the claim, the health plan has a limited time (it varies per state) to inform you if they have accepted or denied the claim. The company will send you an explanation of benefits. If you selected the payment to be sent directly to you, you will receive the payment and then you will need to pay the provider directly if you have not already done so.
What is medical necessity?

Medical necessity is a term used by health insurance companies to describe the coverage that is offered under a benefit plan. In the policy and benefit summary, the language that informs a person about what is covered under their insurance plan will generally describe benefits that are available “when medically necessary.” So, what does this mean?

How does medical necessity affect coverage for my health care services?

The way your health plan defines medical necessity impacts how it decides which health care services it will pay for. Generally, health plans pay a portion of the bill for covered services that fit the definition of medical necessity.

Health insurance plans will provide a definition of “medical necessity” or “medically necessary services” in the policy. There may also be a definition that is found in state law. The following elements may be included within a definition for “medical necessity.” These are services that are:

• provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and except for clinical trials that are described within the policy, not for experimental, investigational, or cosmetic purposes;
• necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease or its symptoms;
• within the generally accepted standards of medical care in the community; and/or
• not solely for the convenience of the insured, the insured’s family or the provider.

Policy language may also include provisions to consider:

• the cost effectiveness of the requested treatment;
• alternative services or supplies for covered services; and/or
• the setting where medically necessary services are eligible for coverage.

Self-funded plans that are not under state insurance regulatory authority typically hire Third Party Administrators to administer their health benefits. The Summary Plan Description, which describes the covered services and issued to covered employees, may include a definition for medical necessity.

Medicare defines “medically necessary” as health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Each state may have a definition of “medical necessity” for Medicaid services within their laws or regulations.

How is “medical necessity” determined?

A doctor’s attestation that a service is medically necessary is an important consideration. Your doctor or other provider may be asked to provide a “Letter of Medical Necessity” to your health plan as part of a “certification” or “utilization review” process. This process allows the health plan to review requested medical services to determine whether there is coverage for the requested service. This can be done before, during, or after the treatment.

A “precertification review” is conducted before the treatment has been provided and allows the health plan to decide if the requested treatment satisfies the plan’s requirements for medical necessity. This can be done by reviewing the Letter of Medical Necessity, medical records, and the plan’s medical policies for coverage.

A “concurrent review” occurs during the treatment to decide if the ongoing treatment is medically necessary.

A “retrospective review” occurs after the treatment has been provided to decide if the services were medically necessary, experimental, cosmetic or sometimes whether there was truly a need for emergency services.

What is a medical policy?

Definitions for medical necessity include a requirement that the treatment is within the accepted standards in the medical community. This is defined in the health plan’s medical policy.

A health plan must make its medical policy available to you if it is used to make a decision to deny you coverage.
What about experimental, investigational or cosmetic services?

Some definitions of medical necessity include the requirement that they are “not for experimental, investigational or cosmetic purposes.” Health plans may use their medical policies to determine if a treatment is considered experimental for your condition. This holds true for conditions that can be considered cosmetic but may also have a medical purpose. Medical records may be used to help make medical necessity determinations, but decisions may be based on the available scientific literature as well.

Does medical necessity affect emergency services?

Emergency services may be reviewed retrospectively to see if the care was appropriate to your diagnosis and medically necessary for an emergency level of care. The standard for making this coverage decision is made on the “prudent layperson” standard, which allows that a precertification is not necessary if a prudent layperson would believe that an emergency condition existed and that a delay in treatment would worsen that condition.

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The Health Innovations (B) Working Group met July 27, 2021. The following Working Group members participated: Andrew R. Stolfi, Chair, and TK Keen (OR); Laura Arp, Co-Vice Chair (NE); Nathan Houdek and Jennifer Stegall, Co-Vice Chairs, Barbara Belling, Diane Dambach, Darcy Paskey, Jody Ullman, and Richard Wicka (WI); Andria Seip and Cynthia Banks Radke (IA); Stephen Chamblee, Meghann Leaird, and Alex Peck (IN); Craig Van Aalst, Julie Holmes, Vicki Schmidt, and Tate Flott (KS); Sherry Ingalls, Joanne Rawlings-Sekunda, and Mary Hooper (ME); Karen Dennis, and Sarah Wohlford (MI); Carrie Couch, Chlora Lindley-Myers, and Amy Hoyt (MO); Chrystal Bartuska, John Arnold, Angie Voegele and Karri Volk (ND); Lisa Cota-Robles, Michelle Heaton and Maureen Belanger (NH); Philip Gennace (NJ); Paige Duhamel and Viara Ianakieva (NM); Jessica K. Altman and Sandra L. Ykema (PA); Rachel Bowden, Valerie Brown, Blake Davenport, R. Michael Markham, Dylan MacInerney, Monica Pinon, and Barbara Snyder (TX); Heidi Clausen, Shelley Wiseman, Tanji J. Northrup, and Jaakob Sundberg (UT); Jane Beyer and Jennifer Kreitler (WA); and Joylynn Fix (WV).

1. **Adopted March 26 Minutes**

The Working Group met March 26 and took the following action: 1) heard presentations on telehealth policy changes during the COVID-19 pandemic; and 2) discussed changes to state insurance department business practices during the pandemic.

Commissioner Altman made a motion, seconded by Commissioner Schmidt, to adopt the Working Group’s March 26 minutes (see NAIC Proceedings – Spring 2021, Health Insurance and Managed Care (B) Committee, Attachment Two). The motion passed unanimously.

2. **Discussed New Charges from the Special (EX) Committee on Race and Insurance**

Commissioner Stolfi brought up charges for the Working Group recently approved by the Special (EX) Committee on Race and Insurance. He said they focus on two methods that could be used to reduce disparities, including telehealth and alternative payment models. He said they also ask the Working Group to evaluate programs to reduce racial disparities. Commissioner Stolfi said a potential way is to gather information on two questions: 1) Does telehealth reduce disparities by improving access to care?; and 2) Do alternative payment models reduce disparities by improving access to care? He said after evaluating the questions, the Working Group could make recommendations to the Health Insurance and Managed (B) Committee and ultimately the Special (EX) Committee on Race and Insurance.

Commissioner Stolfi asked for input on this approach. Commissioner Altman said the plan makes sense. She said that telehealth could possibly exacerbate disparities but also has the potential to reduce them. Commissioner Stolfi said another part of the charge centers on programs to improve access to historically underserved communities. He asked Working Group members and interested parties to send ideas and programs that should be addressed under this part of the charge.

3. **Heard Presentations on Price Transparency**

Commissioner Stolfi said price transparency ideally would be beneficial to consumers and that it could change dynamics between payers and providers and reduce costs.

Dr. Terri Postma (federal Centers for Medicare and Medicaid Services—CMS Center for Medicare) provided an overview of the hospital price transparency requirements. She said the rule is a first step and must be viewed in context with other transparency rules. She said prior rules required chargemaster prices to be posted online. She said that due to concerns with this rule, the CMS updated the rules to require hospitals to post their standard charges in two ways. She said they must display charges for “shoppable” services in consumer-friendly formats and all charges in machine-readable format. She outlined key definitions in the rule, including which hospitals must comply, how items and services are identified, and what “standard charges” means. She noted the monitoring and enforcement authorities of the CMS.

Matthew Lynch (federal Center for Consumer Information and Insurance Oversight—CCIIO). Mr. Lynch said a recent executive order on transparency shows the administration’s commitment to the issue. He reviewed the transparency in coverage...
requirements applicable to insurers. Mr. Lynch identified the two key provisions as: 1) a requirement for a self-service price comparison tool for consumers to determine their out-of-pocket costs in advance of a service; and 2) a requirement to post prices for 500 shoppable services by January 2023. He said insurers must disclose the remainder of services by January 2024. He said the rule also requires posting of machine-readable files with in-network negotiated rates and historical out-of-network payments. He said states have primary enforcement authority, so the CMS would enforce only if a state does not substantially enforce, except for federal Employee Retirement Income Security Act (ERISA) plans. He provided the email for questions about the insurer transparency rules, PriceTransparencyinCoverage@cms.hhs.gov.

Commissioner Stolfi asked what level of compliance the CMS has seen with the rules. Dr. Postma said the CMS has conducted proactive audits since January and also received complaints. She said her impression is most issues are with the comprehensive machine-readable file requirement. She said the CMS plans an open-door forum to clarify the requirement. She said some hospitals offer price estimator tools that give a range of prices, not a consumer-specific amount that takes their insurance coverage into consideration.

Dr. Postma discussed billing codes, clarifying the different types of codes used to classify prices. Mr. Lynch said the CCIIO would use similar codes.

Commissioner Stolfi asked about the shoppable services. Dr. Postma said her team worked with the CCIIO to analyze Exchange data and other research to identify commonly used services. Mr. Lynch said the CCIIO looked at both commonly used services and services that have wide cost differences in the same geography.

Mr. Sundberg asked whether price transparency could lead hospitals to raise prices and how prices could be tracked over time to determine if prices do increase. Dr. Postma said the CMS concluded that the benefits of transparency greatly outweigh the risk of higher prices. She said machine-readable files must include date information. Mr. Lynch said the long-term goal is lowering prices, but in the short-term, there could be an effect of reduced dispersion in prices, which would include raising the lowest prices and lowering the highest.

Robin Gelburd (FAIR Health) outlined FAIR Health’s work as a private claims repository. She said FAIR Health works with federal agencies and state governments to provide trusted, independent data. She discussed the tools FAIR Health makes available for consumers to research medical costs, including both in-network and out-of-network prices. She said integrating price transparency into clinical decision aids can improve shared decision making between patients and providers. She mentioned FAIR Health’s research and resources, including reports on COVID-19 and a monthly telehealth tracker.

Eric Ellsworth (Consumers’ Checkbook) presented on how greater data would be more useful for consumers. He said consumers shop not only on cost, but also on value, so health care shopping should evolve in that direction. He said price transparency is a big step forward, but consumers still lack key information to aid their shopping. He said that consumers do not order medical services for themselves and that insurers determine payment amounts. He pointed out that consumers often hold the risk for unexpected costs and bad outcomes and that they may never know the full cost of their care. He said consumer needs include individual provider-level quality information, better information on network status, cost information organized around consumer decisions rather than billing codes, detailed estimates of costs with contingency information, and better protection from claim denials. He described requirements for advance explanations of benefits (EOBs) as a game changer, but he said machine-to-machine data flows need to be improved. He said patient-reported outcomes are the biggest gap in quality reporting.

Commissioner Stolfi asked about the use of data from All Payer Claims Databases (APCDs). Ms. Gelburd said that FAIR Health conducted a pilot with New York to make APCD data available to consumers.

Having no further business, the Health Innovations (B) Working Group adjourned.
HEALTH ACTUARIAL (B) TASK FORCE

The Health Actuarial (B) Task Force did not meet at the Summer National Meeting.
REGULATORY FRAMEWORK (B) TASK FORCE

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Draft: 8/9/21

Regulatory Framework (B) Task Force
Virtual Meeting (in lieu of meeting at the 2021 Summer National Meeting)
July 28, 2021

The Regulatory Framework (B) Task Force met July 28, 2021. The following Task Force members participated: Michael Conway, Chair (CO); Glen Mulready, Vice Chair (OK); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling represented by Anthony L. Williams and Jennifer Li (AL); Evan G. Daniels represented by Jon Savary and Erin Klug (AZ); Ricardo Lara represented by Tyler McKinney (CA); Andrew N. Mais represented by Jared Kosky (CT); David Altmaier represented by Chris Struk (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron (ID); Dana Popish Severinghaus represented by Ryan Gillespie (IL); Amy L. Beard represented by Claire Szpara and Alex Peck (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); Gary D. Anderson represented by Kevin Beagan (MA); Eric A. Cioppa represented by Marti Hooper (ME); Anita G. Fox represented by Renee Campbell and Karen Dennis (MI); Grace Arnold represented by Galen Benshoof, Peter Brickwedde, and Sarah Wohlford (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Ted Hamby (NC); Jon Godfred represented by John Arnold and Chrystal Bartuska (ND); Eric Dunning (NE); Chris Nicolopoulos represented by Michelle Heaton (NH); Judith L. French represented by Laura Miller, Theresa Schaefer, and George McNab (OH); Andrew R. Stolfi represented by TK Keen (OR); Jessica K. Altman (PA); Larry D. Deiter (SD); Doug Slape represented by Rachel Bowden, David Bolduc, and Richard Lunsford (TX); Jonathan T. Pike represented by Jaakob Sundberg and Shelley Wiseman (UT); Scott A. White represented by Julie Blauvelt, Bob Grissom, and Bradley Marsh (VA); Mike Kreidler represented by Molly Nollette, Jane Beyer, and Kimberly Tocco (WA); Mark Afable represented by Richard Wicka and Nathan Houdek (WI); and James A. Dodrill represented by Joylynn Fix and Tonya Gillespie (WV). Also participating was: Russell Toal (NM).

1. **Adopted its June 15 and Spring National Meeting Minutes**

The Task Force met June 15 to adopt a new 2021 charge for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup to develop a white paper on issues related to the state regulation of certain pharmacy benefit manager (PBM) business practices and the effect, if any, of the recent U.S. Supreme Court decision in *Rutledge v. the Pharmaceutical Care Management Association (PCMA)* on these current and emerging state laws and regulations regulating such business practices. The white paper will also examine the role PBMs, pharmacy services administrative organizations (PSAOs), and other prescription drug supply chain entities play in the provision of prescription drug benefits.

Commissioner Altman made a motion, seconded by Commissioner Deiter, to adopt the Task Force’s June 15 (Attachment One) and March 25 (see NAIC Proceedings – Spring 2021, Regulatory Framework (B) Task Force) minutes. The motion passed unanimously.

2. **Adopted its Subgroup and Working Group Reports**

Commissioner Altman made a motion, seconded by Commissioner Clark, to adopt the following reports: the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its July 12 (Attachment Two) and June 7 (Attachment Three) minutes; the Employee Retirement Income Security Act (ERISA) (B) Working Group; the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, including its April 21 minutes (Attachment Four); and the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup. The motion passed unanimously.

3. **Received a Work Status Update for the ERISA (B) Working Group and the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup**

a. **ERISA (B) Working Group**

Jolie Matthews (NAIC) said the Employee Retirement Income Security Act (ERISA) (B) Working Group plans to meet July 30 to discuss any updates to the *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook) related to the U.S. Supreme Court’s decision in *Rutledge* with respect to ERISA preemption of state laws regulating PBM business practices. The Working Group will also discuss the *Rutledge* decision in relation to the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup’s new 2021 charge to develop a white paper discussing state laws regulating PBM business practices. Following these discussions, the Working Group plans to adjourn into regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings.
b. Pharmacy Benefit Manager Regulatory Issues (B) Subgroup

Mr. Keen said the Pharmacy Benefit Manager (B) Subgroup plans to hold a few organizational meetings to determine what information it needs to work on its new 2021 charge to develop the white paper. He explained that the Subgroup will not be starting its work from scratch because of its work related to the development of the proposed [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM model), but he anticipates the Subgroup will have to hold informational meetings on subjects that it did not consider during that work. The Subgroup also could establish a few ad hoc groups to work on different aspects of the white paper. Mr. Keen said he anticipates the Subgroup will begin meeting following the Summer National Meeting to develop a work plan. He said some the Subgroup’s first meetings will be regulator-to-regulator meetings to discuss a path forward. Mr. Keen said he plans to provide updates to the Task Force on the Subgroup’s work as it moves forward.

4. Heard an Update on the CHIR’s Work Related to the ACA

Christine Monahan (Center on Health Insurance Reforms—CHIR, Georgetown University’s McCourt School of Public Policy) provided an update on the CHIR’s work related to the federal Affordable Care Act (ACA) and recently enacted federal laws such as the federal No Surprises Act (NSA) and the federal American Rescue Plan Act (ARPA) and other issues of interest to state insurance regulators. She discussed the CHIR’s recent publications, including a 50-state survey of state employee benefit plans and efforts to restrain health care costs. The CHIR received responses from 47 states and interviewed state employee benefit plan administrators in 11 of those states to better understand what these states are doing to address health care costs. The CHIR also recently published issue brief on state actions between March 2020 and March 2021 to expand telemedicine access during COVID-19 and future policy considerations.

Ms. Monahan said the CHIR is researching and expects to release issue briefs or blogs on standardized plans, limited plan sales, state “Easy Enrollment” programs, efforts by select state-based marketplaces (SBMs) to improve health equity, and small group health insurance market trends. She highlighted some of the CHIR’s future work related to NSA implementation, including working with states with existing balance billing laws and technical assistance available to the states and its ongoing work related to network adequacy. Ms. Monahan said the CHIR is closely monitoring federal and state efforts to develop and implement public options. She said the CHIR recently published a blog post for the Commonwealth Fund comparing the laws in Washington, Colorado, and Nevada.

Ms. Monahan said the CHIR is beginning to examine the role of ERISA and its impact on state efforts to address cost containment with respect to employer plans. She said that among other things, the CHIR wants to better understand the legal landscape facing states that want to try to encourage cost containment among employer plans and document current efforts in this area. She said that one goal of this research is for the CHIR to make recommendations on whether and to what extent federal legislative or regulatory changes are needed to better foster cost containment by employer plans. As part of this research effort, the CHIR plans to reach out to stakeholders and conduct interviews in late 2021. She said to let the CHIR know if anyone is interested in this issue or knows of specific stakeholders the CHIR should interview.

5. Heard a Presentation on the NSA IFR and Implications for the States

Katie Keith (Out2Enroll) and Jack Hoadley (Georgetown University Health Policy Institute) presented on the recently issued NSA interim final rule (IFR) and implications for the states. Ms. Keith provided an overview of the NSA’s scope, including what types of plans it covers and where its protections apply. She said the NSA’s IFR was issued July 1 with an effective date of Sept. 13. The IFR was issued jointly by the U.S. Department of Labor (DOL), the U.S. Department of Health and Human Services (HHS), the U.S. Department of the Treasury (Treasury Department), and the U.S. Office of Personnel Management (OPM).

Ms. Keith said the IFR includes provisions focused on both patients and regulated entities. She explained that the patient-focused provisions outline how patients can calculate cost-sharing, include notice-and-consent waivers provisions, and establish a consolidated complaints process. The regulated entities-focused provisions outline how to calculate the qualifying payment amount and include disclosure requirements and provisions related to communications between insurers and providers.

Mr. Hoadley discussed the scope of the NSA’s balance billing protections with respect to the types of providers subject to its requirements. He explained that the NSA applies to emergency care provided in in-network or out-of-network facilities. Specifically, the NSA includes emergency departments and independent free-standing emergency departments. He said the IFR extends the scope of the NSA’s protections to urgent care services licensed by the state for emergency services. Mr. Hoadley also discussed the NSA’s protections with respect to post-stabilization services, including its application regardless of where in a hospital the services are furnished. He said the IFR includes strong patient protections for waivers in
these circumstances, including requirements that: 1) the patient must be able to travel using nonmedical/nonemergency transportation; 2) the patient gives informed consent; and 3) the in-network facility is within a reasonable distance. He also discussed the scope of the NSA’s protections regarding air ambulance services providers.

Mr. Hoadley discussed the NSA’s protections in circumstances where a patient receives non-emergency services from an out-of-network provider while at an in-network facility. He explained what facilities are included in the NSA’s definition of “health care facility” but noted that the IFR does not identify any additional facilities, which leaves open as to whether the NSA’s protections for non-emergency services would apply to other facilities not included in the NSA’s definition, such as urgent care facilities and retail clinics. Mr. Hoadley discussed other clarifying provisions in the IFR regarding services provided by out-of-network providers in an in-network facility.

Mr. Hoadley detailed the notice and consent provisions explaining what a patient can and cannot waive with respect to the NSA’s balance billing protections. Patients can knowingly and voluntarily agree to be balance billed by out-of-network providers but only for: 1) non-emergency care from an out-of-network provider; or 2) out-of-network post-stabilization services. Patients can not waive protections: 1) when there is no in-network provider available; 2) for urgent or unforeseen care; 3) when services are delivered by providers in designated specialties, such as anesthesiology, radiology, hospitalists, or intensivists; and 4) post-stabilization services except for out-of-network post-stabilization services. The IFR includes a draft standard notice and consent form. He said the federal agencies are seeking comment on the draft notice and consent form and are interested in any forms that those states with existing balance billing laws may use.

Mr. Hoadley explained the IFR’s provisions concerning the in-network qualifying payment amount (QPA) for an out-of-network provider. The IFR spells out definitions and methodology for determining the QPA. It also includes additional provisions affecting the QPA, including minimizing the influence of outlier prices that could skew the QPA higher. He pointed out that the IFR does not include the NAIC’s recommendation to base region on qualified health plan (QHP) rating areas, but uses another principle suggested—metropolitan statistical areas (MSAs) and non-MSA areas in a state. Mr. Hoadley also explained that the IFR defines what a “specified state law” is for purposes of determining what method will be used to determine the amount of payment to an out-of-network provider, which could be either a payment standard or arbitration or a combination of both. The IFR also specifies that states with self-funded opt-in programs can maintain those programs. If state law does not apply, the NSA applies.

Mr. Hoadley said the IFR confirms that state departments of insurance (DOIs) are the primary enforcers of provisions that apply to insurers and fully insured health products. The HHS will enforce the NSA’s requirements in states that fail to substantially enforce the law. The DOL will enforce the NSA’s provisions for self-funded group health plans. The same enforcement framework is established with respect to providers, including air ambulances. Mr. Hoadley noted that the NSA and the IFR are silent on which state agency is to enforce the NSA’s provider provisions.

Mr. Hoadley discussed key considerations for the states, particularly that state laws can be more protective of consumers if the state law does not “prevent the application of federal law.” The IFR includes a few examples of this. He also noted that the IFR does not specify which state laws qualify as “specified state law” or when the “specified state law” would apply. He explained that the IFR sets out specific scenarios in determining whether the “specified state law” would apply or the NSA.

Ms. Keith said it is anticipated that the federal government will issue additional NSA rules in 2021, including federal rules on the independent dispute resolution process (interim final rule) and enforcement and air ambulance data reporting (proposed rule). She said additional federal rulemaking will occur over time on other NSA requirements, such as accurate provider directories, gag clauses, and PBM reporting requirements. However, these rules will not be promulgated prior to the NSA’s 2022 effective date.

Commissioner Mulready asked about how the NSA and the IFR treats emergency services and urgent care services. He noted Mr. Hoadley’s discussion about whether urgent care facilities will be considered “health care facilities” for purposes of the NSA. Mr. Hoadley said the NSA focuses on emergency services provided in relation to an emergency department—not urgent care services provided in an urgent care center unless the state licenses the urgent care center to provide emergency services. He said that because of this, if a consumer receives services at an out-of-network urgent care center, then the NSA would not provide balance billing protections because the urgent care center will be considered to have provided non-emergency services, not emergency services.

Commissioner Conway asked about the IFR’s provisions regarding the circumstances when a consumer can waive the NSA’s balance billing protections. He said that in Colorado, essentially any provider can ask a consumer to waive Colorado’s balance billing protections. He asked Mr. Hoadley if the NSA, which restricts the ability of certain types of providers from asking
consumers to waive its balance billing protections, would prevail over Colorado’s law. Mr. Hoadley said that although the IFR does not strictly detail this situation, he believes that the NSA would most likely prevail.

Having no further business, the Regulatory Framework (B) Task Force adjourned.
The Regulatory Framework (B) Task Force met June 15, 2021. The following Task Force members participated: Michael Conway, Chair (CO); Glen Mulready, Vice Chair, represented by Andrew Schallhorn and Mike Rhoads (OK); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling represented by William Rodgers, Reyn Norman, and Yada Horace (AL); Evan G. Daniels represented by Jon Savary (AZ); Ricardo Lara represented by Bruce Hinze and Tyler McKinney (CA); Andrew N. Mais represented by Jared Kosky (CT); David Altmaier represented by Chris Struk (FL); Doug Ommen (IA); Dean L. Cameron represented by Kathy McGill (ID); Dana Popish Severinghaus represented by Eric Anderson and Ryan Gillespie (IL); Amy L. Beard represented by Claire Szpara and Alex Peck (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); Gary D. Anderson represented by Kevin Beagan (MA); Eric A. Cioppa represented by Robert Wake (ME); Anita G. Fox represented by Chad Arnold, Sarah Wohlford, and Karen Dennis (MI); Grace Arnold represented by Galen Benshoof, Chad Arnold, and Sherri Mortensen-Brown (MN); Chlora Lindley-Myers represented by Amy Hoyt and Camille Anderson-Weddle (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Martin Swanson and Tom Green (NE); Chris Nicolopoulos represented by Maureen Belanger (NH); Marlene Caride represented by Chanell McDevitt (NJ); Judith L. French represented by Marjorie Ellis (OH); Andrew R. Stolfi represented by TK Keen (OR); Jessica K. Altman (PA); Larry D. Deiter represented by Jill Kruger (SD); Doug Slape represented by Rachel Bowden and David Bolduc (TX); Jonathan T. Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Don Beatty (VA); Mike Kreidler represented by Molly Nollette (WA); Mark Afable represented by Nathan Houdek and Jennifer Stegall (WI); and James A. Dodrill represented by Ellen Potter (WV).

1. **Adopted a New Pharmacy Benefit Manager Regulatory Issues (B) Subgroup Proposed Charge**

Commissioner Conway said that during the Task Force’s March 18 meeting, the Task Force discussed and agreed to consider a new 2021 charge for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup to develop a white paper consistent with some of the comments received on the draft [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM model). He said that prior to the meeting, NAIC staff distributed a draft of the proposed charge for the Subgroup to “develop a white paper to: 1) analyze and assess the role PBMs play in the provision of prescription drug benefits; 2) identify, examine, and describe current and emerging state regulatory approaches to PBM business practices, such as price transparency and reporting requirements, rebating, and spread pricing, including the implications of the Rutledge vs. Pharmaceutical Care Management Association (PCMA) decision on such business practices; and 3) discuss any challenges, if any, the states have encountered in implementing such laws and/or regulations.”

Commissioner Conway said the Task Force received comments on the proposed charge from America’s Health Insurance Plans (AHIP), the Blue Cross and Blue Shield Association (BCBSA), the National Community Pharmacists Association (NCPA), and the Pharmaceutical Care Management Association (PCMA). He requested comments from the Task Force on the proposed charge. Mr. Swanson expressed support for the proposed charge, particularly the importance of cataloging current state laws regulating pharmacy benefit manager (PBM) business practices and emerging state laws. He also stressed the importance of examining PBM functions and seeing how they are operating. Mr. Swanson also discussed the importance of the white paper including some sort of analysis of the cost versus the benefits of PBM regulation and how it is working operationally with respect to consumers and other stakeholders, such as state departments of insurance (DOIs). He said it is important that the white paper examine the entire prescription drug supply chain, starting with the prescription drug manufacturers to the insurer contracts with the PBMs, pharmacists, and other entities involved in the supply chain, and ending with the end user, the consumer. The white paper should not just focus on PBMs. Mr. Swanson also agreed that it is important the white paper examine the Rutledge decision and the implications of that decision, if any, on states implementing laws on PBM business practices, including contracting issues.

Mr. Wake expressed support for Mr. Swanson’s comments suggesting the white paper examine the entire prescription drug supply chain. He also agreed with Mr. Swanson’s comments concerning the Rutledge decision. Mr. Kosky also agreed with Mr. Swanson’s comments with respect to examining and understanding the entire prescription drug supply chain to avoid the balloon effect of making regulatory changes to one part of the supply chain, which might affect costs and unintentionally shifting that change in cost to another part of the chain. Additional Task Force members expressed support for broadening the proposed charge to include other entities in the prescription drug supply chain. The Task Force also discussed, but it deferred.
deciding on, whether the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup’s name would have to be changed to reflect the addition of other entities involved in the prescription drug supply chain.

Kris Hathaway (AHIP) discussed AHIP’s comment letter. She explained AHIP’s recommendation to broaden the proposed charge to include other entities in the prescription drug supply chain in addition to PBMs and the role these entities play in the provision of affordable prescription drug benefits. She noted the recent passage of pharmacy service administrative organization (PSAO) transparency legislation in Maryland. She said this legislation illustrates steps the states can take to conduct a more thorough, holistic review of the prescription drug supply chain and better understand all aspects of drug pricing. Ms. Hathaway also said AHIP supports the NAIC conducting an analysis of the Rutledge decision. Randi Chapman (BCBSA) said the BCBSA, like AHIP, supports broadening the proposed charge to include other entities in the prescription drug supply chain. She said the BCBSA also supports the NAIC’s planned analysis of the Rutledge decision. She noted that this year, at least 35 states have introduced PBM legislation in response to that decision. Given this, it is important for the NAIC to review and analyze this legislation to fully understand the scope of these bills and any unintentional barriers such legislation could place on patient access to medication.

Lauren Rowley (PCMA) discussed the PCMA’s comment letter, which includes a recommendation to expand the charge to include other entities involved in the prescription drug supply chain. She also noted the recent legislation passed in Maryland related to PSAOs and similar legislation recently passed in Louisiana. Ms. Rowley said that although it is not included in the PCMA’s written comments, the PCMA reiterates its suggestion that the Employee Retirement Insurance Security Act (ERISA) (B) Working Group is the more appropriate NAIC group to initially examine the Rutledge decision given its members’ expertise on ERISA preemption issues.

The Task Force discussed the PCMA’s suggested revisions to the proposed charge. Some Task Force members expressed concern with potentially narrowing the charge with the PCMA’s suggestion to revise the language to state “PBM business practices related to drug prices,” particularly if one goal of this proposed charge is to allow the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup to examine the business practices in the drafting note in Section 8—Regulations of the draft [State] Pharmacy Benefit Manager Licensure and Regulation Model Act. For similar reasons, some Task Force members expressed concern with deleting the word “rebating” and substituting in its place the language “manufacturer rebates.” Ms. Rowley explained the PCMA’s reasoning for narrowing the proposed charge with its suggested revisions.

Matthew Magner (NCPA) discussed the NCPA’s comments, including its suggested revisions to the proposed charge. He said the NCPA suggests certain revisions to the proposed charge in recognition of the fact that PBMs play a larger role in the provision of prescription drug benefits far beyond administering reimbursements to providers on behalf of insurers, such as creating provider networks, negotiating drug prices and rebates, and developing drug formularies. Mr. Magner said the NCPA also believes it is important the proposed charge includes not only identifying, examining, and describing current and emerging state regulatory approaches to PBM business practices, but their sources of revenue as well. He said another suggested revision to the proposed charge would require a discussion of any challenges the states have in investigating violations of their laws or regulations. The Task Force discussed NCPA’s suggested revisions to the proposed charge. After discussion, the Task Force concluded that generally, the language of the proposed charge would address the NCPA’s suggested revisions.

Carl Schmid (HIV+Hepatitis Policy Institute) expressed support for the proposed charge, noting the NAIC consumer representatives had initially suggested the Subgroup be charged with developing a white paper during the Task Force’s March 18 meeting. He said the NAIC consumer representatives did have questions as to the process the Subgroup would use to complete the proposed charge, such as contracting out to a third party, and the timeline for completing the charge. He also noted the role PBMs play in other aspects of the prescription drug supply chain, such as PBMs’ role in determining patient cost. Mr. Schmid also expressed support for including the NCPA’s suggested revisions to the proposed charge and expansion of the charge beyond a focus on drug pricing, as the PCMA suggests.

Commissioner Conway said that based on the discussion, he believes the Task Force has consensus to revise the proposed charge to add the following language from the PCMA’s comment letter: “Pharmacy Services Administrative Organizations (PSAOs) and other supply chain entities.” No one disagreed. Mr. Hinze made a motion, seconded by Mr. Keen to add the PCMA language to the proposed charge (Attachment One-A). The motion passed unanimously.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

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2021 REVISED CHARGES

REGULATORY FRAMEWORK (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products and Services

1. The Regulatory Framework (B) Task Force will:
   A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
   B. Review managed health care reforms, their delivery systems occurring in the marketplace and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority and structures.
   C. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
   D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in 2021.
   E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the Employee Retirement Income Security Act (ERISA) (B) Working Group, monitor, analyze and report developments related to association health plans (AHPs).
   F. Monitor, analyze and report, as necessary, developments related to short-term, limited-duration (STLD) coverage.

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

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

4. The Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group will:
   A. Monitor, report and analyze developments related to the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate and coordinate best practices with the states, the DOL and the U.S. Department of Health and Human Services (HHS) related to the MHPAEA.
   C. Monitor, facilitate and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to the MHPAEA.
   D. Provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the NAIC Market Regulation Handbook.
   E. Coordinate with and provide input to Market Regulation and Consumer Affairs (D) Committee groups, as necessary, regarding mental health parity market conduct examinations.
5. The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup will:
   A. Consider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs). The Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.
   B. Develop a white paper to: 1) analyze and assess the role PBMs, Pharmacy Services Administrative Organizations (PSAOs), and other supply chain entities, play in the provision of prescription drug benefits; 2) identify, examine and describe current and emerging state regulatory approaches to PBM business practices, such as price transparency and reporting requirements, rebating and spread pricing, including the implications of the Rutledge vs. Pharmaceutical Care Management Association (PCMA) decision on such business practices; and 3) discuss any challenges, if any, the states have encountered in implementing such laws and/or regulations.

NAIC Support Staff: Jolie H. Matthews/Jennifer R. Cook
The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met July 12, 2021. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andrew Schallhorn, Co-Chair (OK); Debra Judy (CO); Chris Struk and Shannon Doheny (FL); Robert Wake (ME); Sherri Mortensen-Brown (MN); Camille Anderson-Weddle (MO); Gayle Woods (OR); Kathleen Kellock (SC); Rachel Bowden (TX); Tanji J. Northrup (UT); Ned Gaines (WA); and Jennifer Stegall (WI).

1. **Discussed Revisions to Model #171**

Ms. Arp said during the Subgroup’s June 7 meeting, the Subgroup requested new comments and additional comments on Sections 1 through 7 of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171). She said she would like the Subgroup to review and discuss those comments beginning with Section 1—Purpose using the comment chart NAIC staff prepared. There was no objection.

The Subgroup discussed the Missouri Department of Insurance’s (DOI’s) suggestion to add the word “renewal” to Section 1. The Subgroup agreed to add the word “renewal.” No comments were received on Section 2—Authority.

The Subgroup next discussed the Blue Cross Blue Shield Association’s (BCBSA’s) suggestion to add language to Section 3A—Application and Scope defining the term “short-term, limited-duration insurance” to ensure that there is consistency with the meaning and use of this term in both the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170) and this model, which is Model #170’s companion model regulation. The Subgroup discussed the BCBSA’s suggested revision. The Subgroup also discussed whether it should consider adding a new section to Model #171 for definitions that apply to the model along with Section 5—Policy Definitions, which defines terms used in a policy. After additional discussion, the Subgroup agreed to potentially add the BCBSA’s suggested revision and add a new section defining terms used in Model #171, such as a definition of “short-term, limited-duration insurance” and any other terms used only in Model #171. The Subgroup also agreed to specifically discuss what terms should be included in the new definition section after it finishes its review and discussion of suggested revisions to Model #171. The Subgroup also discussed the need for it to be aware that short-term, limited-duration (STLD) insurance, which is a form of major medical insurance, will need to be treated differently than the other types of policies covered in Model #171, which are supplemental policies.

The Subgroup agreed to accept the Missouri DOI’s suggestion to delete “shall apply” and substitute “applies” in Section 3B.

The Subgroup also agreed to accept the Health Benefits Institute’s (HBI’s) suggested revision to Section 3C to add language that Model #171 does not apply to limited long-term care insurance (LTCI) policies subject to the requirements of the Limited Long-Term Care Insurance Model Act (#642).

No comments were received on Section 4—Effective Date.

The Subgroup next discussed Section 5, beginning with the BCBSA’s suggested comments on Section 5A to revise the language to refer to “a supplementary policy or short-term, limited-duration insurance.” Randi Chapman (BCBSA) said the BCBSA’s suggestion is consistent with the discussion related to Section 3A. The Subgroup discussed whether it should add the word “certificate” to address group coverage. Mr. Wake suggested that the Subgroup needs to examine the changes made to Model #170 to ensure that the revisions, both substantively and related to terminology, to Model #171 are consistent with those changes. He said there are various approaches the Subgroup could use to encompass the similarities between supplementary coverage and STLD insurance coverage and figure out what provisions should or should not apply to STLD policies.

Ms. Arp suggested that the Subgroup consider revising the language to state, “short-term, limited-duration coverage” for consistency with Model #170. Ms. Bowden said she does not have an objection to Ms. Arp’s suggestion, but she said the Subgroup needs to keep in mind the idea of adding “certificate,” as appropriate, when using the term “policy.” She suggested that the Subgroup might want to consider adding a definition of “policy,” which would include the term “certificate.” The Subgroup discussed this issue and the issue of having two definition sections—one for definitions of terms used in Model #171...
and the other for terms used in the policy, which is currently Section 5. Ms. Arp pointed out that Model #170 includes a definition of “policy.” She said if the Subgroup wants to find a term for “policy” that will also mean “certificate” or other similar terms, then it would have to find another term to use.

Chris Petersen (Arbor Strategies LLC) suggested that the issue the Subgroup is discussing might not be a definitional issue, but a scope and applicability issue that can be more appropriately addressed in Section 3. Mr. Wake said Mr. Petersen’s suggestion might not address potential issues with regulating a group master policy versus regulating an individual policy. He stressed that whatever approach the Subgroup decides to take that it be consistent. J.P. Wieske (HBI) said this issue illustrates how the Subgroup will have to carefully craft revisions differentiating between STLD insurance coverage and the other types of coverages regulated in Model #171. Mr. Petersen said this also illustrates why STLD insurance coverage should have its own section in Model #171. The Subgroup discussed the issue of group coverage and STLD insurance coverage. Mr. Wieske said the Subgroup might have to consider dealing with it by using terminology such as “individually underwritten policy.” Ms. Arp said as already discussed, the Subgroup will add another definition section to define terms used in Model #171; but to deal with this issue, the Subgroup might have to add in its section for STLD insurance coverage, a provision defining certain terms that would apply only to that type of coverage.

Mr. Schallhorn suggested that the Subgroup might have to use the language “policy or certificate” when referring to STLD insurance coverage. The Subgroup discussed Mr. Schallhorn’s suggestion. The Subgroup also discussed the implications of adding “certificate,” which could potentially require state DOIs to review each certificate. After additional discussion, the Subgroup decided not to make the revision.

The Subgroup discussed other suggestions to revise Section 5A, including revising it to state, “[e]xcept as provided in this regulation, all policies subject to this regulation shall use the definitions as provided in this section.” The Subgroup discussed an issue that not all policies subject to Model #171 would use all the policy definitions in Section 5. To address this issue, the Subgroup discussed whether to revise the suggested revision to Section 5A to state, “[e]xcept as provided in this regulation, to the extent these definitions are used in a policy or certificate, all policies subject to this regulation shall use the definitions as provided in this section.” The Subgroup discussed how to incorporate the idea that the definitions are a minimum standard, but also permit deviations when favorable to the consumer. Ms. Arp suggested that the Subgroup consider for discussion during its next meeting July 26 the language, “shall not be defined more restrictively” and “shall not be more restrictive.” She said this language is used in several of the policy definitions in Section 5, such as the definition of “preexisting condition,” “sickness,” and “total disability.” The Subgroup discussed this with respect to whether such language is favorable or unfavorable to the consumer. The Subgroup also discussed how this is further complicated in the policy definition of “preexisting condition” because of its inclusion of the prudent person standard language.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
The Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
June 7, 2021

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met June 7, 2021. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair (OK); Debra Judy (CO); Chris Struk (FL); Robert Wake (ME); Sherri Mortensen-Brown (MN); Camille Anderson-Weddle (MO); Katie Dzurec (PA); Shari Miles (SC); Rachel Bowden (TX); Heidi Clausen and Shelley Wiseman (UT); Kimberly Tocco (WA); and Nathan Houdek and Jennifer Stegall (WI).

1. Discussed the Model #171 Working Draft

Jolie H. Matthews (NAIC) walked the Subgroup through a working draft of preliminary revisions to the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171). She explained that the preliminary revisions in italics reflect Subgroup decisions made during the Subgroup’s meetings in late 2019. Ms. Matthews said other preliminary revisions reflect her attempt to revise Model #171 for consistency with the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170), which is the companion model to Model #171. She highlighted provisions the Subgroup had deferred deciding on whether to revise, including revisions to the term “preexisting condition” in Section 5L—Policy Definitions.

Ms. Matthews said that during the Subgroup’s last meeting on Dec. 16, 2019, the Subgroup ended its discussion of the comments received on Sections 1–5 with the term “total disability” in Section 5O. She said that also during this meeting, the Subgroup set a public comment deadline ending Feb. 7, 2020, to receive comments on Sections 6–7 of Model #171. She said the comments received by the Feb. 7, 2020, public comment deadline are posted on the Subgroup’s web page on the NAIC website.

Ms. Matthews explained that during its Dec. 16, 2019, meeting, the Subgroup requested: 1) information on how the term “preexisting condition” is defined in state law; 2) examples of how this definition is applied differently to various products that are applicable to Model #171; and 3) feedback on how Section 7—Preexisting Conditions of Model #170 applies or does not apply to the policy definition of “preexisting condition” in Section 5L of Model #171. She said she received comments from several states, which she has included in a chart posted on the Subgroup’s web page. The Subgroup also received comments from America’s Health Insurance Plans (AHIP), the Health Benefits Institute (HBI) and the NAIC consumer representatives. These comment letters also are posted on the Subgroup’s web page.

Ms. Arp asked for clarity about the term “preexisting condition” in Section 5L. Chris Petersen (Arbor Strategies LLC) explained that there appeared to be some confusion among Subgroup members when this term was discussed in 2019. He said the Subgroup should be cognizant of the fact that Section 5 is not a typical “definitions” section. He said Section 5 is a policy definitions section, which means the terms “defined” in this section are terms that can be used in policies subject to Model #171’s requirements. The terms in Section 5 are not terms necessarily used in Model #171, but terms that, if included in a policy subject to Model #171’s requirements, the insurer must “define” those terms in the policy consistent with the way the term is “defined” in Section 5 or consistent with state law requirements if those requirements are different from Model #171’s requirements. The Subgroup discussed the potential implications with taking certain approaches to revising the term “preexisting condition” based on stakeholder comments, including the use of the prudent layperson standard or a more objective definition of the term to make it easier for consumers to understand.

Noting that it has been a while since the Subgroup last met, Ms. Arp suggested the Subgroup set a new public comment period ending July 2 to receive comments from stakeholders on Sections 1–7 of Model #171. She said stakeholders who have already submitted comments on those sections may resubmit those comments or submit new comments. She said the Subgroup would meet sometime in mid-July to resume its discussion of revisions to Model #171 based on the comments received by the July 2 public comment deadline. Mr. Petersen reminded the Subgroup that Model #170 has been adopted by the full NAIC membership. He said because of this, during its discussions of revisions to Model #171, the Subgroup should not spend time relitigating provisions already resolved in Model #170. Ms. Arp asked NAIC staff to post a redline version of Model #170 to the Subgroup’s web page to assist the Subgroup in its discussions.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Virtual Meeting
April 21, 2021

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met April 21, 2021. The following Working Group members participated: Katie Dzurec, Chair (PA); Jane Beyer, Vice Chair (WA); Crystal Phelps (AR); Erin Klug (AZ); Sheirin Ghoddoocy (CA); Cara Cheevers (CO); Kurt Swan (CT); Howard Liebers (DC); Sarah Crittenden (GA); Andria Seip (IA); Ryan Gillespie and Erica Weyhenmeyer (IL); Julie Holmes (KS); Erica Bailey (MD); Andrew Kleinendorst (MN); Jeannie Keller (MT); Rosemary Gillespie, Tracy Biehn and Kathy Shortt (NC); Sara Gervings and Chrystal Bartuska (ND); Tyler Brannen and Michelle Heaton (NH); Ralph Boeckman (NJ); Paige Duhamel and Viara Ianakieva (NM); Todd Oberholtzer, Kyla Dembski, Molly Mottram, Theresa Schaefer and Marjorie Ellis (OH); Mike Rhoads, Theresa Green and Cuc Nguyen (OK); Alyssa Metivier (RI); Kendall Buchanan (SC); Jill Kruger (SD); Rachel Bowden (TX); Tanji J. Northrup (UT); Brant Lyons (VA); Barbara Belling (WI); Joylynn Fix (WV); and Tana Howard (WY).

1. Received Updates from the DOL and the CCIIO

Amber Rivers (U.S. Department of Labor—DOL) discussed the federal Consolidated Appropriations Act of 2021 (CAA), which amended the MHPAEA to provide important new protections. She said one of the main new protections is a requirement in the CAA to expressly require group health plans and health insurance issuers offering group or individual health insurance coverage that offer both medical/surgical (M/S) benefits and mental health or substance use disorder (MH/SUD) benefits and that impose non-quantitative treatment limitations (NQTLs) on MH/SUD benefits to perform and document their comparative analyses of the design and application of NQTLs.

Ms. Rivers explained that in addition, beginning 45 days after the date of enactment of the CAA, these plans and issuers must make their comparative analyses available to the DOL, the U.S. Department of Health and Human Services (HHS), and the U.S. Department of the Treasury (Treasury Department) (collectively, “the Departments”) or applicable state authorities, upon request. She said under the CAA, the Departments must request a plan or issuer to submit comparative analyses for plans that involve potential MHPAEA violations or complaints regarding noncompliance with the MHPAEA that concern NQTLs and any other instances the Departments determine appropriate. After review of the comparative analyses, the Departments must share information on findings of compliance and noncompliance with the state where the plan is located or the state where the issuer is licensed to do business.

Ms. Rivers said given the shared responsibilities in the CAA between the Departments and the states, the Departments recently released a set of frequently asked questions (FAQ) about MH/SUD parity implementation and part 45 of the CAA, which can be found on the DOL website at this link: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf. She highlighted a few key points in the FAQ document, including guidance on what a sufficient comparative analysis would include and examples of reasons the Departments might find a comparative analysis to be insufficient. The FAQ document also highlights the fact that the state insurance regulators can request a copy of a plan’s or issuer’s comparative analysis. Ms. Rivers said the FAQ document also notes the DOL’s intent to focus on four areas when making a request for a plan’s comparative analysis, including prior authorization, standards for participation in a provider network, and reimbursement rates.

Mary Nugent (Center for Consumer Information and Insurance Oversight—CCIIIO) expressed support for Ms. Rivers’ comments about the importance of the CAA in providing new protections related to MHPAEA parity compliance. She noted that the recently issued FAQ document that Ms. Rivers discussed was developed and issued jointly by the Departments. As such, the HHS will be using them as a guidance as it moves forward with implementing the CAA’s NQTL comparative analysis review requirements. Ms. Nugent explained that moving forward, due to overlapping jurisdiction, the HHS anticipates that the states will generally continue to enforce the MHPAEA parity requirements, including the CAA’s new NQTL comparative analysis requirements. The HHS will continue to enforce the MHPAEA parity requirements in the three states it currently has enforcement authority over.

2. Heard a Discussion on Equity and Diversity in the MH/SUD Treatment Context

Ms. Dzurec said the Working Group’s next agenda item concerns a proposed new 2021 charge to the Working Group from the Special (EX) Committee on Race and Insurance to “develop model educational material for state departments of insurance
(DOIs) and research disparities in and interplay between mental health parity and access to culturally competent care for people of color and other underrepresented groups.” She said the Working Group included this item on the agenda in preparation for working on this new charge.

Kris Hathaway (America’s Health Insurance Plans—AHIP) discussed AHIP’s health equity activities as a precursor to additional conversations with the Working Group in the future. She highlighted three AHIP proactive strategies—promoting behavioral health integration, value-based mental health care, and the effective use of technology. She noted the substantial increase in the use of telehealth for the provision of mental health services during the past year. She said because of this, some of AHIP’s member plans have been looking at how to provide access to telehealth services for those plan enrollees who would lack the technology to do so, such as setting up private cubicles in community centers for telehealth visits with providers. She also touched on AHIP’s health equity activities, particularly a new initiative, “Project Link,” which is a collaborative partnership initiative examining social determinants of health to find ways and best practices to effectively address social barriers to good health. She also briefly discussed current AHIP health equity workstreams. One of the workstreams is examining approaches to collecting demographic data from plan enrollees in a culturally sensitive way. Ms. Hathaway also discussed the work of AHIP’s Health Equity Measures Value-Based Care Work Group. She highlighted the work AHIP has been doing with the Blue Cross Blue Shield Association (BCBSA) regarding the Vaccine Community Connectors program, which is a program seeking to reduce vaccination disparities for individuals over 65 in the most vulnerable and underserved communities, such as Black and Hispanic communities. She reiterated AHIP’s willingness to make subject matter experts (SMEs) available to speak to the Working Group in more detail about AHIP’s health equity activities that she just highlighted.

Andrew Sperling (National Alliance on Mental Illness—NAMI) discussed findings from studies already conducted underscoring the link between mental health and race and health disparities, particularly the findings from a study trying to determine the state-of-the-art treatment for schizophrenia. He also discussed a large mental health study conducted by a former U.S. Surgeon General documenting the slow pace in which the mental health/behavioral health field was addressing cultural competence and care as well as the wide disparities that exist there in terms of exploring cultural competence and defining cultural conflicts, while also ensuring that providers were trained in cultural competence in the way they deliver behavioral health care. He said these challenges and disparities remain today 20 years later, particularly with respect to access to mental health services and the quality of the services provided. He noted NAMI’s commitment to addressing these disparities. He also discussed issues with the lack of precision in diagnosing mental health disorders. He concluded his remarks by underscoring how important it is for providers to be trained in cultural competence to recognize and treat mental health disorders in traditionally underserved groups. He also discussed the challenges with mental health parity compliance and enforcement, given that it is typically complaint driven. He suggested that consumer education is key. He also noted that the CAA could help in this effort because of the involvement of employers in the comparative analysis assessments instead of consumers who may not have the ability to understand the complexity of the parity law to determine if there is a violation and file a complaint. He pledged NAMI’s assistance in helping the Working Group work on its proposed new 2021 charge, particularly in assisting the Working Group to invite diverse voices to speak during its future meetings to gain the perspective of racial and ethnic minorities in the country.

Jennifer Nowak (BCBSA) said Blue Cross Blue Shield (BCBS) companies are committed to improving the quality of care, while providing access to effective treatment for substance use disorders. The BCBSA has been developing centers of excellence programs for over 30 years, always with a strong focus on quality and evidence-based care. Ms. Nowak said when the BCBSA began to develop its first center of excellence program focused on mental health/behavioral health, Blue Distinction Centers for Substance Use Treatment and Recovery (BDC SUTR), the BCBSA found that this is a very different landscape than medical and surgical health care, such as the extreme variations in the quality of care delivered and significant differences in providers using evidence-based treatments. These findings heightened the need to build a center of excellence program that enables BCBS members to find resources and identify and access quality providers using evidence-based treatments.

Ms. Nowak discussed the work of BCBS companies’ National Health Equity Strategy (Strategy), which aims to confront the country’s crisis in racial health disparities and intends to change the trajectory of health disparities and re-imagine a more equitable health care system. This Strategy includes: 1) collecting data to measure disparities; 2) scaling effective programs; 3) working with providers to improve outcomes and address unconscious bias; and 4) influencing policy decisions at the state and federal levels.

Ms. Nowak said this multi-year Strategy will focus on four conditions that disproportionately affect communities of color—maternal health, behavioral health, diabetes and cardiovascular conditions. She said the BCBSA will focus first on maternal health, and it intends to focus on behavioral health later this year. She said to assist it in working on the Strategy, the BCBSA convened a national advisory panel of doctors, public health experts, and community leaders to provide guidance.
Lastly, Ms. Nowak discussed BCBS plan examples to address health inequities and behavior health services, such as the Blue Shield of California’s partnership with ScaleLA Foundation, the Center for Youth Wellness, and the Compton Unified School District. The goal of this partnership is to develop and implement initiatives that fill behavioral health gaps in care for adolescents, teens and families in Compton and Premera Blue Cross’ development of public-private partnerships to fund capital grants supporting crisis care and stabilization and ensuring that people are treated at the appropriate level of care.

Ms. Dzurec noted that at certain points, maternal health can be mental health. As such, the BCBSA’s Strategy initiative to focus first on maternal health is not completely outside the Working Group’s focus at this point in its discussions, particularly when discussing integrated care. She asked for additional comments. Daniel Blaney-Koen (American Medical Association—AMA) discussed the disparities in access to and the provision of MH/SUD services for people of color. He discussed specific examples of the differences in treatment for people of color and whites having the same substance use disorder issues. He said this type of structural racism and other issues leading to disparities in treatment and services is pervasive throughout the health care system. He also said some of these disparities could be a result of parity issues in areas such as prior authorization requirements and inadequate provider networks. He offered suggestions for the Working Group to consider in looking at this issue, including the importance of collecting demographic data to pinpoint what problems are leading to this disparity.

Ms. Beyer asked Ms. Hathaway about the challenges plans have in trying to collect demographic data from plan enrollees and the extent of this information being available in state all-payer claims databases (APCDs). She noted that in discussing the data issue with Washington’s APCD, the APCD suggested linking with census tracks because census tracks include race and ethnicity demographic data. Ms. Hathaway reiterated the challenges plans have in obtaining the data from plan enrollees, including a plan’s ability to collect such data on a state-by-state basis. She suggested that the Working Group might want to first focus on the obstacles to obtaining the necessary demographic data and look at possibly utilizing APCDs later in the discussions. She said AHIP is asking how some of its members have been able to obtain demographic data at higher rates, and it is looking at potentially developing a set of best practices to assist all carriers in obtaining such data.

Ms. Dzurec asked Working Group members to submit any thoughts and/or suggestions concerning any research, tools and educational materials for the Working Group to consider as it moves forward with working on its proposed new 2021 charge.

Having no further business, the MHPAEA (B) Working Group adjourned.
The Senior Issues (B) Task Force met July 29, 2021. The following Task Force members participated: Marlene Caride, Chair (NJ); Lori K. Wing-Heier, Vice Chair, represented by Sarah Bailey (AK); Jim L. Ridling represented by Anthony L. Williams (AL); Evan G. Daniels represented by Steve Fekety (AZ); Ricardo Lara represented by Tyler McKinney (CA); Michael Conway represented by Peg Brown (CO); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Howard Liebers (DC); Trinidad Navarro represented by Susan Jennette (DE); David Altmairer represented by Chris Struk (FL); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Amy L. Beard represented by Rebecca Vaughan (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon represented by Ron Henderson (LA); Gary D. Anderson represented by Kevin Beagan (MA); Kathleen A. Birrane represented by Joy Hatchette (MD); Eric A. Cioppa represented by Sherry Ingalls (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by Jan Ludwigson (MN); Chloris Lindley-Myers (MO); Troy Downing represented by Ashley Perez (MT); Mike Causey represented by Tracy Biehn (NC); Jon Godfread represented by Yuri Venjohn (ND); Eric Dunning represented by Martin Swanson (NE); Chris Nicolopoulos represented by Roni Karris (NH); Judith L. French represented by Tynesia Dorsey (OH); Glen Mulready represented by Mike Rhoads (OK); Andrew R. Stolfi represented by Gayle Woods (OR); Jessica K. Altman (PA); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Vickie Trice (TN); Doug Slope (TX); Jonathan T. Pike represented by Tanji J. Northrup (UT); Scott A. White represented by James Young (VA); Mike Kreidler (WA); Mark Afable represented by Jennifer Stegall (WI); and James A. Dodrill (WV). Also participating were: Eric Anderson (IL); Bob Williams (MS); Bogdanka Kurahovic (NM); Martin Wojcik (NY); Andrew Dvorine (SC); Brenda R. Clark (VT); and Mavis Earnshaw (WY).

1. **Adopted its June 8 Minutes**

The Task Force met June 8 and took the following action: 1) adopted its Feb. 23, 2021, and Oct. 20, 2020, minutes; and 2) discussed an article on bundling Medicare Supplement and Short-Term Care.

Ms. Kruger made a motion, seconded by Ms. Biehn, to adopt the Task Force’s June 8 minutes (Attachment One). The motion passed unanimously.

2. **Adopted the Report of the Long-Term Care Insurance Model Update (B) Subgroup**

The Long-Term Care Insurance Model Update (B) Subgroup met July 15, May 27, May 6, and April 22. During its July 15 meeting, the Subgroup heard from stakeholders on the current long-term care insurance (LTCI) marketplace and what products are being seen, filed, and produced in the marketplace. During its May 27 meeting, the Subgroup completed its cursory review of Sections 8 through 14 of the Long-Term Care Insurance Model Act (#640). During its May 6 meeting, the Subgroup completed its cursory review of Sections 1 through 7 of Model #640. During its April 22 meeting, the Subgroup discussed the agenda, format, and procedures for its work in the coming year.

Mr. Henderson made a motion, seconded by Ms. Kruger, to adopt the report of the Long-Term Care Insurance Model Update (B) Subgroup, which included its July 15 minutes (Attachment Two). The motion passed unanimously.

3. **Discussed Other Matters**

Commissioner Caride asked if there are any other matters or issues to be raised before the Task Force. Mr. Henderson raised an issue about Medicare cold calling. He said Medicare beneficiaries in Louisiana are getting lots of cold calls from outfits, whom are not agents, but refer the beneficiary to an agent. He said the outfit appears to be out of Florida. He said many of these beneficiaries are changed into a different health plan that is not helpful and, in some cases, detrimental to their needs. He said he received a call because his mother’s Medicare is attached to his cellphone. He said the Louisiana Department of Insurance (DOI) and the State Health Insurance Assistance Program (SHIP) have been working hard to help these beneficiaries and get them back into their original plans. He asked if other states have experienced a rash of cold calls.

Commissioner Caride said she has not been made aware of or is aware of any increase in cold calls in New Jersey. She asked if other states had any experiences.
Mr. Swanson said the Antifraud (D) Task Force members have been participating in monthly regulator-only meetings concerning the improper marketing of health plans. He said Nebraska has prosecuted one of these outfits. He said the cold call came to an attorney who had worked at the Nebraska DOI 50 years ago. He said if Louisiana would like to raise this before the next monthly regulator-only meeting, he would send Mr. Henderson the information about the next meeting.

Mr. Henderson said he will provide his and other information to David Torian (NAIC) to share with Mr. Swanson. Commissioner Caride asked Mr. Torian to inform Task Force members of the day and time of the next monthly regulator-only meeting on the improper marketing of health plans.

Bonnie Burns (California Health Advocates—CHA) said both SHIP and Senior Medicare Patrol (SMP) have been dealing with this issue for years, and they work with the federal government to prosecute these outfits, presuming they are not out of the country. She suggested that some of SHIP could present before this monthly regulator-only meeting on the improper marketing of health plans.

Having no further business, the Senior Issues (B) Task Force adjourned.
The Senior Issues (B) Task Force met June 8, 2021. The following Task Force members participated: Marlene Caride, Chair (NJ); Lori K. Wing-Heier, Vice Chair, represented by Sarah Bailey (AK); Jim L. Ridling represented by Anthony L. Williams (AL); Evan G. Daniels represented by Steve Fekety (AZ); Ricardo Lara represented by Tyler McKinney (CA); Michael Conway represented by Peg Brown (CO); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Howard Liebers (DC); Trinidad Navarro represented by Susan Jennette (DE); David Altmairer represented by Chris Struk (FL); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Amy L. Beard represented by Rebecca Vaughan (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon represented by Ron Henderson (LA); Gary D. Anderson represented by Kevin Beagan (MA); Kathleen A. Birrane represented by Joy Hatchette (MD); Eric A. Cioppa represented by Sherry Ingalls (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by Jan Ludwigson (MN); Chlora Lindley-Myers (MO); Troy Downing represented by Ashley Perez (MT); Mike Causey represented by Robert Croom (NC); Jon Godfried represented by Yuri Venjohn (ND); Eric Dunning represented by Martin Swanson (NE); Chris Nicolopoulos represented by Roni Karnis (NH); Judith L. French represented by Tynesia Dorsey (OH); Glen Mulready represented by Mike Rhoads (OK); Andrew R. Stolfi represented by Gayle Woods (OR); Jessica K. Altman (PA); Larry D. Deiter (SD); Carter Lawrence represented by Vickie Trice (TN); Doug Slape (TX); Jonathan T. Pike represented by Tanji J. Northrup (UT); Scott A. White represented by James Young (VA); Mike Kreidler (WA); Mark Afable represented by Jennifer Stegall (WI); and James A. Dodrill (WV). Also participating were: Eric Anderson (IL); Bob Williams (MS); Bogdanka Kurahovic (NM); Martin Wojcik (NY); Andrew Dvorine (SC); Brenda R. Clark (VT); and Mavis Earnshaw (WY).

1. Adopted its Feb. 23 and Oct. 20, 2020, Minutes


Director Lindley-Myers made a motion, seconded by Mr. Henderson, to adopt the Task Force’s Feb. 23 (see NAIC Proceedings – Spring 2021, Senior Issues (B) Task Force) and Oct. 20, 2020 (see NAIC Proceedings – Fall 2020, Senior Issues (B) Task Force) minutes. The motion passed unanimously.

2. Heard a Presentation on Bundling Medicare Supplement and Short-Term Care Insurance

Commissioner Caride introduced Ken Clark (Milliman) and Robert Eaton (Milliman) to discuss their article. Mr. Eaton said he and Mr. Clark looked at both products, Medicare Supplement (Medigap) and short-term care (STC); where it may make sense to bundle the sale of these products; and what the benefits of such bundling would be. He said looking at the long-term care (LTC) product, including the newer STC products, they are triggered by the inability to do activities of daily living (ADLs). He said both have steep claim costs curves, and people need the benefit a lot more later in life. He said the pricing of these LTC products hinges on key actuarial assumptions, such as lapse assumption, which is critical. He said he and Mr. Clark believe a company may benefit from having both these policies sold to the same policyholder. He said if you look through the list of key risks for all these policies, such as persistency, morbidity and selection risk, the joining of these products may be beneficial to both the insurer and the consumer policyholder.

Mr. Eaton said the article looks at the hedging of risks of combining these two products. He said if looking at other products that hedged the risks by combining (e.g., LTC and life insurance), the increasing sales of the combined product (e.g., the natural hedging of risks with mortality) is a positive. He said he and Mr. Clark believe this could be done with STC and Medigap, where the policyholder is given an incentive to buy these policies at the same time through something like a discount and recognizing that purchasing together means a better risk profile and the insurer is able to offer a lower price on the STC policy. He said he and Mr. Clark believe a company may benefit from having both these policies sold to the same policyholder. He said if you look through the list of key risks for all these policies, such as persistency, morbidity and selection risk, the joining of these products may be beneficial to both the insurer and the consumer policyholder.

Mr. Eaton said the article looks at the hedging of risks of combining these two products. He said if looking at other products that hedged the risks by combining (e.g., LTC and life insurance), the increasing sales of the combined product (e.g., the natural hedging of risks with mortality) is a positive. He said he and Mr. Clark believe this could be done with STC and Medigap, where the policyholder is given an incentive to buy these policies at the same time through something like a discount and recognizing that purchasing together means a better risk profile and the insurer is able to offer a lower price on the STC policy. He said he and Mr. Clark wrote the article to illustrate a case study of the potential advantages—i.e., intern the volatility of future earnings—for a company that offers both these products combined.

Mr. Clark said health arena Medigap and STC are kind of unique in that they are both priced on a lifetime basis versus Medicare Advantage or commercial business insurance. He said if a carrier wants to be profitable and competitive with Medigap, they really need good persistency, which is at odds with STC models where too good persistency could result in potential losses. He
said he and Mr. Eaton used a simple case study of a carrier having both products and selling them together, showing that there would be some crossover in terms of membership of both products. He said under the current regulatory environment, it would not be possible to actually create a hybrid-type product. He said nothing like that exists today.

Commissioner Caride asked if there were any questions. Mr. Lombardo asked Mr. Eaton and Mr. Clark to talk more about the loss ratios for both products. He said they mentioned that both products are priced on a lifetime concept, and that is true for LTC and STC; but for Medigap, there are fairly quick durational loss ratio requirements by plan, so he asked if they could provide more background on lifetime loss ratio pricing for Medigap.

Mr. Clark said in their case, they assumed Medigap as an attained age product; but even so typically, there is a durational pattern for Medigap. He said depending on the state and what is allowed in the state, there can be a durational component of loss ratio; but it is definitely flatter than what is assumed for STC products, and they typically level out at a point in time for Medigap. He said even if the loss ratio increases, it does not increase the magnitude of STC products.

Commissioner Caride asked about the pricing for the consumer and how affordable it would be for the consumer. Mr. Eaton said an average stand-alone STC policy may be about $800 to $900 a year; but overall, it would probably be south of $1000 a year and north of $500 a year. Mr. Clark said to keep in mind that Medigap rating, like STC, will go up by age; but the ballpark range would be about $150 to $250 a month. He said that would be for middle range, not necessarily something all-inclusive, and of course it would vary by state.

Commissioner Caride asked if there is a chance that the consumer may be paying double for service of the crossover benefits. Mr. Eaton said one of the reasons they like this pairing of Medigap and STC is that STC usually picks up where original Medicare leaves off; at least in terms of facilities days. He said this is why there is a kind of prevalence of a 90-day elimination period and LTC or STC come in after Medicare. He said there may be some overlap in the benefits; but generally, they are usually separate.

Commissioner Caride said she asked this because she had an incident of a company wanting to offer a product already offered in Medigap and charge seniors for that when there was no reason to do that. Mr. Clark said as long as the STC product is just for custodial care and there are no other bells and whistles, then he does not believe there would be a crossover.

Mr. Trexler asked if this could be structured as an innovative benefit for Medigap. Mr. Clark said in his opinion and from a regulatory point of view of what would be allowed, it seems that innovative benefits are intended to be little or small additional benefits. He said if it were added as an innovative benefit, it would be half or almost as big as the Medigap benefit itself. He said some states obviously do not allow innovative benefits, so it would not be possible to be done nationally; but if a state wanted to, it would be hard because it would be difficult to add an innovative benefit that large. Mr. Trexler agreed that the usual innovative benefit is for vision or dental; but he asked whether from what they are describing with STC products, none of that is duplicative with Medicare or Medigap. Mr. Clark said no as long as it is just custodial, such as home care or nursing care. Mr. Eaton said this is one of the paths forward to solve the LTC and STC risk issues. He said there is a lot of coverage for the first 90 days in the skilled nursing facility after an inpatient stay, then that risk for any of those long-term needs is transferred to the policyholder. He said some of them may have an LTC policy of a hybrid combo product, but the incentives are created when a carrier is incentivized to deliver the best care to the policyholder, whether they are kind of within the first 90 days or after that. He said he believes there is some benefit in a confluence of incentives to have that managed in some part by a single entity, but an entity to be at risk for both portions for someone’s LTC stay.

Mr. Trexler asked if Mr. Clark or Mr. Eaton are aware of companies that offer both Medigap and STC or if they are usually different types of companies. Mr. Clark said both he and Mr. Eaton are aware of companies. He said there are more Medigap carriers than STC carriers, but they both know of companies.

Mr. Sundberg said he had two questions. He said his first question was whether Mr. Clark and Mr. Eaton are thinking of a particular plan to pair this bundling. He said Plan A does not cover nursing home benefits and have generally higher premiums because of other regulations around it. He said his second question was whether they intended for companies to only offer the Medigap product to the folks that get the STC type option, because in his experience over time, the Medigap rates for a company can become stale and no longer marketable to the general public. He said that can take a cycle of five years, but limited LTC or STC companies usually have those rates available for five to 10 years and do not need a lot of manipulation afterward unless there are larger changes. He asked what happens if the Medigap rates are no longer palatable, but the STC product is still palatable. Mr. Clark said he and Mr. Eaton us Plan G in their case study. He suggested starting out with understanding that these are two products priced on a stand-alone basis and that there may be a program of bonus incentives to agents and encouraging the bundling, but the underlying premise is that these are two separate product lines appropriately priced on a
stand-alone basis. He said when it comes to rate actions, he presumes that the Medigap product would go through their normal rate filing increases. He said within each product line, there will be some membership that has both products as policies, and there will be some that only have Medigap policies. He said from an actuarial point of view, the overall rate level needs to be adequate in total, but if pointing out how some carriers might close out blocks of business or sell under a different carrier, that is an issue and a very good point.

Mr. Lombardo asked how a Medigap policy and an STC policy being sold by the same company to an individual when they sign up for Medigap and the individual wants to change Medigap carriers affects the individual’s STC policy. Mr. Eaton said one way to envision this is if there was a small discount offered on the STC premium when the products are purchased together, and in that case, the discount may go away, but the STC coverage could continue to stay over. He said a company may decide that the discount is worth keeping and the idea is to kind of incentivize them to the policies together because there are benefits of having both together.

Commissioner Caride asked questions from the chat box, and the first was from Jeffrey M. Klein (McIntyre & Lemon PLLC) asking how deductibles and copayments would be treated with a combined product. Mr. Eaton said they would be handled independently, and the products would each continue to function similar to the stand-alone product; so if one has a deductible for Medigap and they already collected some benefits under STC, the same deductible would continue to apply for the Medigap policy.

Commissioner Caride asked another question from the chat box from Harry Ting (Consumer Advocate Volunteer, Chester County Department of Aging Services – Apprise Program), who asked whether a consumer would be able to purchase the short-term policy later than the supplement (e.g., the supplement at age 65 and the short-term policy at age 75). Mr. Eaton said that is a very good question and he had not contemplated that. He said he does not think that means a company would not be able to do this if, for example, the policyholder already owns a Medigap policy and they want to purchase an STC policy many years later. He said the underwriting would get more difficult the older they get for STC because they would be closer to the age of when they need that care. He said he does not see why it could not be done, but it was not envisioned for the purposes of the article; it was still a great question.

Bonnie Burns (California Health Advocates—CHA) said the Medicare benefit for skilled nursing care is not an easy benefit to get and very few people ever get the full 90 days. She said the average number of days is around 20 days. She said she can see the benefit for companies, but she has a much harder time seeing the benefit for consumers. She said these STC policies have a higher threshold for benefits. She said they can use three ADLs as opposed to two; they have a much lower loss ratio requirement, at 50%; and they often have the same deductible period that LTC does. She said what she has seen with these products is that they are sold in 90-day increments, so people buy benefits for 90 days. She said that is a question of value given the premium. She said if they have a 90-day waiting period and then 90 days of benefits, that seems to be a very questionable benefit for the value related to the premium. She said she is very concerned about any product that is linked to a Medigap in a way that could potentially jeopardize the health care coverage of that individual. She said she wants to interject a little reality about how these policies have been sold, the amounts of coverage, and having a higher threshold for benefits may mean that people are going to have a much harder time getting coverage for their care.

Commissioner Caride asked a question from the chat box from Silvia Yee (Disability Rights Education and Defense Fund—DREDF), who asked if Mr. Clark or Mr. Eaton ever see policies as being in potential conflict. For example, the short-term policy could be drawn down for a period of personal care at home for a few weeks or for more expensive rehab hospital care; and if the short-term policy claim is denied, it increases the chances of a fall in the home that would result in medical claims. Mr. Eaton said that is a good question, and he thanked Ms. Burns for her good observations. He said the reason he and Mr. Clark believe these products may potentially go together quite naturally is that there is very little overlap in the benefits. He said there may be situations where if a claim in one is denied, it makes it tougher for the other; but he believes there is a kind of net gain even if there may be some cases where someone does not end up qualifying for the benefits according to the contract. He said these kinds of incidents are something all companies would want to be aware of when approaching this kind of market; and when selling these products together, they are very clear on the coverages, what that really means, and how they work together or how they do not work together when they are just independent.

3. Discussed Other Matters

Commissioner Caride asked if there are any other matters or issues to be raised before the Task Force. None were heard.

Having no further business, the Senior Issues (B) Task Force adjourned.
The Long-Term Care Insurance Model Update (B) Subgroup met July 15, 2021. The following Subgroup members participated: Philip Gennace, Chair (NJ); Laura Arp, Vice Chair (NE); Mayumi Gabor (AK); Tyler McKinney (CA); Roni Karnis (NH); Jill Kruger (CT); Susan Jennette (DE); Benjamin Ben (FL); Teresa Winer (GA); Jason Asaeda (HI); Andria Seip (IA); Kathy McGill (ID); Eric Anderson (IL); Scott Shover (IN); Craig VanAalst (KS); Ron Kreiter (KY); Fern Thomas (MD); Sherry Ingalls (ME); Karen Dennis (MI); Fred Andersen (MN); Amy Hoyt (MO); Bob Williams (MS); Ashley Perez (MT); Ted Hamby (NC); Yuri Venjohn (ND); Bogdanka Kurahovic (NM); Sean Becker (NY); Tynesia Dorsey (OH); Cuc Nguyen (OK); Jim Laverty (PA); Andrew Dvorine (SC); Vickie Trice (TN); Chris Herrick (TX); Mary Block (VT); Julie Walsh (WI); Dena Wildman (WV); and Mavis Earnshaw (WY).

1. **Adopted its May 27 Minutes**

The Subgroup met May 27 and took the following action: 1) adopted its May 6 minutes; and 2) discussed comments received on Sections 8 through 14 of the Long-Term Care Insurance Model Act (#640).

Ms. Kruger made a motion, seconded by Ms. Karnis, to adopt the Subgroup’s May 27 minutes (Attachment Two-A). The motion passed unanimously.

2. **Heard Presentations on the Current LTCI Marketplace and What Products Are Being Seen, Filed and Produced in the Marketplace**

Karen Schutter (Interstate Insurance Product Regulatory Commission—Compact) began with a little background about the Compact. She said the Compact was created in the early 2000s in response to the threat of federal preemption. She said what are called asset-based or retirement protection products are long-term care (LTC) products. She said regarding life annuity and disability income that compete with the federally regulated products, like banking and securities, there was a call for more efficiency in terms of speed to market and uniformity. The Compact became a solution of the states to come together and develop what is called uniform standards.

Ms. Schutter said the Compact statute ties the LTC uniform standards to NAIC model law and regulation. She said the standards shall provide “same or greater protections for consumers as but shall not provide less than” the NAIC models, including subsequent amendments. She said the uniform standards were amended in 2017 to incorporate 2016 amendments to NAIC Models #640 and the Long-Term Care Insurance Model Regulation (#641). She said the Compact has qualified actuaries and form reviewers, many who came from insurance departments. She said the review of a product, including LTC, come under detailed uniform standards. She said although some states have opted out in terms of LTC, those states that are participating in LTC follow the 10 standards the Compact has, and those standards were built off of the LTC model regulation.

Ms. Schutter said the scope of products reviewed include products advertised, marketed, or offered to provide benefits for one or more of the following: nursing home care, assisted living care or home health care, and adult day care. She said the LTC insurance definition follows the Model #640 definition, and the LTC insurance (LTCI) definition excludes life policies that accelerate death benefits for chronic illness or annuities with guaranteed living benefits when the guaranteed withdrawal increases for certain events. She said the standards for accelerated death benefits (ADBs) do not apply to the products/riders within scope of LTC policy standards. She said the Compact follows Model #640, and when the model was updated several years ago, the Compact opened its standards and updated them at that time.

Ms. Schutter said the Compact makes sure the uniform standards apply broadly, and many states treat LTC as a health product. She said the Compact’s standards are clean. She said they cover the LTC product and if a product is being advertised, marketed, and offered to provide LTC benefits, or pay for LTC services, it falls under the LTC standards. She said the uniform standards for LTC policies and rate schedules specifically cover stand-alone traditional LTC policies and rates; riders and rates to ADBs of life insurance policies or annuity contracts, defined as “dollar for dollar LTCI”; and riders and rates to extend LTC benefits after exhaustion of policy death benefits/annuity account value, defined as an extension of benefit rider.
Ms. Schutter said the Compact has approved a large number of products, with some as dollar-for-dollar riders, others under universal life products, and others attached to whole life products. She said there are some that come from annuities. She said extension of benefit riders are treated differently even though those riders go with LTC. She said in many ways, they operate as stand-alone as they have their own rate schedule. She said the Compact standards are based off the rate stability framework from Model #641. She said the Compact wants to serve as a resource and that the uniform standards are more detailed than the model regulation.

Ms. Schutter highlighted the differences between the Compact’s standards and the model regulation. She said the benefit trigger cannot be more than two activities of daily living (ADLs); the exclusion based on mental or nervous disorders is not permitted; the exclusion due to a preexisting condition or disease is limited to loss occurring within six months; the coordination of benefit provision is not permitted; there must be a product offered with inflation protection; there must be a product offered with issue age rates; there must be a product offered with home health care benefits at 100% of nursing home benefits; and for home health care benefit options, there must be a coverage requirement of 50% of nursing home benefit minimum.

Ms. Schutter said that the Compact takes no position on changes to Model #641 to accommodate designs that have been requested by the industry, and the Compact is happy to provide reviewer and actuarial resources for technical assistance. She said the Compact publishes an annual report on Compact-approved iLTCRate Schedule Certifications, and it provides a state-specific report to each Compacting state on iLTCproducts/riders and annual rate certifications.

Ms. Ahrens asked for clarification about rate increase requests and new business schedules. Ms. Schutter said the Compact does not call it a rate increase but a refresh of new business or a new business schedule. She said the Compact does see companies that are still in the market and cannot certify the sufficiency of their rates; they will have to come in with a new business schedule. She said she does not know if the Model #641 talks about new business rate schedules as it may need to.

Ms. Ahrens said Model #640 or Model #641 states that an insurance commissioner can modify or bypass any requirement of the regulation for innovative products with a hearing, and she asked what the Compact does with a state that does that. Would the Compact recommend to the state to opt out of LTC since those provisions would be for product innovations that are not allowed in the current model? Ms. Schutter said the uniform standards are intended to put parameters around the products the Compact can review so that state insurance regulators know what products are coming in, and those innovative products are ones that the standards do not accommodate today. She said there is an action item in the strategic plan the Compact developed a couple years ago to coordinate with states to facilitate if there are innovative designs, but that would start at the state level, and the Compact would play a coordinating role. Ms. Ahrens asked about the non-duplication benefit and said that the Compact really could not help companies with that issue. Ms Schutter said the Compact thinks this was a public policy issue and that perhaps this could be an issue for this Subgroup.

Birny Birnbaum (Center for Economic Justice—CEJ) asked if there is evidence of the use of the mix-and-match tool when the company rejects a rate filing on the policy form and asked for clarification about the new business schedule, whether there is a requirement for a new policy form, or whether a company can simply have a new schedule for an existing policy form. He said the latter would seem to be unfairly discriminatory. Ms. Schutter said the Compact does not allow for mix-and-match among the LTC component so that under a traditional product, everything would have to be filed through the Compact. She said she has not seen any anecdotal evidence or information on the rider side. She said for the new business schedule that is in the standards and allows a company to come in on the same product and get a new business, that is only for new business going forward, and it is to stabilize the rates for anybody purchasing that product after a date certain.

Jan Graeber (American Council of Life Insurers—ACLI) said she will speak to the industry perspective with respect to the evolving LTC market. She said according to the U.S. Department of Health and Human Services (HHS), more than half of Americans turning 65 today will need some type of LTC, and more than 20% will likely need care for five or more years. She said there are 10,000 Americans turning 65 every day, and the median cost for a one-year stay in a private nursing home room is more than $100,000. She said a recent study by the Boston College Center for Retirement Research (CRR) showed that about 20% of retirees will need no support, and about 25% are likely to experience severe needs. She said in between these extremes, 22% will have low needs, and 38% will have moderate needs. She said those needs will vary by marital status, education, and health.

Ms. Graeber said there is a misconception by some that the private LTCI market has collapsed. She said millions of Americans are covered by private LTC insurance today. She said ACLI members paid out nearly $12 billion in LTCI claims in 2019 and that consumers find private LTC coverage to be invaluable. She said there is a growing hybrid LTC market and a growing interest in state and federal LTC initiatives and programs. She said examples of the state and federal LTC initiatives and
programs include what is being done in Washington state and California, as well as the federal Well-Being Insurance for Seniors to be at Home (WISH) Act.

Ms. Graeber said Washington state passed the first public operated LTC program in 2019. She said the program is funded by a payroll tax, and in January 2022, all W-2 employees in the state will be assessed at 0.58% premium assessment based on their wages. Employers must cover this premium assessment through a payroll deduction. She said the proceeds are put into a state trust account, which is the WA Cares Fund, and that is going to be used to pay for people who need LTC in the future. She said self-employed and federal employees are exempt from the mandate. She said when an individual triggers the eligibility for benefits under the Washington state plan, the fund will then pay out a maximum of $36,500. The plan will require an inability to perform three out of 10 ADLs in order to receive a benefit. She said if an employee leaves the state, he or she will not receive any LTC benefits, and the taxes that were taken from his or her income will not be returned.

Ms. Graeber said under the federal WISH Act, workers and their employers must each contribute 0.3% of wages, and these contributions will find a new LTCI trust fund that will provide catastrophic LTC benefits. She said the WISH Act also contains educational provisions to help seniors and their families understand the likelihood of requiring LTC, the costs of that, and the options for paying for it. She said these proposals and initiatives are well intentioned, but they provide limited benefits. Ms. Graeber said it is critical that any new government-run program coordinate and build upon the existing foundation of the private LTCI market. She said one priority is to ensure that state or federal plans are compatible with existing private market, eligibility rules and benefit periods, and it may be useful to explore public and private partnerships where states could design an LTC program that synchs up with the private LTC plans, and then that provides a seamless transition of care that really would leave no gap and coverage.

Ms. Graeber said looking at the current model, there are several issues or areas to focus on that could determine the model’s flexibility and ability to remain compatible. She said the inclusion of a non-duplication of benefit provision would be helpful in getting people to start purchasing coverage at age 40 instead of age 60. She said a non-duplication of benefit provision would allow a carrier to sell or issue new or secondary coverage, maybe every five years, in order to allow the consumers to build their plan over time. The secondary average would have, instead of the 90-day or 180-day elimination period, maybe a two- or three-year elimination period. She highlighted other opportunities, such as: inflation protection requirements; flexibility in pricing and benefit structure; the ability to provide a cash value in stand-alone LTC; opportunities to age-in-place; and reviewing some consumer protections in light of the changing market, such as agent education and training.

Mr. Birnbaum said he opposed many of the proposals the ACLI mentioned and strongly believes consumer protections in the slides should not have been presented with quotation marks around the word “protections.” He said these protections are not fake but are real consumer protections. He said the solution to inadequate producer training for universal life is not to lower the standards but to improve the training. He said it is critical to consumer protection to make the inflation offer an opt-out, not an opt-in. He also said the non-duplication of benefits and flexible premiums are already an extraordinary complex product, and the ACLI proposals would take an extraordinarily complex product and make it even more complex and difficult to understand. He said the goal is not to create more complexity and more opportunities for the consumer to misunderstand; rather, it is to simplify the product so that it is easier for the consumer to understand.

Ms. Ahrens said she has a document will bullet points she will share with the Subgroup. She said she was going to break down the product innovations that she has seen, and those comments would be general. She said she would next address management that companies are allowed to do on enforced rate increases and reduced benefit options (RBOs). She said she would address the life stage product in Minnesota. She said it is a Minnesota project with input from the Society of Actuaries (SOA), and surveys were conducted of Minnesota residents and citizens asking if they could buy LTC, what would it look like and what would their primary considerations be. She said one of the biggest goals for the development of the project was to find a way to reach more of a middle market since stand-alone LTC can be expensive. She said through that inquiry process, a concept was developed called a life stage project. She said that it is a concept and not a public program. She said since it is a term product that converts to LTC at age 65, it would not meet the approval standards under the Compact. However, she said that the state is examining language that could make it approvable. Minnesota sees the concept filling a need to serve more of the market and gives people an opportunity to have a valid life insurance product while pre-funding LTC before it is needed.

Ms. Ahrens said both the Washington state program and the WISH Act are limited in benefits, pointing out that the Washington state program goes into effect next year and the WISH Act was just introduced in Congress and is not going to be law any time soon. She said the Washington state program is a $100 per day, one-year benefit plan. Checking prices and rates in Lincoln, NE, and Omaha, NE, the nursing care rate is about $250 per day and, if comparable to Washington state, the person would pay half the costs. She said the WISH Act is catastrophic care and pays only after certain triggers have been met. She said there
would be limitations on industry on a stand-alone LTC product because there cannot be an elimination period longer than one year. So, if Washington state covers a year, then there is a stand-alone product issue where there cannot be duplication of benefits because companies have to cover benefits before a year has expired.

Ms. Ahrens said the question for the Subgroup is whether to open the model now and whether the work would be done on the model as long as there are states that have these public programs. She asked if the model would have to be opened again or wait until these programs are approved and have had some time to move forward in the event there are reasons to edit the model that have not been thought of prior to these public programs. She said it is important to be aware that there are companies that will pull out of the market and that she is aware of two that have pulled out of Washington state, at least temporarily, as Washington state has an opt-out provision from the payroll tax if one has his or her own LTC.

Ms. Ahrens said she would discuss the RBO and said Section 27 of Model #641 requires companies to allow an insured to reduce their benefits. She said those reductions have to be fair and reasonable, but there is nothing in Model #641 that says there cannot be different benefit reductions than what exists in the original rate schedule. She said she does not think it is necessary to open Model #641 to deal with the RBO, but if the model is to be opened, then everything should be looked at.

Ms. Ahrens said when companies innovate, they say they have a guaranteed renewable rate, rates are changed in the future, that is one of the management tools available. She said if the companies do not know how states are going to review their rates and they do not know if there is going to be uniformity, then the companies cannot make a decision on whether to enter the market or stay in the market. She said that is one of the reasons why there have been fewer companies willing to issue new business. She said if there is to be new business issued, there has to be thought about how to coordinate and add uniformity across states. She said if there is a way to do that within the LTC models, that can be explored. But if there is anything related to rates, there has to be no exacerbation of the lack of uniformity.

Ms. Ahrens said companies have always offered RBOs so that if a policy has, for example, eight years in lifetime benefits, the policyholder could reduce his or her benefit in any year and not have to wait for a rate increase, and the company would have to allow it. She said recently, in the past five to seven years, companies started to reason there may not be enough choices, and there may be more ways to offer the policyholders to manage their risk and the companies started to innovate RBOs, such as riders to policies that, upon a rate increase, allow for more options. She said an example is where a company uses the inflation there may be more ways to offer the policyholders to manage their risk and the companies started to innovate RBOs, such as riders to policies that, upon a rate increase, allow for more options. She said another example is a shared care concept where the benefit is, for example, $100 per day; the premium rate does go up because he or she is paying a higher rate for a lower benefit but that the policyholder is paying the same number of dollars. She said another example is a shared care concept where the benefit is, for example, at $100 per day; the policyholder would pay 20%, and the company would pay 80%. She said these options have been found to be approvable under Model #641. She said she thinks more options are better than no options.

Bonnie Burns (California Health Advocates—CHA) said she would like to make comments to the some of the points that Ms. Graeber raised in her presentation, but due to lack of time, she will discuss what she has seen from the consumer perspective. She said there are many consumers who have many questions about what is happening to them in this LTC marketplace. She said there is no dispute that LTC is a vexing problem, it is not clear how to finance it, and everyone is struggling with these issues. She said consumers are struggling with the options given as part of rate increase. She said there are class action lawsuits and settlements that complicate matters for consumers as they navigate through the options. She said most of the questions from consumers are having to do with the options issue, the options that are presented to them, and having trouble understanding those options. She said another problem is consumers who have complicated financial products that they either were told to buy or have bought and how LTC works within that complicated financial product. She said these consumers are looking for information or advice or confirmation that they did the right thing buying such a product.

Ms. Burns said in other instances, consumers are coming with questions about claims, such as a family member asking about how to file a claim or a claim has been filed, but there are problems and lots of paperwork they do not understand. She said the challenge for consumer representatives is how to unwind LTC benefits from these complicated financial products in order to help the consumer understand how those benefits will work when they need them or if they need them now. She said these products are complex, based upon so many different life insurance platforms, that it is extremely hard for consumers to understand them. Ms. Burns said a year after they may have bought such a financial product, they will have forgotten the information someone had told them about the product. She said these products are mostly being sold to higher net worth clients because they are not feasible for a middle-income person looking for a way to finance this kind of care, and many of them are combining life insurance with investment and LTC benefits. She said it is a complicated process, and these products are poorly understood.
Ms. Burns said consumers do not understand that there are internal costs applied to the policy itself and will be applied to the benefit before it is actually paid. She said the only thing consumers really know about these financial products with the LTC benefit in them is that someone is going to get money either when one dies or when they need LTC. She said there is a multiplicity of life platforms now. She said a universal life policy can be an indexed policy, it can be a variable life policy, or it can be an indexed variable life policy. She said there are so many different ways that companies are combining these various benefits, and then they put LTC into them, which makes them even more complicated. She said these policies are not adequately addressed in the LTC models, and they compete with other ways of funding LTC because people are selling life settlements and reverse mortgages to pay for LTC.

Ms. Burns said the structure of these policies varies considerably, from accelerated death benefits and critical care policies to riders that may extend a LTC benefit one way or another. She said these are hard for consumers to understand. She said all of the pieces of these are complicated in and of themselves. She said the benefits payments vary from a reimbursement model that requires LTC services and payment and uses LTC triggers to indemnity payments, where there is no use of services required, but they may use the same triggers. Ms. Burns said it is hard for people to understand the difference between these products. She said these are not adequately addressed in Model #641, either in the definitions or in the performance standards sections of the model. She said consumers need to know the type of insurance platform that the LTC benefit is included in in order to understand how the policy works. She said consumers need to understand there are internal fees within the policy and that some are guaranteed, while some are not. She said consumers need to understand whether there are separate pools of money or whether all of the benefits for everything in that policy is combined in one pool of benefits. She said consumers need to understand if they have an annuity and a LTC benefit in that annuity or if that annuity payment changes when they need LTC and start drawing down on that benefit. She said consumers need to understand cash value and surrender charges and added that consumers do not understand the implications of those surrender charges.

Ms. Burns said making these policies more complex is not the answer. She said these products need to be simplified so the average person can understand what they are buying, how it works, and how they can use it in the future. She said they do not need the complexity of knowing or not knowing how rates are going to change in the future when they are going to actually need those benefits. Ms. Burns said these consumers are at a distinct disadvantage in making a decision about these complex financial products they bought to pay for LTC benefits. She said the complexity of the design and benefits, the reams of illustrations, and disclosures are not helpful to consumers for making decisions about purchasing coverage or using those benefits when they need them.

Ms. Arp asked Ms. Ahrens about how the Subgroup can get better educated addressing the changes in the market and whether the LTC models, as they stand now, still give what is needed and are broad enough to allow the flexibility to approve innovative options. Ms. Ahrens said she thinks there is the ability to approve innovative options for benefit reductions. She said there are the tools to work with the balance to the obligation of the company and the consumer and the risks that may be shared between them. She said she thinks state insurance regulators have the ability within the model to be open to what companies have tried, but it also may be that companies are only trying things that seem feasible through the model. She said, however, that on the innovation side of things, there is definitely room to expand.

Mr. Birnbaum said the flip side of states viewing the model as giving them the flexibility to address all sorts of innovations and approaches seems inconsistent with the other efforts of the NAIC, which is to develop more consistency and uniformity in LTC regulation among the states. He said to the extent that the model is flexible enough that states can interpret it differently and approve products in a different fashion is not useful and is inconsistent with the NAIC’s stated goals.

Ms. Ahrens said that is why she is an advocate for the multi-state review process in trying to create a platform for coordination or rate reviews, which includes benefit reduction reviews, and that platform would help apply the regulation consistently.

Having no further business, the Long-Term Care Insurance Model Update (B) Subgroup adjourned.
The Long-Term Care Insurance Model Update (B) Subgroup of the Senior Issues (B) Task Force met May 27, 2021. The following Subgroup members participated: Philip Gennace, Chair (NJ); Laura Arp, Vice Chair (NE); Sarah Bailey (AK); Tyler McKinney (CA); Roni Karnis (NH); Jill Kruger (SD); Tomasz Serbinowski (UT); and Elsie Andy (VA). Also participating were: Dusty Smith (AL); Andrew Greenhalgh (CT); Susan Jennette (DE); Martha Im (HI); Andria Seip (IA); Kathy McGill (ID); Christina Roy (IL); Alex Peck (IN); Craig VanAalst (KS); Ron Kreiter (KY); Jamie St. Clair (MD); Sherry Ingalls (ME); Renee Campbell (MI); Fred Andersen (MN); Carrie Couch (MO); Bob Williams (MS); Ashley Perez (MT); David Yetter (NC); Yuri Venjohn (ND); Jennifer Catechis (NM); Martin Wojcik (NY); Shannen Logue (PA); Mei Feng (TX); Mary Block (VT); Julie Walsh (WI); Joylynn Fix (WV); and Mavis Earnshaw (WY).

1. **Adopted its May 6 Minutes**

The Subgroup met May 6 and took the following action: 1) adopted its April 22 minutes; and 2) discussed comments received on Sections 1 through 7 of the Long-Term Care Insurance Model Act (#640).

Mr. McKinney made a motion, seconded by Ms. Kruger, to adopt the Subgroup’s May 6 minutes (Attachment Two-A1). The motion passed unanimously.

2. **Discussed Comments Received on Sections 8 Through 14 of Model #640**

Mr. Gennace said before beginning on the latter sections, he would like to hear from Mr. Serbinowski on whether he has more to comment on the issues of extraterritoriality. Mr. Serbinowski said if the current language is sufficient to address the certificates of group policies and rate increases, then the language should remain.

Birny Birnbaum (Center for Economic Justice—CEJ) said the language is not sufficient, and he cited the example he raised at the previous meeting. He said there needs to be clarification. Jan M. Graeber (American Council of Life Insurers—ACLI) said there are different types of products that are classified as group, such as true group. She said the model may not be specific, but the language is clear, and the states have the flexibility. Mr. Serbinowski said it may be useful to look at the question of why group long-term care (LTC) policies are still needed. Ms. Andy said language is still needed for group policies in existence today. Bonnie Burns (California Health Advocates—CHA) said group policies are used for marketing. She said employees believe the group policies are something different than what is out in the private sector. Ms. Logue said the reason why group sales come in with low benefits is to avoid anti-selection issues and offer a modified guaranteed issue product.

Mr. Gennace asked for comments on the consumer representatives’ comment on Section 8 of Model #640 on nonforfeiture benefits. Ms. Burns said the language ties the size of the premium increase to the age of the policyholder over time. She said it unfairly penalizes policyholders who are unable to continue funding an ever-increasing premium (e.g., a widow left with diminished income after their spouse’s death). She said she has not seen a lot of non-forfeiture, but no one should have to give up a policy that is paid for, and there should be options for policyholders should there be an income change. Mr. Serbinowski said the Subgroup may want to consider requiring that the non-forfeiture benefit be equal to the greater of premiums paid, and 30 days of benefits should be built (required, not optional) in every policy. He said it should not cost too much, because this is a fairly low benefit and lapse rates are very low anyway. Ms. Graeber asked Ms. Burns if she is looking for the ability to reduce coverage or terminate and pay the non-forfeiture and whether Section 22 of Model #641 would be of help. Ms. Burns said the reason why group sales come in with low benefits is to avoid anti-selection issues and offer a modified guaranteed issue product.

Mr. Gennace asked if anyone wished to discuss the consumer representatives’ comments on Section 9 of the Long-Term Care Insurance Model Act (#640). Ms. Burns said producers do not believe they need training or additional training since they are not selling long-term care insurance (LTCI). She asked if the term includes benefits in life and annuity products, and she said knowing and being able to explain the difference between free standing products for LTC and life and annuity-based products should be included for agents and brokers selling life or annuity-based products.
Mr. Gennace asked if anyone wished to discuss the consumer representatives’ comments on Section 13 of Model #640. Ms. Burns said the penalties are rather low and pointed out that some life and annuity commissions are above the current penalty level.

Mr. Gennace said he would inform the Subgroup of the next steps in terms of reviewing Model #641, and he asked if anyone had any further comments. Ms. Karnis informed the Subgroup of a New Hampshire Supreme Court decision in February that analyzed New Hampshire’s LTC rulemaking authority statute, which follows Section 10 in Model #640. She said the Court invalidated a New Hampshire rate cap administrative rule, which was not based on Model #640, but the rulemaking authority statute for LTC has the same language as the current Model #640 language. She said given the court case, the Model #640 language may continue to create questions in other states that are trying to provide consumer protection for policyholders before a large rate increase is implemented and updating those terms or clarifying the balance of how they work together would be recommended based on New Hampshire’s experience.

Ms. Karnis said it would be helpful to see what is currently out in the marketplace and what has evolved over time in relation to Model #640 and Model #641.

Having no further business, the Long-Term Care Insurance Model Update (B) Subgroup adjourned.
The Long-Term Care Insurance Model Update (B) Subgroup met May 6, 2021. The following Subgroup members participated: Philip Gennace, Chair (NJ); Laura Arp, Vice Chair (NE); Sarah Bailey (AK); Tyler McKinney (CA); Heather Silverstein (NH); Lisa Harmon (SD); Tomasz Serbinowski (UT); Bob Grissom (VA); and Michael Bryant (WA). Also participating were: Jennifer Li (AL); Andrew Greenhalgh (CT); Susan Jennette (DE); Teresa Winer (GA); Martha Im (HI); Cynthia Banks Radke (IA); Kathy McGill (ID); Karl Knable (IN); Brenda Johnson (KS); Ron Kreiter (KY); Adam Zimmerman (MD); Marti Hooper (ME); Renee Campbell (MI); Carrie Couch (MO); Bob Williams (MS); Ashley Perez (MT); Ted Hamby (NC); Angie Voegele (ND); Bogdanka Kurahovic (NM); Jack Childress (NV); Martin Wojcik (NY); Laura Miller (OH); Jim Laverty (PA); Sarah Neil (RI); Andrew Dvorine (SC); Vickie Trice (TN); Mei Feng (TX); Anna Van Fleet (VT); Julie Walsh (WI); and Tana Howard (WY).

1. **Adopted its April 22 Minutes**

The Subgroup met April 22 to discuss its work.

Ms. Bailey made a motion, seconded by Mr. Grissom, to adopt the Subgroup’s April 22 minutes (Attachment Two-A1a). The motion passed unanimously.

2. **Discussed Comments Received on Sections 1 Through 7 of Model #640**

Mr. Gennace asked Mr. Serbinowski to elaborate on his comments sent to the Subgroup. Mr. Serbinowski said he believes the scope section as well as the definition of long-term care insurance (LTCI) deserves a look. He said he has seen products that claim not to be long-term care (LTC) and are deemed not to be LTC by several states even though they would appear to meet the definition of LTC in the Long-Term Care Insurance Model Regulation (#641). He said most of the LTC policies sold today are combo products, and the Subgroup may want to revisit the parts of Model #641 that exempt life insurance policies that accelerate benefits for LTC.

Mr. Gennace said the Subgroup would go through the comments received from the consumer representatives to the first seven sections of Model #640. He asked if anyone wished to discuss the consumer representatives’ comments on Section 1 of Model #640. Bonnie Burns (California Health Advocates—CHA) said the focus of Section 1 is on the beginning of the process, but it does not address the issue of claims and other factors during the process. She said so many LTCI benefits are attached to life insurance products, and Section 1 does not address any of these products, which leads to a lot of confusion.

Karrol Kitt (University of Texas at Austin) said Section 1 is not broad enough and needs to be more inclusive of newer products. Brenda J. Cude (University of Georgia) said the thought expressed in the drafting note to Section 1 should be expressly incorporated into the section.

Mr. Gennace said the Subgroup would go through the comments received from the consumer representatives to the first seven sections of Model #640. He asked if anyone wished to discuss the consumer representatives’ comments on Section 2 of Model #640. Ms. Burns said the section does not make it clear that limited LTCI products exist and there are models; i.e., the Limited Long-Term Care Insurance Model Act (#642) and the Limited Long-Term Care Insurance Model Regulation (#643). She said the reference to Medicare supplement in Section 2 is still included even though home recovery is no longer sold. Mr. Grissom asked Ms. Burns to elaborate on why Model #642 and Model #643 should be mentioned or referenced in Model #640. Ms. Burns said Section 2 requires insurers to comply with all other applicable statutes, and limited LTCI competes with traditional LTCI.

Mr. Gennace asked if anyone wished to discuss the consumer representatives’ comments on Section 4 of Model #640. He said the consumer representatives’ comments on Section 4 said there are no definitions, reference to or description of a reduced benefit option (RBO) or the full scope and range of RBOs that might be offered to policyholders. He said the comments further reflect that while there is some language in Model #640 about the right to reduce benefits, there is neither anything in Model #642 or Model #643 that describes or defines all of the potential options insurers can give policyholders as a way to reduce the effect of a rate increase, nor is there anything that specifies how, when, or under what circumstances these options have to be offered.
Mr. Serbinowski said this section may be something the Subgroup should look at. He said there are several products in the marketplace that could arguably be LTC but are not deemed LTC. He reiterated that as most LTC policies are combo products, revisiting the parts of Model #640 that exempt life insurance policies that accelerate benefits for LTC may be necessary. He said some issues with these exemptions are: 1) it is not always clear how the prohibition against LTC premiums increasing above age 65 should be interpreted; 2) if a state does not regulate premiums on the underlying life product, adverse LTC experience could be passed on to the policyholders through the increase of the charges on the life insurance policy, effectively bypassing regulatory oversight of LTC rates; 3) LTC benefits attached to life or annuity policies typically do not offer inflation protection; 4) attaching LTC benefits to a non-permanent form of life insurance (including universal life [UL]) may lead to underfunding and lapse of the policy when most needed; and 5) attaching LTC benefits to life insurance with flexible premiums deprives policyholders of vital protection against unintentional lapse.

Mr. Serbinowski said given the change in the marketplace, LTCI connection to life insurance may warrant a look. He said he would be willing to provide more concrete examples at the next meeting. Ms. Burns said agents debate among themselves, and they are at times confused as to whether something is LTCI or not. Mr. Gennace reminded the Subgroup that it is not rewriting anything now; but he said it was a good discussion, and it may be worth looking into the definitions of LTCI.

Mr. Gennace asked if anyone wished to discuss the consumer representatives’ comments on Section 5 of Model #640. Birny Birnbaum (Center for Economic Justice—CEJ) said the section could use clarification. He said he was asked by a policyholder about a group policy issued to an organization in Washington, DC on a form approved by the Washington, DC Department of Insurance, Securities and Banking (DISB) and with initial rates approved by the DISB. He said the insured is a Washington resident who encountered a rate increase approved by the DISB. He said Section 5 seems to cover whether the group policy approved in one state can be offered to organization members living in another state, but it does not address rate increases. He asked whether there can be differential rate increases across states if the group policy initially had the same rates regardless of insured location. He also asked why the Washington, DC DISB would not be responsible for all other rate changes if the DISB initially approved the group policy rates.

Mr. Gennace asked if anyone wished to discuss the consumer representatives’ comments on Section 6 of Model #640. Mr. Birnbaum, Ms. Burns and Ms. Cude said Section 5 should be divided into two different sections, and significant thought must be given to what and how disclosures are made. Ms. Cude said there must be a more robust disclosure section. Ms. Burns said unintentional lapses and the waiver of premiums should be addressed and mentioned. Mr. Birnbaum said Model #641 has a lot of disclosure, and Model #642 and Model #643 cannot be viewed in isolation but in conjunction, as Model #642 must be read with Model #643.

Mr. Gennace asked if anyone wished to discuss the consumer representatives’ comments on Section 6J of Model #640. He said it seems this has already been discussed, and he asked if there were any further comments. He asked if anyone wished to discuss the consumer representatives’ comments on Section 6L of Model #640 that a policyholder should not have to wait 60 days for an explanation to contest an unreasonable benefit denial. Ms. Burns said it is self-explanatory.

Mr. Gennace said the next meeting of the Subgroup would be held on May 27, and he asked for comments to Sections 7 through 14 of Model #640 to be submitted by close of business on May 21.

Having no further business, the Long-Term Care Insurance Model Update (B) Subgroup adjourned.
The Long-Term Care Insurance Model Update (B) Subgroup met April 22, 2021. The following Subgroup members participated: Philip Gennace, Chair (NJ); Laura Arp, Vice Chair (NE); Sarah Bailey (AK); Tyler McKinney (CA); Maureen Belanger (NH); Jill Kruger (SD); Elsie Andy (VA); and Michael Bryant (WA). Also participating were: Steve Dozier (AL); Erin Klug (AZ); Paul Lombardo (CT); Susan Jennette (DE); Andria Seip (IA); Kathy McGill (IL); Karl Knable (IN); Eric Anderson (KS); Ron Kreiter (KY); Adam Zimmerman (MD); Sherry Ingalls (ME); Renee Campbell (MI); Fred Andersen (MN); Carrie Couch (MO); Bob Williams (MS); Martin Wojcik (NY); Stephen Flick (OH); Mike Rhoads (OK); Jim Laverty (PA); Sarah Neil (RI); Andrew Dvorine (SC); Vickie Trice (TN); Rachel Bowden (TX); Mary S. Block (VT); Julie Walsh (WI); Grego Elam (WV); and Tana Howard (WY).

1. Discussed the Work of the Subgroup

Mr. Gennace explained the process, procedure and format for the Subgroup moving forward. He said one of the charges of the Senior Issues (B) Task Force is to review the existing long-term care insurance (LTCI) models to determine their flexibility to remain compatible with the evolving delivery of long-term care (LTC) services and remain compatible with the evolving LTCI marketplace. He said the Subgroup was established to determine whether the Long-Term Care Insurance Model Act (#640) and the Long-Term Care Insurance Model Regulation (#641) need to be updated to remain flexible and compatible with the LTCI marketplace. He said if the Subgroup determines an update is needed, it will report to the Senior Issues (B) Task Force, and the Subgroup would begin work. He said if the Subgroup determines an update is not needed, the Subgroup will report to the Senior Issues (B) Task Force and will await any recommendations from the Long-Term Care Insurance (EX) Task Force.

Mr. Gennace said Model #640 and Model #641 have not been fully reviewed since 2009/2010. He said the most recent updates to the models were done in 2016, specifically to Section 6 of Model #640 and to Appendix B and Appendix F of Model #641. He said it is important the Subgroup focuses on the purpose of its work and not get sidelines by comments, requests and/or recommendations to edit the model. He said the Subgroup is not editing Model #640 or Model #641 but rather will determine if Model #640 or Model #641 retains the flexibility to remain compatible with LTC services and the LTCI marketplace or if it needs an update to language, terms or definitions.

Mr. Gennace said the Subgroup would first review Sections 1–7 of Model #640. He said comments should be submitted to David Torian (NAIC) by close of business on April 30. He said Mr. Torian will redline the comments, share with the Subgroup, and those comments will be discussed during the Subgroup’s next meeting scheduled for 1:00 p.m. ET on May 6. He asked if there were any questions or comments.

Birny Birnbaum (Center for Economic Justice—CEJ) said he thinks the timeline is too short for a full review and will result in an ineffective review. He said there are sections that are referenced in different parts of the model that may not be in the sections the Subgroup would be reviewing at that time. Mr. Gennace said if there is a cross reference, it can be noted in the comments to be submitted. Mr. Birnbaum said he still thinks the format does not allow for sufficient time for parties to review, edit and comment. Ms. Kruger said there is nothing preventing the Subgroup from going back to a previous section if necessary. Ms. Andy said this beginning process is not edit and update but rather to determine whether to edit and update. Karrol Kitt (University of Texas at Austin) said her experience with other model updates was to go section by section or smaller grouped sections. Mr. Gennace said the Subgroup should see how this works and move ahead with the planned format, and if the timing does not seem to work, the Subgroup will make the necessary adjustments.

Having no further business, the Long-Term Care Insurance Model Update (B) Subgroup adjourned.
PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

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The Property and Casualty Insurance (C) Committee met in Columbus, OH, Aug. 16, 2021. The following Committee members participated: Vicki Schmidt, Chair (KS); Mike Chaney, Vice Chair (MS); Jim L. Ridling (AL); Ricardo Lara represented by Ken Allen (CA); Andrew N.Mais (CT); Colin M. Hayashida represented by Martha Im (HI); Amy L. Beard (IN); James J. Donelon (LA); Kathleen A. Birrane (MD); Grace Arnold represented by Phil Vigliaturo (MN); Larry D. Deiter (SD); Tregenza A. Roach (VI); Michael S. Pieciak (VT); Mike Kreidler represented by Molly Nollette (WA); and James A. Dodrill (WV). Also participating were: Lori K. Wing-Heier (AK); Michelle Brugh Rafeld (OH); and Don Beatty (VA).

1. **Adopted its Spring National Meeting Minutes**

Director Deiter made a motion, seconded by Commissioner Chaney, to adopt the Committee’s April 13 minutes (see NAIC Proceedings – Spring 2021, Property and Casualty Insurance (C) Committee). The motion passed unanimously.

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

   a. **Casualty Actuarial and Statistical (C) Task Force**

   Mr. Vigliaturo reported that the Casualty Actuarial and Statistical (C) Task Force has been assisting the Blanks (E) Working Group in evaluating two proposals for expansion of information to be included on the Property and Casualty Annual and Quarterly Statements: 1) proposal 2021-11BWG, which adds data reporting on policy writings for private passenger and homeowners insurance; and 2) proposal 2021-13BWG, which expands reporting for general liability insurance to include subline detail. The Task Force responded to the initial requests from the Working Group by offering future assistance on the first proposal and supporting the second proposal. After the Working Group met at the end of July, it sent the Task Force a modified personal lines proposal and asked for feedback while simultaneously asking financial groups whether the proposed data assists financial solvency regulation in line with the purpose of the annual statement. Mr. Vigliaturo said the Statistical Data (C) Working Group will be exploring the possibility of getting the data from statistical agents earlier each year.

   Mr. Vigliaturo said the Task Force is also in the process of responding to a second exposure draft for U.S. qualification standards from the American Academy of Actuaries (Academy). He also reported that the predictive model training called the “Book Club” and the monthly regulator-only discussion about rate filing issues continue, and both offer valuable information for actuaries and non-actuaries. He said both are valuable projects for the NAIC when it comes to educating state insurance regulators on predictive models and sharing expertise on rate issues.

   b. **Surplus Lines (C) Task Force**

   Commissioner Donelon said the Surplus Lines (C) Task Force met Aug. 16 and adopted the 2022 proposed charges of the Task Force and the Surplus Lines (C) Working Group. He said the Surplus Lines (C) Working Group met in June in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss two applications seeking admission to the July 1 Quarterly Listing of Alien Insurers. Commissioner Donelon also reported that the Task Force has formed a drafting group to amend the Nonadmitted Insurance Model Act (#870).

   c. **Title Insurance (C) Task Force**

   Ms. Rafeld said the Title Insurance (C) Task Force met May 11 and heard an update on revisions to the Title Insurance Consumer Shopping Tool Template. She said AM Best presented on current trends in the title insurance sector as detailed in its recent “Market Segment Outlook: U.S. Title Insurance.” In February, AM Best revised its U.S. title industry outlook from negative to stable due to exceptional performance in 2020. The title industry overall was the most profitable segment in the property/casualty (P/C) industry. The use of innovative technology and a surge in home refinances and purchases in the latter half of 2020 supported the industry. She also reported Birny Birnbaum (Center for Economic Justice—CEJ) presented on how state insurance regulators could use after-tax return on capital to determine what a reasonable profit is for a title insurer.

   Ms. Rafeld said the Task Force also met July 13 and took the following action: 1) adopted revisions to the Title Insurance Consumer Shopping Tool Template; 2) heard a presentation from the Federal Bureau of Investigation (FBI) on business email
compromise schemes and other cybercrimes; and 3) heard from state insurance regulators about title insurance fraud trends in their respective states. Trends included fraudulent settlement transactions, wire fraud complaints, cybercrime, and defalcations.

d. Workers’ Compensation (C) Task Force

Director Wing-Heier said the Workers’ Compensation (C) Task Force met July 21 and heard a presentation about the classification of telecommuters and the potential implications of an increase in telecommuting on workers’ compensation. She said the National Council on Compensation Insurance (NCCI) reported that in May 2020, about 35% of the employed work force reported they had worked from home due to COVID-19. A McKinsey Global Institute study estimated that about 29% of the work done in the U.S. could be done remotely with no loss in productivity. The NCCI sees no indication that there will be any significantly large impacts to workers’ compensation even if remote work does catch on as expected.

Director Wing-Heier noted the Task Force continues to monitor COVID-19 as claims information becomes available. To date, there has not been a significant impact on workers’ compensation insurance. Workers’ compensation rates continue to fall in 2021, and the market is still stable.

e. Cannabis Insurance (C) Working Group

Mr. Allen said the Cannabis Insurance (C) Working Group met April 27 and held a panel discussion on cannabis insurance-related legislation, including: 1) the Secure and Fair Enforcement (SAFE) Banking Act of 2021, which would create a safe harbor for banks providing services to cannabis-related businesses in legal states; and 2) the Clarifying Law Around Insurance of Marijuana (CLAIM) Act, which would create a safe harbor for insurers engaging in business with cannabis-related businesses.

Mr. Allen said the Working Group also met May 27 and discussed a draft memorandum to the Government Relations (EX) Leadership Council recommending that the Leadership Council consider supporting the SAFE Banking Act and CLAIM Act. These bills would help remove federal barriers for insurers to conduct business with any state legalized cannabis-related businesses, thereby helping to provide insurance coverage options for these commercial policyholders that will mitigate their business risks.

Mr. Allen said the Working Group held a two-day hearing on July 19 and July 27. The first day of the hearing provided a foundation of understanding and a look at insurance product availability in the cannabis-related insurance market. It included presentations on the impact of the geographical expansion of legalized cannabis states; the cannabis regulatory and licensing landscape; the unique insurance needs of the cannabis market; commercial cannabis product options; and admitted and nonadmitted coverage availability across the cannabis business sectors. The second day of the hearing focused on structural obstacles inhibiting insurers from offering coverage; insurance gaps and how insurance regulators can support growth of the admitted market, including presentations on balancing actual and perceived risks in the cannabis space; obstacles to insurers offering coverage in the cannabis-related business space; insurance coverage challenges for cannabis-related businesses; and emerging trends and how insurance regulators can support growth of the cannabis insurance market.

Mr. Allen said the Working Group plans to use the information gained over this two-day hearing to update its white paper, Understanding the Market for Cannabis Insurance, through the addition of an appendix. Drafting sessions on the white paper appendix will begin in August. The Working Group also plans to leverage the feedback gained from the hearing to discuss during its next meeting how state insurance regulators can better collaborate with each other and other regulatory agencies.

f. Catastrophe Insurance (C) Working Group

Commissioner Chaney said the Catastrophe Insurance (C) Working Group received a referral from the Climate and Resiliency (EX) Task Force asking it to update the Catastrophe Computer Modeling Handbook (Handbook) by: 1) determining how state insurance regulators are currently using the Handbook; 2) coordinating with the Catastrophe Risk (E) Subgroup to understand the materials it is developing regarding catastrophe models; 3) updating questions in Section VII of the Handbook to include wildfire; 4) considering the addition of questions specific to additional perils used in catastrophe models including flood; and 5) exploring which catastrophe modelers have begun including climate data in their models. He said the Working Group formed a drafting group to work on these referral items. Commissioner Chaney said the Working Group recently heard from Mississippi regarding the Mississippi Windstorm Underwriting Association (MWUA) FORTIFIED Roof upgrade program that was implemented in Mississippi and began discussions regarding the American Property Casualty Insurance Association’s (APCIA’s) Catastrophe Actions Toolkit.

Commissioner Chaney also noted that the newly formed NAIC/Federal Emergency Management Agency (FEMA) (C) Advisory Group held its first meeting to discuss its charges related to prioritizing and recording interactions with the NAIC’s
FEMA colleagues (Attachment One). The group heard a summary of recent engagements with FEMA and will be putting materials on the NAIC’s Catastrophe Resource Center.

g. **Pet Insurance (C) Working Group**

Mr. Beatty said the Pet Insurance (C) Working Group adopted the Pet Insurance Model Act during its Aug. 4 meeting, but subsequently state insurance regulators and NAIC legal staff found there were some unclear issues that remained in the model. Mr. Beatty said he believes a few of these are not substantive, but a couple should be discussed. He said he would recommend the Committee vote to keep the model open so that the Working Group could meet to receive input from all parties before adopting the model.

Director Deiter made a motion, seconded by Commissioner Birrane, to adopt an extension to the Fall National Meeting for revisions to the proposed Pet Insurance Model Act. The motion passed unanimously. Commissioner Schmidt said the Property and Casualty Insurance (C) Committee will likely meet in the near future so that it can consider the model and perhaps refer it to the full NAIC membership at the Fall National Meeting.

h. **Terrorism Insurance Implementation (C) Working Group**

Commissioner Schmidt said the Terrorism Insurance Implementation (C) Working Group has not met since the Spring National Meeting, but state insurance regulators decided to pause the State Supplement portion of the state regulator terrorism risk insurance data call for fall. The Working Group plans to meet soon to discuss workers’ compensation and other data received in the data call earlier this year.

i. **Transparency and Readability of Consumer Information (C) Working Group**

Ms. Hatchette said the Transparency and Readability of Consumer Information (C) Working Group has been working on several items for a best practices document on disclosures for premium increases. The Working Group formed three drafting groups to work on three different documents: 1) the Thresholds and Communications Standards Drafting Group; 2) the Rate Checklist Drafting Group; and 3) the Consumer Education Drafting Group.

Ms. Hatchette said the Thresholds and Communications Standards Drafting Group discussed and determined several requirements for disclosures to be sent to consumers regarding premium increases. At this time, this document will be a part of the best practices document and is not required, as states will have to make these requests of insurers if they want to use the disclosures. The Drafting Group determined the following items would be necessary for a disclosure: 1) a 10% threshold (any rate change >= 10% on renewal) will trigger a notice; 2) the notice must be sent at least 30 days prior to renewal; 3) the notice must include the new premium vs. the old premium; 4) items affecting the premium increase should be listed by dollar amount; 5) the top reasons for premium increase should be listed; 6) these reasons should account for 80% of the premium increase; and 7) the top five reasons for the premium increase should be listed.

Ms. Hatchette said the Rate Checklist Drafting Group found that many states do not have a rate checklist in place. Kansas and Connecticut both have them in place and have found them to be extremely helpful. The use of a checklist is not required but will be included in the best practices document. This document is to be filled out by the insurer during the rate filing process. The Drafting Group is using the rate checklist developed by Kansas in addition to adding two questions about rate modeling, as there are times where insurers do not mention this, and asking the questions will bring awareness to the insurer.

Ms. Hatchette said the Consumer Education Drafting Group has formed three smaller drafting groups to draft specific topics, such as underwriting and rating, factors affecting premium increase, and discounts for auto insurance. The goals of the consumer education document are to: 1) provide consumers with a basic understanding of rate making so they can better understand a disclosure, especially if the consumer receives a premium increase; 2) inform consumers of things they can do to mitigate premium increases; 3) provide information that can be readily available in various forms for inquiries to departments of insurance (DOIs) from other entities such as legislators and media; and 4) reduce the number of consumer calls to the DOIs regarding understanding of why their rates increased. Once this work is complete and a document is in place, the NAIC Communications department has agreed to put together infographics, social media pieces, consumer alerts, etc. that will be available to the DOIs to use. The Working Group will also work with the NAIC Communications department to see what types of consumer testing would be available to determine the effectiveness of the disclosure document.

Commissioner Mais made a motion, seconded by Commissioner Donelon, to adopt the following task force and working group reports: Casualty Actuarial and Statistical (C) Task Force; Surplus Lines (C) Task Force; Title Insurance (C) Task Force; Workers’ Compensation (C) Task Force; Cannabis Insurance (C) Working Group (Attachment Two); Catastrophe Insurance (C) Working Group (Attachment Three); Pet Insurance (C) Working Group (Attachment Four); Terrorism Insurance
Implementation (C) Working Group; and Transparency and Readability of Consumer Information (C) Working Group (Attachment Five). The motion passed unanimously.

3. **Adopted Revisions to the Title Insurance Consumer Shopping Tool Template**

Ms. Rafeld said the Title Insurance (C) Task Force formed a drafting group to include questions and answers about title insurance-related fraud topics within the Title Insurance Consumer Shopping Tool Template. The drafting group included information about wire fraud schemes and steps consumers can take to avoid fraud. The drafting group consulted with consumer groups to assist with the language. The drafting group also made changes to modernize the language. The Task Force adopted the revisions on July 13. Commissioner Dodrill pointed out the table of contents would need to be revised.

Commissioner Dodrill made a motion, seconded by Commissioner Chaney, to adopt the revisions to the Title Insurance Consumer Shopping Tool Template (Attachment Six). The motion passed unanimously.

4. **Heard Presentations on How to Close the Insurance Protection Gap**

John Huff (Association of Bermuda Insurers and Reinsurers—ABIR) said the Bermuda market responded in the 1990s to Florida hurricanes with a strong reinsurance market. The Bermuda market works to balance noncorrelated risks such as Kansas tornado risks with European flood risks. The Bermuda market provides more than 50% of the capacity for U.S. mortgage reinsurance, helping to facilitate home ownership for Americans. Bermuda reinsurers make up 36% of the global P/C reinsurance market. In the Texas 2021 winter storm, the Bermuda reinsurance market covered 20% of that loss, resulting in $2.7 billion. Mr. Huff noted that capital capacity is what is needed to close the protection gap.

Mr. Huff said the Centre for Risk Studies at Cambridge Judge Business School recently released a report titled *Optimizing Disaster Recovery: The Role of Insurance Capital Improving Economic Resilience*. This report noted that the annual average loss from natural disasters worldwide jumped from $27 billion in the 1970s to nearly $200 billion in the 2010s. The report analyzed more than 100 natural catastrophe case studies from around the world and found that countries with higher insurance penetration were able to recover far more quickly than communities with lower insurance penetration. Mr. Huff noted that the report found for each percentage point increase in insurance penetration, a country’s economic recovery time was reduced by almost 12 months.

Mr. Huff also said the recent California report *Protecting Communities, Preserving Nature and Building Resiliency: How First-of-its Kind Climate Insurance Will Help Combat the Costs of Wildfires, Extreme Heat, and Floods* provides guidance on how states can handle the protection gap.

Mr. Huff noted there are advantages of leveraging the international reinsurance capacity, including ensuring consumer coverage remains affordable and accessible, diversifying risk pools, exporting risks away from a jurisdiction, providing private market solutions, protecting communities and taxpayers, and helping to close the protection gap.

Mr. Huff said the ABIR is involved with the Insurance Development Forum (IDF), which is a public-private partnership with the World Bank and United Nations (UN). Ekhosuehi Iyahen (IDF) said the IDF’s objective is to extend insurance and risk management capabilities to build resilience and protection for individuals and communities. She noted the IDF has five working groups focused on: 1) risk modeling; 2) improving the quality of risk information; 3) sovereign and humanitarian efforts; 4) inclusive insurance; and 5) investments. She said governments sit on the steering committee for the IDF.

Ms. Iyahen noted the size of the global insurance protection gaps is $162 billion. The percentage of natural disaster losses in developing countries that were insured is around 1%. She said economic shocks are absorbed by individuals and governments, and funds are diverted away from health and education. Ms. Iyahen said developed countries also have a protection gap, and it is often those most in need of protection that are unprotected. She said communities often are not properly prepared for disasters. She noted that international organizations are taking this problem seriously in how to proactively address the protection gap. She said there is need for greater investment in risk awareness and understanding, risk reduction, and disaster response activities. She also noted there is a growing appreciation among international bodies of the role of finance and insurance.

Ms. Iyahen said innovative services and products to help governments understand natural hazard risks can be used to design systems to protect citizens and infrastructure. She noted there has been an increase in parametric products used by governments. She said regulators can support the broader conversation of how to build effective risk management and protection systems for the future by engaging with the insurance industry. She said regulators can help to drive the conversation by keeping pace of
innovation and new products and fostering collaboration and coalitions with knowledge sharing. Ms. Iyahen also said the IDF has issued a number of reports that explore these critical issues.

Commissioner Schmidt asked about the open-source modeling workstream at the IDF. Ms. Iyahen said the modeling work is critical because it creates a foundation for the understanding of risk. She said there is a need for communities to have more information to support decision-making. She said the IDF works with governments and vulnerable communities in better understanding risk through modeling.

Commissioner Schmidt asked about the growing protection gap in the U.S. as it relates to flood and earthquake risks being optional endorsements to coverage. Mr. Huff said flood is the top peril in all states. He said there is a reputational risk for the insurance industry due to some risks being optional endorsements and consumers being uninsured due to a lack of education about those risks. He said regulators need to have honest dialogue with the insurance industry and perhaps consider an all-perils approach to insuring risk. Mr. Huff noted that earthquake is an issue throughout the U.S. as well and that the Missouri Department of Commerce and Insurance is planning an earthquake summit in St. Louis, MO, to be held in September. He said the industry must do better job of making sure these risks are covered. He stressed that protection gaps exist even in the U.S., which is the most developed insurance market in the world.

Lieutenant Governor Roach asked whether there has been conversation about the cost and availability of insurance products leading to the protection gap. Ms. Iyahen said for developing communities, only 1% to 3% of the population is insured. She said where insurance is not part of the conversation, the IDF is working with partnerships to discuss the cost coverage, new products like parametric products, and how risks can be measured. She said it is critical that jurisdictions share knowledge with each other.

5. **Heard a Report on the Cybersecurity Insurance Market**

Aaron Brandenburg (NAIC) provided an overview of the data received in the Cybersecurity and Identity Theft Insurance Coverage Supplement. He said the data does not include the alien surplus line data because that data comes into the NAIC’s International Insurance Department in a separate filing. He noted that the alien surplus lines data would be included in a later report, likely to be released during a cyberinsurance session at the September Insurance Summit.

Mr. Brandenburg reported $2.74 billion was reported in combined direct written premium in stand-alone and package policies for 2020, which is a 22% increase over 2019. This follows increases of 11% and 7% the two years before that. He also noted there were more than 4 million cyber policies in force in 2020, an increase of 21% over the prior year. About 35%–37% of claims have been closed with payment over the past three years.

Mr. Brandenburg reported the largest writers in 2020 were Chubb, AXA, and AIG. Loss ratios varied across companies. The top five insurers made up more than 50% of the market, and the top 20 insurers wrote 84% of total premium. He said 2020 saw particularly high losses compared to prior years, rising from 65% in aggregate from below 50% in prior years.

Mr. Brandenburg noted that there has been a great increase in ransomware attacks across the last year. He said insurers have taken action to address changes to the market, including in the most extreme cases some insurers pulling out of the cyber market. Insurers have responded to large ransomware events by adding coinsurance and sublimits on their cyber policies, especially for businesses that do not have the best cyber hygiene. Other insurers have refreshed policy language to address the scope of coverage, exclusions, and sub-limits, as well as to identify areas where there is greater exposure.

Mr. Brandenburg said an Aon report called on the NAIC to create separate statutory categories for cyberinsurance to better illustrate how the industry is handling cyber risk as both premiums and claims continue to grow. The report suggests adding a separate line of business including on Schedule P, splitting cyber liability third-party commercial, cyber damage for first-party commercial, and cyber for personal lines. He noted other reports such as: 1) the Verizon *Data Breach Investigations Report*, which provides information on data breaches and incident classification patterns by industry; 2) an AM Best report that provides an analysis of the data contained within the Annual Statement Supplement; 3) the *Betterley Report*, which includes insights from 20 insurers and covers exclusions found in policies and the increasing costs of cyberinsurance; 4) a Gallagher report that provides information about the hardening cyberinsurance market and market capacity; 5) a U.S. Government Accountability Office (GAO) report that summarizes take-up rates coverage limits; and 5) the *Coalition Cyber Insurance Claims Report*, which covers different types of incidents that make up cyberinsurance claims.
Director Farmer asked if there is a risk to the cyberinsurance market, similar to what happened in the long-term care (LTC) market where insurers underpriced the risk. Mr. Brandenburg said NAIC financial staff have been working with regulators in looking at solvency issues.


Mr. Brandenburg said the Private Flood Insurance Supplement was new in 2021. Previously, through 2019, commercial and residential private flood data were combined on line 2.5 of the state page. State insurance regulators embarked on a data call in 2020 to collect 2018 and 2019 data and break commercial from residential. The data call also broke out stand-alone from endorsement and first dollar from excess. It included new data elements such as number of policies, claims opened, and claims closed. Mr. Brandenburg said the new Private Flood Insurance Supplement mirrors what was collected through the data call.

Mr. Brandenburg said there may be data errors within the Supplement as some states have identified insurers that should have but did not file the Supplement. He reported that the number of private commercial flood policies grew in 2020, but the number of residential policies fell. He said premiums rose greatly in commercial policies but fell slightly in residential. The total amount of direct written premium was $700 million in 2020.

Mr. Brandenburg said the NAIC and state insurance regulators have been working closely with FEMA in recent years in building the flood insurance market—whether that is the National Flood Insurance Program (NFIP) or the private market—in order to make sure individuals are better protected from flood risks. He said the number of companies writing residential private flood insurance grew over the last few years, from 55 in 2018 to 58 in 2019 to 81 in 2020. Premium fell slightly in 2020; 82% of the premium was in stand-alone rather than endorsements. He noted that residential private flood losses rose from $28 million in 2019 to $50 million in 2020. The residential private flood average premium fell in stand-alone products but rose in endorsements. He noted that loss ratios were highest in Alabama, Massachusetts, Michigan, Tennessee, and Utah for residential private flood in 2020.

Mr. Brandenburg said 15 insurance groups wrote at least $1 million in residential premium in 2020, with the top 15 insurers totaling $160 million in premium, which was over 85% of the market. Stand-alone first dollar policies had the most premium, with stand-alone excess next. Mr. Brandenburg said the results would be put on the NAIC website once additional data is received from insurers.

Mr. Birnbaum asked whether lender-placed flood insurance had been analyzed by the NAIC yet, and Mr. Brandenburg responded that it had not.

7. **Discussed the Special (EX) Committee on Race and Insurance**

Commissioner Schmidt said the Special (EX) Committee on Race and Insurance has adopted new charges and that the (P/C) issues will remain with Workstream Three of the Special Committee. She noted that the Special Committee met Aug. 15, where several interesting presentations will be leveraged by Workstream Three as it begins to create a work plan.

8. **Discussed Future Conference Call**

Commissioner Schmidt noted that Robert Hunter (Consumer Federation of America—CFA) reached out recently with a request to speak to the Committee about auto insurer premium refunds related to reduced driving throughout the COVID-19 pandemic. Due to the late nature of the request and the Committee having a full agenda, Commissioner Schmidt said the Committee may wish to take up the issues during a future meeting. She noted that regulatory actuaries have had many discussions regarding rate filings with COVID-19 adjustments. Mr. Birnbaum reiterated the desire to have a discussion about auto insurance refunds, and he also noted that he spoke before the NAIC/Consumer Liaison Committee on the impact the COVID-19 pandemic had on credit scores and before the Special (EX) Committee on Race and Insurance about how to test for bias in insurance models.

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

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Draft: 8/12/21

NAIC/Federal Emergency Management Agency (FEMA) (C) Advisory Group
Virtual Meeting
August 3, 2021

The NAIC/FEMA (C) Advisory Group of the Property and Casualty Insurance (C) Committee met Aug. 3, 2021. The following Working Group members participated: James A. Dodrill, Chair (WV); Glen Mulready, Vice Chair (OK); Katie Hegland (AK); Brian Powell (AL); Lucy Jabourian and Deborah Halberstadt (CA); George Bradner (CT); Virginia Christy (FL); Travis Grassel (IA); Patti Dorn (MD); Jo LeDuc (MO); David Dahl (OR); Beth Vollucci (RI); MaryAnn Carney (VA); and Matt Stoutenburg (WA).

1. Welcomed Members

Commissioner Dodrill welcomed members and thanked Commissioner Mike Chaney (MS), the chair of the Advisory Group’s parent group, the Catastrophe Insurance (C) Working Group. He announced that Commissioner Mulready would be serving as vice chair of the Advisory Group. He also noted that 18 states had signed up to be members. He noted that in future meetings, representatives of FEMA would be asked to speak to state insurance regulators about how to better engage with them.

2. Reviewed its Charge

Commissioner Dodrill said the Advisory Group’s charge reads:

The NAIC/FEMA Advisory Group will assist state regulators in engaging and collaborating with FEMA on an ongoing basis by establishing a process for the oversight, prioritization and reporting of disaster-related regional workshops and other exercises to improve disaster preparation and resilience.

Commissioner Dodrill noted the charge indicates the Advisory Group will need to create a process for oversight and prioritization and a reporting mechanism. He said before deciding on how to oversee and create priorities, the Advisory Group probably needs to understand recent activities that state insurance regulators and FEMA have been engaged in. Commissioner Dodrill said this may lead state insurance regulators to want to participate in similar or new activities. He said the Advisory Group will need to receive feedback from members in order to help oversee and prioritize those projects.

Commissioner Dodrill said the reporting mechanism will be key in order to keep track of not just historical activities, but also upcoming ones. He said the Catastrophe Insurance (C) Working Group has created a Catastrophe Resource Center web page, where it has housed catastrophe resources like bulletins, NAIC disaster capabilities, and some workshops that have already been held with FEMA. He said the Advisory Group should build off that and use it to keep track of historical and future activities.

Ms. Jabourian asked if the Advisory Group would discuss what entails oversight of state insurance regulator activities. Commissioner Dodrill said the Advisory Group would have that discussion early in the process but would receive reports on activities first.

Ken Klein (California Western School of Law) asked if the Advisory Group might consider working with FEMA to see if statewide loss and exposure data could be obtained so that state insurance regulators could determine how much property is insured and what a total loss would look like in a geographic area. Commissioner Dodrill said state insurance regulators have shared data with FEMA in the past and will continue to examine future data capabilities.

3. Heard an Overview of Recent Activities between State Insurance Regulators and FEMA

Aaron Brandenburg (NAIC) said he would provide an overview of activities state insurance regulators have recently held with FEMA, but he said in the future, the Advisory Group might want to hear directly from FEMA staff. He said NAIC staff have begun to put many of these FEMA-related resources on the NAIC’s Catastrophe Resource Center web page.

Mr. Brandenburg noted that state insurance regulators have held meetings dealing with flood and other disasters with FEMA Region IV and Region VII last year and a combined meeting with FEMA Region VIII, Region IX and Region X in 2021. Recordings and materials for these sessions are included in the Catastrophe Resource Center. He said for Region IV, an
agreement has been signed between the states and FEMA to form a working group so that the parties can continue to engage, typically on a monthly basis through conference calls. That working group has met several times already this year to share consumer resources and data, to talk about practical and logistical issues arising during disasters, and to hear about technologies that can assist them while in the midst of a disaster. He noted that other regions might wish to set up similar working groups and that the Advisory Group might be one way to manage and provide assistance to those groups. The NAIC is also looking at how to create a regulator-only portal within the Catastrophe Resource Center to house that information.

Mr. Brandenburg said the pre-mitigation workstream of the Climate and Resiliency (EX) Task Force held a mitigation workshop in March 2021. The Center for Insurance Policy and Research (CIPR) worked with the Federal Alliance for Safe Homes (FLASH) and FEMA in putting on this workshop, which focused on building codes, mitigation, and resiliency funding. FEMA provided an overview of its building codes strategy. States heard about FEMA’s Hazard Mitigation Assistance (HMA) grant program and Building Resilient Infrastructure and Communities (BRIC) program. The NAIC recently hosted a workshop for states and a contractor on assisting states in applying for BRIC grants.

Mr. Brandenburg said several Insurance Summit sessions were held in June that built off the mitigation workshop. FEMA personnel made several presentations that are relevant to state insurance regulators, including a presentation about the National Flood Insurance Program’s (NFIP’s) Community Rating Service (CRS). CRS is a voluntary program for NFIP communities. It is a rating program where the CRS rating results in a direct insurance premium discount. Mr. Brandenburg noted that an addendum to the CRS Coordinator M was updated in 2021 and included a new credit given to communities if they hold a flood insurance meeting such as a town hall and provide brochures or other information. There is an additional credit for participation if the state insurer commissioner’s office is involved as a rep to talk or be available to answer insurance questions. He noted that most departments of insurance (DOIs) already hold such consumer events, so it may be an easy way for communities to receive additional credits. Mr. Brandenburg said FEMA also spoke at the Insurance Summit about the importance of partnerships related to mitigation efforts. CRS is evolving and creating new information and priorities through 2025. FEMA is gathering data over the next year and is seeking feedback from state insurance regulators. A presentation was held during the Insurance Summit on building codes, including results from the FEMA study on building codes showing total losses avoided and the annual amount of money saved annually based on hazard-resistant building codes. There was an Insurance Summit session on earthquake mitigation that covered: state grants for mitigation and preparedness; the Wasatch Front Unreinforced Masonry Risk Reduction Strategy; and a program in Salt Lake City, UT, known as “Fix the Bricks” that seeks to repair the worst buildings. Finally, Mr. Brandenburg said FEMA covered its National Risk Index, which shows expected annual losses, social vulnerability, and community resilience to create a risk index that represents the potential for negative impacts resulting from natural hazards.

Mr. Brandenburg said the state of Washington is planning a Cascadia Rising 2022 exercise with FEMA partners and has been planning the event with neighboring states, the NAIC, and FEMA. FEMA also released a report in July 2021 titled Building Private-Public Partnerships, which helps public and private sector emergency managers collaborate to increase resilience.

Mr. Brandenburg said the NAIC will put as many of these documents and engagements as it can on the Catastrophe Resource Page and will work with the Advisory Group on how to organize the materials.

Jeff Czajkowski (CIPR) also noted that the NAIC has an agreement with FEMA used for Region IV that could be used for other states. He said state insurance regulators have participated in training provided by FEMA on the NFIP’s Risk Rating 2.0. He also noted the Missouri Department of Commerce and Insurance will host an earthquake summit will be held in September in St. Louis, MO. Mr. Bradner asked if the FEMA sessions on Risk Rating 2.0 are available, and Mr. Czajkowski said he would check and have links sent to state insurance regulators.

4. Discussed its Next Meeting

Commissioner Dodrill said FEMA staff may be asked to speak to state insurance regulators during the next Advisory Group’s next meeting. He said the Advisory Group would also look at recent updates to the Catastrophe Resource Center in order to help with the reporting mechanism for historical and future events.

Having no further business, the NAIC/FEMA (C) Advisory Group adjourned.
Draft: 8/20/21

Cannabis Insurance (C) Working Group
Virtual Meeting (in lieu of meeting at the 2021 Summer National Meeting)
July 27, 2021

The Cannabis Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met July 27, 2021. The following Working Group members participated: Ricardo Lara, Chair, represented by Melerie Michael (CA); Michael Conway, Vice Chair, represented by Peg Brown (CO); Jimmy Harris (AR); Angela King (DC); Tanisha Merced (DE); C.J. Metcalf (IL); Marlene Caride represented by Randall Currier (NJ); Gennady Stolyarov and Mark Garratt (NV); Shelly Scott (OK); Raven Collins (OR); Christina Rouleau (VT); and Michael Walker and Ned Gaines (WA). Also participating was: George Bradner (CT); and Benjamin Yardley (ME).

1. Heard a Presentation on Balancing Actual and Perceived Risks

Ms. Brown stated that the second day of the Fact-Finding Hearing on Insurance for Cannabis-Related Businesses will focus on barriers to affordability and moving forward. As much has transpired in this industry over last decade, the Working Group intends to use the information gained from the two-day hearing to update its white paper, Understanding the Market for Cannabis Insurance, through the addition of an appendix. Drafting sessions on the white paper appendix will begin in August. Working Group members interested in participating in these drafting sessions were directed to notify NAIC staff by Aug. 10.

The Working Group also plans to leverage the feedback gained from the hearing to discuss at its next meeting how state insurance regulators can better collaborate with each other and other regulatory agencies.

Brenda Wells (East Carolina University) stated that cannabis businesses pay several times what other industries pay for insurance. Directors and officers liability insurance costs well into the six-figure range for $1 million in coverage. A small mercantile general liability policy might cost around $1,000, but a cannabis policy without products liability is about $10,000. Consumer concerns and misperceptions include a belief that coverage is not available or not worth the cost. Additionally, there is a fear that information provided to the insurer can be accessed by the federal government or others. Some also have concerns about deceptive trade practices, like being initially promised coverage but then being denied by the insurer based on the federal illegality of cannabis.

This occurred in the Green Earth Wellness Center LLC v. Atain Specialty Insurance Company lawsuit. Green Earth, a retail medical marijuana business in Colorado Springs, CO, attained commercial insurance for its business from Atain effective on June 29, 2012. Several days later, Green Earth contended that the smoke and ash from a nearby fire caused damage to its ventilation system, eventually damaging its plants. In November 2012, Green Earth made a claim under the insurance policy to Atain. Atain denied the claim on the grounds that the policy expressly excluded coverage for contraband, and it was void as against public policy. Attain moved for summary judgment. The court agreed with Atain that possession of marijuana for distribution is a federal crime. However, Atain solely pointed to the federal statute and did not assert whether Green Earth’s operation violates Colorado law. Therefore, due to Atain’s neglect to assert that Green Earth’s operation was a violation of Colorado law, the court found that there is a genuine issue of material fact and denied Atain’s motion for summary judgment.

Ms. Wells stated that a major issue is lack of data. While cannabis has been used for thousands of years, the legal industry in the U.S. is in its infancy. We know very little about the losses and expenses associated with this industry. Ms. Wells plans to conduct a cannabis industry Cost of Risk Survey soon. Underwriting for cannabis has been extrapolating data from other industries where similarities exist. For instance, underwriters can look at pharmacies when evaluating medical cannabis and liquor stores when evaluating vape shops. Underwriting factors include third-party inspection results, security systems wired to an outside monitoring station, an adequate electrical system with proper wattage and circuits, fire suppression systems, the type of safe used for storing cash/product, motion detectors in the room where finished product is stored, membership in state trade associations, education and training of owners/operators, and use of related regulations.

2. Heard a Panel Discussion on Uncovering Obstacles to Offering Coverage

Ms. Brown asked what additionally needs to happen at state and federal levels to make insurers comfortable entering the cannabis insurance industry. She also asked if this would likely be under this administration.

Ian Stewart (Wilson Elser) stated that the status quo is not sustainable. There must be some clarity of cannabis’ legality at the federal level. There have been comments from democratic senators that they should not allow a vote on the Secure and Fair...
Enforcement (SAFE) Banking Act without a broader social equity and social justice provisions. Arguably the most conservative U.S. Supreme Court justice, Clarence Thomas, criticized the federal ban on marijuana and the U.S. government’s inconsistent enforcement in a statement a couple weeks ago, questioning whether the government has the authority to “intrude on” state-legal cannabis markets. This indicates that time is limited for the U.S. Congress (Congress) to act before the U.S. Supreme Court does so. For carriers, Schedule One of the Controlled Substances Act (CSA) is the largest hinderance because it prevents primary protection of its banking relationships. The directives in the proposed U.S. Senate (Senate) bill for the federal government to study cannabis are needed to increase the data available to insurers.

Ms. Brown asked what additional actuarial and experience data is needed to help insurers write cannabis-related business coverages.

Tim McCarthy (Insurance Services Office—ISO) stated that cannabis is an emerging type of risk, and more public data on it is needed to better analyze information on a state-by-state basis because operations differ so much by state. It may take several years before there are sufficient court cases for products liability. Long-term studies on the impacts of cannabis are also needed. The ISO has introduced 10 new classifications related to cannabis that will be implemented in 40 jurisdictions later this year. The ISO will begin to collect data next month related to this to more uniformly analyze and update its commercial general liability cost information.

Lois J. Massa (G.J. Sullivan Co. Reinsurance—GJS Re) stated that in lieu of lack of data, carriers are benchmarking to similar industries and/or evaluating and aggregating their own data.

Ms. Brown asked how reputational concerns factor into insurers and reinsurers’ willingness to participate in the cannabis space.

Mr. Stewart stated that reputational concerns are still relevant, but much less of a concern than they were just a couple years ago. Marijuana has become socially accepted over the past year or two. Conservative states are now enacting adult-use cannabis laws very quickly. However, a positional schism is beginning to form in the cannabis community between the regulated marijuana market and the hemp-derivatives market. There is reputation risk in hemp derivatives because they are not laboratory tested and regulated the same way as regulated cannabis companies’ products.

Ms. Massa agreed and said the greater acceptance of cannabis is due to the cannabis industry’s educational efforts. However, the impact of future claims going to court will determine if this industry sees payouts that might affect reputational risk. This happened with the liquor industry a decade ago. The Juul vaping case is a good example of this.

Michael Hall (Golden Bear) stated that many of the countries that the global reinsurers are from still view cannabis as an illicit drug. As a result, the global reinsurers have great concern on reputational risks that may stem from bad press in their respective countries.

Ms. Brown stated that Lloyd’s of London stopped insuring in the U.S. cannabis industry due to the continuing legal uncertainty. She asked what this had on the insurers ability to buy reinsurance.

Ms. Massa stated that Lloyds’s syndicates had been the lead cannabis writers in the U.S. in 2015 because they are regulated by one entity. They decided as a group collectively to withdraw from the U.S. market due to legal uncertainty at the federal and state levels and concerns about U.S. banking regulations. The impact in the U.S. was on primary coverage and reinsurance support, as Lloyds provided both. It was temporarily difficult to get primary policies; then, companies such as Golden Bear and James River stepped in to fill the void. Most global reinsurers are not based in the U.S. and operating in the U.S. cannabis market due to the aforementioned concerns. However, there is some exposure to cannabis through reinsuring portfolios. In October 2018, Canada passed the federal Cannabis Act. The bill amended the criminal code to remove it from the CSA, established cannabis operations as legal in Canada (only the second country to do so), and put in place a series of regulations to manage it in a similar manner as liquor liability. As a result, Lloyds’s and global reinsurers have entered their market. Some U.S. companies have bought or established Canadian carriers to write cannabis.

Ms. Brown asked to what extent exclusions and reinsurance contracts are impeding carriers’ abilities to offer coverage to cannabis-related businesses.
Ms. Massa stated that reinsurance is insurance that insurance companies buy. So, insurers can choose to hold the risk on their books, but it is not advisable. There have been 30–40 new fronting companies in the past two years. There is some global reinsurance support through large treaty arrangements that include other pieces of business. However, reinsurance is difficult to obtain for new carriers.

Mr. Hall stated that the Bermuda Monetary Authority (BMA) issued a statement to reinsurers in late-2019, encouraging them to enter the now legal cannabis market in Canada. This implied to reinsurers that they should not enter markets, like the U.S., where cannabis still remains federally illegal. The result was a freeze in reinsurance capacity in the U.S. for cannabis operators.

3. Heard a Panel Discussion on Insurance Challenges

Ms. Brown asked what factors drive the lack of capacity for organizational coverage.

Norman Ives (Amwins) stated that the cannabis industry has been experiencing the same trends as the general insurance industry, just to a greater extent. The insurance market has been hardening. Professional lines risks were significantly affected when the Cole Memorandum was rescinded in January 2018. The market almost shrank in half overnight and rates rose. Since this time, the market has hardened.

Mr. Stewart stated that cannabis is a hard market inside of a hard market, especially for coverages like directors and officers. Compliance is very difficult for many of these companies leading to an uptick in securities litigation, shareholder and derivative suits, investor disputes and allegations of mismanagement actions by regulators. These cases are expensive and caused by the chaos surrounding the disparate regulations and lack of traditional financing. This leaves companies seeking private investment where they need to disclose all risks in a memo to investors, which is extremely difficult to do and leads to predictions that do not come to fruition. The genesis of the current suits is the foreign exchanges and reverse takeovers occurring in a very fragmented environment. A study in late-2000 by Stanford Law School found that there were 2008 securities class action lawsuits filed against U.S. and Canadian cannabis businesses. However, the majority of the suits had been filed within the previous two years. The filings are for failing to disclose weak demand for products, misstating inventory, failing to report operational problems, making revised earning reports that cause a stock drop, and allegedly misleading investors about contamination issues. There is a magnifying glass over the cannabis industry, resulting in several lawsuits all at once. Federal legalization in the form of the SAFE Banking Act could have a very positive impact because companies would start to operate more similarly to other industries. However, broad federal legalization may result in a temporary period of increased chaos due to the introduction of interstate commerce.

Ms. Brown stated that there are definite parallels between how insurance is regulated by states and how cannabis state-based regulation is evolving. She asked if there are gaps in products liability insurance coverage for cannabis-related businesses.

Mr. Stewart stated that the science and products are being developed concurrently, making it difficult to know what is unreasonably dangerous. This makes it hard for juries who must make decisions in product liability suits. There is a developing standard of care around agreed standards but not enough case law. The cannabis industry could see large uninsured risks materialize as tort cases get filed in the coming years. Recent science findings on vascular conditions arising out of high tetrahydrocannabinol (THC) edible products. However, insurance companies usually do good at insulating themselves with certain types of exclusions.

Mr. Hall stated that the cannabis industry has uninsured risks related to long-tail liability. Some carriers are covering things like mental illness, knowingly or unknowingly, and others are excluding it. There is a gap in the perception of what is covered and what is actually covered once you read deep into the 100-page policy.

Ms. Brown asked about products liability coverage for cannabis businesses.

Beth Medvedev (James River) stated that cannabis is very similar to other products, and underwriters can leverage similarities. One issue James River has encountered is that the industry is so unique it must anticipate the coverages. For example, on-site consumption cafes are not quite the same as alcohol because there is not a test to determine how much a person is impaired by cannabis. It is difficult to determine the effect of someone eating an edible on site and then leaving 30 minutes later. In the absence of a full understanding of all the risks, insurers may be covering unanticipated risks. Carriers also differ in their interpretations of coverage, like health hazard forms. Another issue is cannabis insureds must be aware of how the language in standard policy forms needs to be modified to remove exclusions for federal legal issues, or they could potentially face a declination of a claim.
Ms. Brown asked if there are alternate arrangements being developed or already being used in the market.

Mr. Stewart stated that there has been an increased interest in fronting over the past year. The market has also seen single cell captives being domiciled in a few states and offshore and some cannabis-specific group captives.

Mr. Ives asked Mr. Stewart if its federal legalization was needed before more progress occurs with captive risk retention groups (RRGs).

Mr. Stewart said there has been a natural reluctance to move money offshore because it gives people the impression of money laundering. There needs to be a banking solution. State insurance departments would likely have a greater comfort level with regard to actively domiciling cannabis captives if there was more certainty at the federal level.

Ms. Brown asked what risks in the cannabis industry affects property coverage.

Summer J. Jenkins (National Cannabis Industry Association [NCIA] and Cannasure) stated that an underwriter would consider the known risks. This would include anything that would increase frequency or severity of the loss; i.e., construction, occupancy, protection, and class exposure. Factors that will increase the frequency and severity include wind, hail, crime zone, and types of controls in place. Many of these questions are answered by the law. Cannabis businesses must have safe volts and multiple secured access and entry points for areas where cash is stored. Unique to the cannabis industry is that businesses tend to be cash based. They also grow much more rapidly than other businesses, making business income an important factor. This could lead to their potential loss of revenue exceeding the amount of all other covered property from an insurance standpoint. Some carriers have a coinsurance penalty.

Mr. Hall stated that oftentimes, a fast-growing cannabis-related business will find it is maxed out on the capacity it has with its primary carrier. This is the main property exposure in the cannabis industry.

Mr. Stewart asked what can be done in cases where there is a disconnect between what was written and when the claim comes in the insured finds its underinsured.

Mr. Hall stated that some of the issue lies in educating brokers. However, the largest issue is businesses in this industry foregoing insurance because it is so expensive.

Ms. Jenkins stated that there are some coverage forms in the market for things like peak season limit endorsements, fluctuating valuation endorsements, and monthly reporting endorsements. The issue is carriers being able to navigate the administrative hurdles to implement them.

Peg Brown stated that if it were legal, there would likely be a lot of interest in interstate commerce for cannabis between California and Colorado.

Mr. Stewart stated that once interstate commerce is allowed, there is likely to be an increase in confusion due to the different state regulatory structures that require different things for their distributors. For example, in California, there are requirements that the vehicle must have a security cage or other type of protective equipment installed in the vehicle. There are restrictions that require drivers to be an employee of a certain age. Insurance provisions often go off what is required in the state. This can be an issue for cannabis businesses because they often only focus on complying with state regulations and do not read their policies. A problem will arise when the business operates in multiple states with just one system for its various distributors. The solution lies in achieving more consistency between state regulations.

4. **Heard a Panel Discussion on What the Horizon Looks Like and How State Insurance Regulators Can Help**

Ms. Michael asked how coverage will evolve from the surplus market to the admitted market in the coming years. She also asked if there was something that could be done to encourage this process.

Ms. Wells stated that it would take a long time for the admitted market to want to provide coverage to some of the exposures in the cannabis industry. It would need sufficient data in addition to a federal solution. Liquor liability coverage is still being provided for by the nonadmitted market.

Ms. Michael asked how cannabis businesses find insurers willing to provide coverage.
Mr. Ives stated that the internet is a good source to find information on insurers in the cannabis space. He also recommended that state insurance regulators provide a list of brokers similar to the one the California Department of Insurance (DOI) provides online.

Ms. Michael asked what supportive measures state insurance regulators can provide when reinsurance conditions and federal laws change.

Ms. Jenkins stated that state insurance regulators can help by making the filing rate approval process much easier, providing more clarifying documents, and implementing a more expedient process.

Ms. Medvedev stated support for promoting those regulations in the industry to attract more insurers and reinsurers into the market. The major hurdle is having more options of insurance coverage.

Ms. Michael asked how the NAIC can support availability and affordability of coverage.

Mr. Hall stated that lack of data currently has insurers making educated guesses. Providing more flexibility inside rate filings for rates to increase or decrease would allow more insurers to feel comfortable entering the market.

Ms. Jenkins stated that the availability of forms and rate justifications are big issues because of the nature of the industry. It would be greatly helpful if state insurance regulators established justification reasoning requirements more representative of the tenure of the industry. It would also be helpful if state insurance regulators accepted data from a similar industry in lieu of data that is directly applicable.

Ms. Medvedev stated that it is important that states remain welcoming to nonadmitted carriers, as they provide an important service to emerging industries by having more flexibility.

Ms. Michael asked what innovation can facilitate better availability of coverage.

Ms. Wells stated that it really all comes down to changes with federal regulation.

Ms. Michael asked how support for legalized cannabis will evolve in the future.

Ms. Wells stated that Pew Research’s April poll showed over 90% of the U.S. population thinks cannabis should be legal in some form. However, there are well-funded campaigns pushing against its legalization.

Ms. Michael asked what private solutions exist for crop insurance.

Mr. Ives stated that the federal government allowed crop coverage to be available for hemp crops for the first time last year, but only if the insured had grown crops the previous year. The crop coverage that is available would not benefit businesses growing hemp or cannabidiol (CBD) products for human or animal consumption. Crop programs are based around a federal program and the commercial insurance policies available for crop are supplemental to coverage provided through the federal program. There will not be much movement on agricultural product coverage until there is a federal crop program that is really viable for hemp farmers. The only programs currently offered for crop coverage are parametric programs, which are very limited risk-specific programs.

Mr. Bradner asked if it would be likely that the tobacco and alcohol industry would enter the cannabis industry once the federal illegality is no longer an issue. He also asked if there is anything to learn from Canada’s legalization of recreational cannabis.

Ms. Wells stated that the tobacco and alcohol industry are already diversifying into the space with things like infused alcohol drinks. They are also a force against the legalization of cannabis for competitive reasons.

Mr. Stewart stated that both industries are involved, and there will likely be a coalescent around a smaller number of brands in the future. The focus of the alcohol industry is to get control of those brands. Canada is regulated very differently than what federal regulation will end up looking like in the U.S.

Kristen Augustine (Colorado Marijuana Enforcement Division) asked if a business owner would be considered higher risk if he/she has a felony record for unlawful distribution.
Ms. Jenkins stated that from an underwriting standpoint, it is illegal to discriminate or give someone preference based on their application status. But underwriters can provide things like association membership or rating credits that apply directly to the decrease of exposure on the risk. In some instances, carriers will offer a 10% credit for social equity applicants that are also members of a trade association. Trade association members are required to go through more rigorous training. Underwriting is based a lot on the underwriter’s personal perceptions.

Ms. Medvedev stated that it depends on the risk, the offense, and how much it affects what is being done. Offenses, such as embezzlement, would be looked at as a moral offense.

Mr. Yardley asked how valid experience data develops in the absence of a federal solution.

Ms. Medvedev stated that individual carriers will have their own data and experience. There is also a part of underwriting that looks at where lawsuits and claims are occurring.

Mr. Ives stated that it can be difficult to try to aggregate data, as claim data is still proprietary. Aggregating litigation data can be difficult because many state courts do not provide searchable databases. States need to provide good state-level data on cannabis regulatory schemes. Traceability systems and reporting capabilities within the states need to be upgraded to generate usable data, such as gross sales. The Washington State Liquor and Cannabis Board (WSLCB) makes this type of information available.

Mr. Bradner asked if the information is obtainable though a Freedom of Information Act (FOIA) request.

Mr. Stewart stated that to a certain extent, this information can be acquired through an FOIA request, but it would be time consuming and costly. The information would only be provided through redacted records, and there are some privacy concerns. California coordinated through its various agencies to amend regulations to make it easier to share data that insurers and banks need, such as the owners, financial interest holders, and background information. This has provided marked improvement in the turnaround time and amount of data that is provided to ancillary service providers. What is allowed to be disclosed and the system set-up varies by state.

Ms. Brown stated that state insurance regulators may need to take up coordinating with sister state agencies and the Cannabis Regulators Association (CANNRA) to help provide the needed data to the insurance industry.

Having no further business, the Cannabis Insurance (C) Working Group adjourned.
The Cannabis Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met July 19, 2021. The following Working Group members participated: Ricardo Lara, Chair, represented by Melerie Michael (CA); Michael Conway, Vice Chair, represented by Peg Brown (CO); Jimmy Harris (AR); Angela King (DC); C.J. Metcalf (IL); Marlene Caride represented by Randall Currier (NJ); Gennady Stolyarov (NV); Andrew Schallhorn (OK); John Lacek (PA); Elizabeth Kelleher Dwyer (RI); Christina Rouleau (VT); and Michael Walker (WA).

1. Heard a Presentation on the Geographical Expansion of States Legalizing Cannabis and its Impact at the Federal Level

Ms. Michael stated that the first day of the Fact-Finding Hearing on Insurance for Cannabis-Related Businesses will focus on setting the cannabis stage and insurance product availability. In 2017, the California Department of Insurance (DOI) held the nation’s first public hearing for cannabis insurance and approved the nation’s first admitted carrier, Golden Bear, to write cannabis insurance products in California. Two years later, the Working Group adopted its white paper, Understanding the Market for Cannabis Insurance. As much has transpired in this industry over the last decade, the Working Group will use the information gained over its two-day hearing to update the white paper through the addition of an appendix. The Working Group also plans to leverage the feedback gained from the hearing to discuss how state insurance regulators can better collaborate with each other and other regulatory agencies.

Ian Stewart (Wilson Elser) stated that nearly all Americans now live in a state where some form of cannabis is legal. Additionally, over 90% of Americans believe cannabis should be legal either for adult or medical use. The geographic expansion of state cannabis markets now includes 18 states and Guam legalizing cannabis for adult use and 37 states; Washington, DC; Puerto Rico; Guam; and the U.S. Virgin Islands legalizing cannabis for medical use. Since last November, 10 states have passed new adult-use or medical cannabis laws, including Alabama, Arizona, Connecticut, New Jersey, New Mexico, New York, Mississippi, Montana, South Dakota, and Virginia. In 2021, six states have passed expansions to their medical cannabis regulations, including Georgia, Louisiana, Minnesota, Pennsylvania, Tennessee, and Texas. Adult-use legislation is currently being considered in Delaware, Florida, Hawaii, Iowa, Maryland, Minnesota, North Carolina, North Dakota, Pennsylvania, Rhode Island, and Wisconsin. Adult-use ballot initiatives in 2022 are expected in Arkansas, Florida, Missouri, Ohio, and Oklahoma.

The Cannabis Administration and Opportunity Act is a draft bill released by Sen. Chuck Schumer (D-NY), Sen. Cory Booker (D-NJ), and Sen. Ron Wyden (D-OR) on July 14 to remove marijuana from Schedule 1 of the Controlled Substances Act (CSA) and have it regulated similar to alcohol. This would allow states to determine their own cannabis laws and transfer federal agency jurisdiction from the Drug Enforcement Administration (DEA) to the U.S. Food and Drug Administration (FDA), the U.S. Department of Health and Human Services (HHS), Alcohol and Tobacco Tax and Trade Bureau (TTB), and Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF). It would also lift restrictions on research and direct various federal agencies and departments to study and report on cannabis. It automatically expunges criminal convictions for non-violent marijuana offenses. Grant programs would be established for non-profits, small business loans, and state funding to assist individuals disproportionately affected by the war on drugs. It would levy federal excise tax on cannabis products and establish a federal track and trace regime. Interstate commerce would be restricted for cannabis products that fail to comply with mandated packaging and labeling requirements. A legal pathway would be created for Cannabidiol (CBD) in dietary supplements with a maximum recommended daily serving. It would also establish a process for delivery of inadvertent “hot hemp” to a licensed cannabis operator for processing.

2. Heard a Presentation on the Cannabis Business Regulatory and Licensing Landscape

Norman Birenbaum (Cannabis Regulators Association—CANNRA) stated that the CANNRA is a national organization of cannabis regulators that provides policy makers and regulatory agencies with the resources to make informed decisions when considering whether and how to legalize and regulate cannabis. Its members are the primary regulatory agencies and officials charged with the oversight of adult-use cannabis and/or medical cannabis in Arizona; California; Colorado; Connecticut; Delaware; Florida; Georgia; Hawaii; Illinois; Iowa; Louisiana; Maine; Maryland; Massachusetts; Michigan; Minnesota; Montana; Nevada; New Jersey; New York; North Dakota; Oregon; Rhode Island; South Dakota; Utah; Washington; and
Washington, DC. Each of the 36 states and four territories that have legalized some form of cannabis have their own unique regulatory framework. Licensed activities, tax mechanisms and rates, market structure, the role of local governments, marketing and advertising, approved qualifying medical conditions, and many more regulatory issues vary greatly between jurisdictions. As an association, CANNRA brings states together, even with varying regulatory frameworks, to discuss shared challenges and identify best practices in cannabis regulation.

The evolution in federal oversight and how standards are created has really affected the work of CANNRA. This included shifts from voter initiatives to legislative process and U.S. Department of Justice (DOJ) enforcement to U.S. Department of the Treasury (Treasury Department) compliance. There is a trend of states pushing back against federal initiatives, particularly around background checks and past criminal history, to embrace social and economic equity priorities around the cannabis industry and licensing. The U.S. is now entering into a stage of learning from other jurisdictions. CANNRA members often discuss how they are moving towards product standards, including everything from packaging to labeling. Testing and product safety regulations vary greatly between states in terms of what is being tested and how it is being tested. This includes how labs are credentialed and how different action levels and limits around mold microbials, pesticide residual solvents, and heavy metal toxicity are determined. Sampling processes and procedures also vary between jurisdictions. Additional issues include how to perform cross jurisdiction verification if there is change at the federal level to make sure there are consistency and good regulatory tools for product recalls and administrative action. The labs are the hardest in the cannabis space to regulate because of the nature of the testing and the competition amongst labs for market share. E-cigarette or vaping use-associated lung injury (EVALI) was identified in 2019 by the federal Centers for Disease Control and Prevention (CDC) as a dangerous lung disease linked to vaping. The plethora of young people becoming seriously ill after vaping prompted a wave of regulations that changed the landscape. States are also issuing policy statements or regulations prohibiting delta-8 tetrahydrocannabinol (THC) and other intoxicating synthetic isomers of CBD currently being marketed as legal because the 2018 Farm Bill legalized hemp extracts.

Tax structures is an area that has produced some of the greatest variations and new innovations over the last year. Initial tax structures were mostly based on ad valorem tax rates and the value at the point of sale. Over the past three years, this has transitioned to using potency or THC concentration to determine the tax rate. This has prompted conversations with stakeholders on whether the tax rate, given limited supply and unlimited distribution in the initial years when prices are the highest, affects the overall price for the consumer or just the margins of the licensees. There was a huge increase in medical and adult-use cannabis delivery services in the wake of the pandemic. There is an emerging trend of social consumption licenses. Policy considerations for this include federal indoor clean air protections, providing a location for consuming that does not conflict with federal restrictions like federal subsidized housing, and public health considerations. Market architecture and licensing is something states are taking a more aggressive stance on, particularly here in New York. In New York, if you are involved in the cultivation manufacturing or wholesale distribution, you cannot be involved in the retail distribution of the product, outside of a few exceptions. States struggle with public health and education programs because the revenue is typically based off sales, which take up to 18 months to realize. This makes it hard to establish baseline data and perform ongoing monitoring of use rates and outcomes. States struggle with issues of workplace impairment and driving under the influence. This is a shift away from per se limits because cannabis-related products affect everyone differently based on individual usage and metabolic rate. There is no breath analyzer equivalent for cannabis, and much research will be needed to develop one.

Social and economic equity is becoming the linchpin in passing legislation. How this is defined is of great deliberation. Jurisdictions have shared that providing someone with prioritization and licensing does not guarantee them access to that license, especially in jurisdictions where there are dual licensing structures. Additionally, access to a license does not equate to market share and capital access. Due to a lack of guidance from the federal government, states are working with institutions to help them satisfy their due diligence requirements under the inset guidance, particularly with banking and financial services. States are speaking more with state banks around what is needed for their disclosure licensing requirements to make them more comfortable providing services to the industry. For the first time, traditional capital is being made available to certain large cannabis licensees. States are also trying to lay the groundwork for interstate commerce; i.e., uniform standards, validation, intellectual property (IP), distribution.

3. Heard a Presentation on the Cannabis Insurance Market Segments and Insurance Needs from Seed to Sale for Vertically Integrated and Niche Players

Michael Hall (Golden Bear) stated that Lloyds stepped out of the cannabis insurance business when it got its federal charter five years ago. The nonadmitted market stepped up to fill the void. Admitted insurers are hesitant to enter the market due to a lack of reinsurance and clarity of legality at the federal level. State insurance regulators have little ability to influence reinsurance, as it mostly occurs at the international level. What they can work on is building strong systems of risk management and clarifying ancillary risks, such as dram shop statutes. From an insurance perspective many regulations, like track and trace
and strict licensing rules, provide a strong starting point for risk management.

Summer J. Jenkins (National Cannabis Industry Association [NCIA] and Cannasure) stated that cannabis businesses are just like any other business in that the biggest needs for most are the basic coverages. For cultivation, nationally recognized success of the agricultural industry affords a wealth of information. Challenges include technological advancement and speed of industry developments. Some technologies like artificial intelligence (AI), nanotechnology, and the use of synthetic DNA are not contemplated in law or insurance coverages. Insurance coverages and laws should also be cognizant of the frequently changing use in types of lighting and equipment. Additionally, there is a need to address commercial and residential exposures with a coverage form that allows the agricultural industry to recognize the residential and habitational exposure blends with commercial exposure. For instance, outdoor crop is only available from nonadmitted carriers in the form of parametric coverage. There is also a need for insurance for things like vehicles or mobile equipment that are licensed for road use and are also used in the outdoor cultivation. Additionally, most policies do not address conveniences like rail and air due to federal legality. There is not much availability for environmental incidents. There is a lack of coverage for testing done by distributors. The bailment bailee-bailor protection coverage is not adequately covered in cannabis law, which makes it difficult from an insurance standpoint. Hired and non-owned auto is also a challenge, with only excess liability coverage and limits over $1 million limited or non-existent.

Mr. Hall stated that despite the wide range of retail set-ups, there has been a push recently on the nonadmitted side for coverage to transition from the wholesale brokerage market into the managing general agent (MGA) binding market. States should focus on how they can encourage admitted carriers to enter the retail space. Part of this should include clarifying shop statutes for onsite consumption lounges at retail dispensaries. Most shop laws address alcohol specifically, but not cannabis. On the manufacturing side, there is an issue with the lack of standardization and the coverage forms, particularly with valuation of product and how it is seen when multiple insurance companies are involved in handling a claim. Standardization of things, such as the current health hazard and cancer exclusions and their evaluation, will help provide clarity from an admitted perspective. A clearer more conservative approach to labeling requirements would also help attract more carrier participants.

Mr. Birenbaum said early approaches to packing and labeling included numerous different disclaimers, which made it hard for the consumer to recall any single warning because there were so many. Canadian federally funded research found that consumers wanted plain packaging and simple labeling that includes only two to three warnings. This approach is just starting to be adopted in the U.S. research from the University of Waterloo, which found that 40–50% of people who consider themselves regular cannabis users on at least a monthly basis could not identify what causes intoxication. This illustrates solutions that may seem good in a vacuum do not execute well because of the lack of education and awareness and the federal stance.

Mr. Stewart said he agrees and believes that as the science comes out, we will likely see a standard of care developing, possibly through civil tort. As with other consumer products, legal verdicts will likely influence voluntary standards over time. It could likely be a diversion between edible products and other forms of products. Things like product inserts may be on the horizon.

Mr. Birenbaum said the majority of consumers get their information from friends or budtenders. For this reason, states are starting to look at budtender certification and training programs. This would address current issues, such as budtenders recommending products to expecting and nursing women for related symptoms, because cannabis is not good for either the mom or the baby. For this reason, it is important to have robust education programs for consumers and trusted messengers, such as budtenders and medical providers. Continuing educational (CE) requirements are really important, as medical schools are just now starting to teach about the endocannabinoid system (ECS).

Kristen Augustine (Colorado Marijuana Enforcement Division) asked who is able to attend the CANNRA meetings. Mr. Birenbaum said CANNRA voting members are the primary state regulatory agencies and offices overseeing cannabis. Associate memberships are open to any statewide office that has anything to do with cannabis policy or regulation or intersects with it. CANNRA also has a statewide membership level that covers every statewide office within the state. Membership is not currently open to the industry or anyone who is on the commercial side of the cannabis sector.

4. **Heard a Presentation on Expanding Commercial Product Options**

Joe Lam (Insurance Services Office—ISO) stated that entities seeking cannabis coverage solutions span the entire production cycle, including cultivation, storage, manufacturing and processing, design, packaging, testing, distribution, selling, serving, dispensing, and disposal. There are three cannabis commercial general liability (CGL) options. The cannabis activity coverage aggregate limit endorsement modifies the CGL form, which includes a “cannabis activity” definition, and specifies that the
“cannabis activity” must be properly licensed and permitted by law. The cannabis exclusion with an exception for hemp subject to the hemp aggregate limit endorsement modifies the CGL coverage form and provides coverage for bodily injury, property damage, personal and advertising injury (P&AI) arising out of hemp products and select offenses. Cannabis exclusion with designated product or work exception subject to cannabis products/completed operations aggregate limit modifies the CGL coverage form and excludes property damage to cannabis and for bodily injury/property damage (BI/PD) included in “products-completed operations hazard” and arising out of cannabis, except for designated products or work related to cannabis (up to a limit). The cannabis coverage endorsement addresses property-related coverages for cannabis stock, business income, and extra expense, with additional provisions for deductible and valuation.

Joseph Jonas (American Association of Insurance Services—AAIS) stated that coverage exclusions related to cannabis include health hazard, contaminated or untraceable cannabis property, noncompliance with pertinent state and local regulations, onsite use or exposure, and professional/medical advice. Myths about the cannabis market include that the industry is unprofessional and inexperienced, there is no due diligence, insured compliance is impossible, no bank will work with the cannabis industry, the insurance industry is a target of federal enforcement, and carriers risk reputational damage. Cannabis insurance truths include that cannabis items and activities are insurable, coverage expectations are reasonable, and contracts are enforceable. However, unresolved legal issues and untested policy language remains an issue. There are unrealized liability trends and unanticipated exposures, with risks and exposures varying significantly among businesses and locations. Insurance solutions include increasing admitted carrier participation; standardizing programs; and working with state insurance regulators, trade organizations, and interested carriers. The AAIS business owner’s policy offers an existing program rate modification based on industry analogues (e.g., pharmaceutical, liquor, tobacco, etc.), informed by state laws, licenses, and regulatory structure. Judgmental rates will be adjusted as loss data becomes more prevalent.

5. Heard a Panel Discussion on Admitted and Nonadmitted Coverage Across the Cannabis Business Sectors

Ms. Brown asked if cannabis business insurance will evolve from the surplus to the admitted market.

Mr. Hall stated that there is no question that eventually coverage for cannabis-related businesses will move from the nonadmitted to the admitted market. There are several companies who provided reinsurance to cannabis-related insurers moving from not wanting anyone to know who they are to openly putting out their name on applications. The retail side of the business will likely be the first to move to the admitted market. Admitted coverage would also be a good fit for dispensary exposures that are serving only as a point of distribution for others’ goods. Products coverage are likely to follow a pick-and-choose type of evolution due to the lack of uniformity of risks across the industry.

Ms. Jenkins agreed that coverage of dispensaries or production-only agricultural that does not involve extraction are natural fits for the admitted market. However, complex extraction risks that involve working with different solvents would not be a good fit for the admitted market.

Ms. Brown asked what insurance product is most available to obtain in the surplus and admitted markets.

Mr. Hall stated that general liability coverage is easily available in the nonadmitted market. However, Golden Bear and two other smaller insurers are the only admitted carriers. Several of the ancillary lines, such as earthquake and storm are almost totally unavailable. Cannabis businesses are starting to look for these coverages as they get larger, but they are unable to find them.

Ms. Jenkins stated that premise operations is the most available coverage type, followed by workers’ compensation and products liability. Product liability coverage is more complex because all the coverage forms and risks being insured differ greatly by carrier. More flexibility and availability of property coverage is needed.

Ms. Brown asked what insurance product is the most difficult to obtain for cannabis industry clients.

Ms. Jenkins stated that some of the ancillary lines and management liability-type coverages are not available. Coverage forms that detail where the ownership is transferred via some type of mechanism is also not available. Warehouse and move-people liability coverage is only available from a few carriers. This leaves it up to each carrier to make their own determinations as to who the real ownership lies with when a claim occurs.

Norman Ives (Amwins) stated that consumption lounges and spaces are an area very underserved in the casualty space.
Coverage is only available to consumption spaces directly attached to a manufacturer making a product that is distributed onsite or a dispensary providing onsite consumption for standalone consumption spaces. Despite the expansion of delivery services, there is a lack of coverage for this exposure. Most casualty placements in the cannabis space are limited to designated premises. A delivery exposure where an employee is going offsite to deliver cannabis to a consumer is a largely uncovered exposure right now.

Ms. Brown asked what type of pricing issues are being found.

Beth Medvedev (James River) stated that when James River first came into the cannabis market, there was very little information to use for pricing. She leveraged research on the cannabis industry and her pharmaceuticals and clinical trials background to find similarities in her underwriting. Rates were high at first because of the numerous unknowns and need to satisfy their reinsurers’ concerns. Marijuana is a very profitable business and a good book of business for James River, given it had few claims in its seven years of writing adult-use coverage. As a nonadmitted insurer, they can lower their rates without regulatory approval, and they have done so in states with stricter regulations.

Mr. Hall stated that Golden Bear is in the process of providing a refund to lower its rates. More flexibility in rate ranges would encourage more admitted carriers to enter the market.

Ms. Brown asked what changes in coverage availability and market participants have occurred over the last decade.

Ms. Jenkins stated that over the last three to five years, the cannabis industry has become recognized as a viable and thriving industry that can add value to our political and economic system. The coverage availability is evolving with this change in perception.

Mr. Ives stated that there has been a slow progression and evolution of the products that are available in the market. Carriers are starting to become more comfortable in this space, expanding their product offerings within their given segments. For example, cyber liability is now available in the market, albeit with small sub limits. It was not available at all three years ago. Significant and quick advances will occur in this market once there is clarity at the federal level.

Ms. Brown stated that vertically integrated companies must insure all aspects of the supply chain. She asked how these risks are approached differently than others that may only participate in one segment of the supply chain.

Ms. Medvedev stated that vertically integrated companies and companies operating in only one segment are not treated differently. Instead, the underwriter fully underwrites for each part of the company. If a company has cultivation, extraction, and a dispensary, the underwriter will have the information and understand the regulations for each of them. A lot of vertically integrated operations are also multi-state operations. Rates and endorsements would reflect the regulations in each state by aggregate location. The audit would be a little different in that intercompany revenues would not be counted. Companies that are vertically integrated may want to insure each piece separately. In this case, there would be a regular policy for each part of their operations.

Mr. Hall stated that Golden Bear focuses a lot on products liability exposure, especially the lack of multiple parties to share in products liability claims defense and eventually the obligation that is available. Golden Bear’s current products liability claims have the entire chain—i.e., dispensary, manufacture, and distributor—sharing in the defense costs. Since Golden Bear will likely be taking on the defense costs, vertically integrated businesses demand a slightly higher rate.

Ms. Brown asked if insurance providers prefer companies that are not vertically integrated.

Mr. Hall stated that it depends on whether the vertically integrated company has strong controls in place, is well-financed, has state-of-the-art facilities, and manages its supply chain well.

Ms. Brown asked what the hardest part about dealing with cannabis businesses seeking insurance is.

Mr. Ives stated that the lack of standardization in vocabulary in the industry can make it more difficult to speak with an insurer or broker about complex risks. The terminology is not uniform between regions or areas. Also, some cannabis companies may lack business acumen and knowledge of insurance, while some investors may fully understand insurance but lack an understanding of the cannabis industry.
Ms. Jenkins stated that it can also be difficult to help a retail agent, broker, or direct consumer understand the difference between legislative requirements and best practices for protecting a business.

Ms. Brown asked if it is difficult to explain an insurer’s data needs to a prospective insured.

Ms. Medvedev stated that James River uses a specific application for cannabis businesses that asks for all the information it needs from the insured. It is important to be very specific. For instance, the application would ask not just about quality controls, but if certain things are tested. This allows the underwriter to have all the information needed up front so they can respond promptly with a decision. James River also makes a concerted effort to educate its agents and brokers, as many lack knowledge of the cannabis industry.

Mr. Ives stated that business operators are asked for such an enormous amount of information just to begin operating that they are accustomed to providing it when insurers request it. Additionally, underwriters have become flexible and willing to work from other carriers’ applications.

Ms. Jenkins agreed that insureds are required to provide extensive information, regardless of the carrier. From a broker perspective, they make it clear to the client that the underwriter is likely to have additional questions, given the use of different vocabulary and descriptions used in the industry. Insureds understand that the few insurance carriers available are going to want to do their due diligence in this space.

Ms. Brown asked about the availability and demand for cyber-related coverage in the cannabis-related business space.

Mr. Ives stated that the average cannabis operator is not purchasing cyber coverage, despite having fairly significant cyber exposure. Some of this is due to a lack of education on the need for cyber coverage.

Ms. Brown asked about crop insurance availability, particularly in the private crop market. However, it is very limited in its defined coverages.

Mr. Hall stated that it is available on a parametric basis and through traditional federal crop insurance.

Ms. Augustine asked if having a business’ employees trained on how to be compliant with state regulations would reduce their perceived risk exposure and rates.

Ms. Medvedev stated that anytime a company puts in place measures that help it comply with regulations or reduce risk, it makes a difference in underwriting.

Ms. Brown asked if there are areas where liquor liability and cannabis can be analogized.

Mr. Hall stated that it is helpful. Ms. Jenkins added that underwriters consider what other guidelines outside of the insurance policy contract are going to control the risk. There are different ramifications for dram shop liability as it relates to consumption law for cannabis business. They can currently be drawn into a claim, whereas liability for liquor is restricted to the provider of the beverage.

Ms. Brown asked how cannabis businesses find insurers willing to provide them coverage.

Ms. Jenkins stated that there are many methods for finding insurers. California provides a list of cannabis insurers on its website. Some licensing bodies and consultants have referral networks. Agents and brokers perform a lot of marketing and use social media and blogs.

Ms. Brown asked what the impact has been from the pandemic.

Mr. Hall stated that coverage for business interruption and directors and officers has diminished and is being written on a much more restricted basis. This is largely related to reinsurers reacting to dynamics outside the U.S.

Mr. Ives stated that from a sales perspective, most cannabis businesses thrived during the pandemic since they were deemed essential businesses.
Ms. Augustine asked about the access minorities and women have in the cannabis space.

Mr. Ives stated that he believes minorities and women are indirectly affected since they tend to have less access to resources, resulting in being pushed out to more rural areas that are at higher fire risk.

Ms. Jenkins stated that social equity is a strong focal point in this space. The procurement aspect has been significantly simplified for marginalized communities.

Mr. Hall stated that underwriters are not likely to know who is submitting the application, as they are usually filed under a limited liability company name.

Ms. Brown stated that the investigation of licensure and the risk from its ownership is robust in Colorado. Mr. Hall stated that licensing checks occur at the end of the underwriting process.

Mr. Ives stated that insurance carriers are not aware of an applicant’s minority status so there is little opportunity for them to discriminate.

Ms. Medvedev stated that insurance is required to get licensed in many states, so underwriters are usually making quotes without a license and then checking later that it is in place.

Having no further business, the Cannabis Insurance (C) Working Group adjourned.
Catastrophe Insurance (C) Working Group
Virtual Meeting (in lieu of meeting at the 2021 Summer National Meeting)
July 22, 2021

The Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met July 22, 2021. The following Working Group members participated: Mike Chaney, Chair, David Browning, and Andy Case (MS); James A. Dodrill, Vice Chair, and Robert Grishaber (WV); Katie Hegland (AK); Brian Powell (AL); Ken Allen, Giovanni Muzzarelli, and Lynne Wehmueller (CA); George Bradner and Wanchin Chou (CT); Virginia Christy (FL); Colin M. Hayashida, Grant Shintaku, and Roland Teruya (HI); Travis Grassel (IA); Judy Mottar (IL); Heather Droge (KS); Warren Byrd and Tom Travis (LA); Matthew Mancini (MA); Joy Hatchette (MD); Carrie Couch, Leann Cox, Jo LeDuc, and Jeana Thomas (MO); Kristin Barrow and Fred Fuller (NC); Carl Sornson (NJ); Tom Botsko and Maureen Motter (OH); Cuc Nguyen and Andrew Schallhorn (OK); David Dahl and Van Pounds (OR); David Buono (PA); Segun Daramola, Elizabeth Kelleher Dwyer, and Beth Vollucci (RI); Bill Huddleston (TN); Marianne Baker and Mark Worman (TX); and David Forte (WA). Also participating were: Vincent Gosz (AZ); Sandy Anderson and Steve Klebba (MN); Eric Dunning (NE); Bogdanka Kurahovic (NM); Gennady Stolyarov (NV); and Donna Stewart (WY).

1. Adopted its June 21 and Spring National Meeting Minutes

Mr. Botsko made a motion, seconded by Mr. Grassel, to adopt the Working Group’s June 21 (Attachment Three-A) and March 10 (see NAIC Proceedings – Spring 2021, Property and Casualty Insurance (C) Committee, Attachment Two) minutes. The motion passed unanimously.

2. Heard an Update Regarding Federal Legislation

Brooke Stringer (NAIC) said there has not been much progress on passing a long-term National Flood Insurance Program (NFIP) reauthorization. The current extension expires Sept. 30, and there will likely be another extension put into place.

Ms. Stringer said the U.S. Senate (Senate) Committee on Banking, Housing, and Urban Affairs has held two NFIP reauthorization hearings. During last month’s hearing, Sen. John Kennedy (R-LA) and Sen. Robert Menendez (D-NJ) criticized the Federal Emergency Management Agency’s (FEMA’s) new methodology, Risk Rating 2.0, which calculates the flood risk of individual properties rather than risk by zones. Sen. Kennedy has introduced the Flood Insurance Fairness Act (S. 1960), which would require Congressional approval before FEMA could make any changes to the NFIP, including the implementation of Risk Rating 2.0. The bill has no cosponsors to date. Ranking Member Sen. Pat Toomey (R-PA) said any plan to reauthorize the NFIP should not interrupt FEMA’s implementation of Risk Rating 2.0.

Ms. Stringer said beginning Aug. 1, current NFIP policyholders can contact their insurer or agent to learn more about how Risk Rating 2.0 will affect them. The updated rates will take effect for new policies on Oct. 1 and for renewing policies on April 1, 2022. However, if a policyholder’s rate will be decreasing, they will be allowed to renew on Oct. 1 to take advantage of the lower premiums.

Ms. Stringer said in April of this year, U.S. House of Representatives (House) Committee on Financial Services Chairwoman Maxine Waters (D-CA) released a draft of the National Flood Insurance Program Reauthorization Act of 2021. This Act would reauthorize the NFIP for five years, institute a cap on premium increases of 9% per year, forgive over $20 billion in NFIP debt, and enact several other reforms. This Act also includes language to ensure that private flood insurance meets the continuous coverage requirement, so policyholders have a choice to return to the NFIP without penalty. Additionally, Rep. Nydia Velázquez (D-NY) released a draft of the NFIP Reform Act of 2021, which would modify the NFIP claims process for policyholders whose NFIP claims are denied, as well as enact other reforms.

Ms. Stringer said in May, Commissioner Andrew N. Mais (CT) testified on behalf of the NAIC at the House Committee on Financial Services’ Housing, Community Development and Insurance Subcommittee hearing entitled, “Built to Last: Examining Housing Resilience in the Face of Climate Change.” The testimony focused on the importance of mitigation to improve disaster resiliency and highlighted the work of the Climate and Resiliency (EX) Task Force. The testimony noted state insurance regulators’ partnership with FEMA and expressed support for a long-term reauthorization of the NFIP.
Ms. Stringer said Sen. Dianne Feinstein (D-CA) and Rep. Mike Thompson (D-CA) are reintroducing the Disaster Mitigation and Tax Parity Act (S. 2432), which would ensure that state-based disaster mitigation grants receive the same federal tax exemptions as federal mitigation grants. She said this is the first time the bill has been introduced in the Senate, and it is being introduced by Sen. Feinstein and Sen. Richard Burr (R-NC) as a bipartisan bill. She said this is a bill the NAIC endorsed during the last U.S. Congress (Congress), and the NAIC continues to support this bill.

Amy Bach (United Policyholders—UP) asked if the NAIC has weighed in on Risk Rating 2.0. Ms. Stringer said the NAIC continues to communicate with FEMA and receive briefings; however, the NAIC has not taken a specific position. She said this is the first time FEMA has made changes to the NFIP program since the 1970s.

3. Discussed the Status of the Catastrophe Modeling Handbook and Drafting Group Formation

Commissioner Chaney said the Working Group met last month to discuss updating the Catastrophe Modeling Handbook (Handbook). He said the referral items include: 1) understanding how state insurance regulators are currently using the Handbook and determine its practical use within the regulatory toolkit; 2) coordinating with the Catastrophe Risk (E) Subgroup to understand the materials it is developing or making available to state insurance regulators regarding catastrophe models; 3) updating questions in Section VII of the Handbook to include wildfire (resource: Application of Wildfire Mitigation to Property Exposure); 4) considering questions specific to additional perils for which catastrophe models in use today are including, such as flood; 5) denoting which questions should be directed to insurers and which questions should be directed to catastrophe modelers; 6) exploring which catastrophe modelers have begun including climate change data in their models; 7) considering alternative formats for the Handbook to be able to more easily keep it current; and 8) updating the necessary sections.

Commissioner Chaney said the drafting group will need to determine the order of completion of these items. He said perhaps the drafting group will want to start with a discussion of how state insurance regulators are currently using the Handbook. He said to date, California, Connecticut, Louisiana, and Mississippi have volunteered to be a part of the drafting group. He said there are also some interested parties that would like to help with the drafting; while they will not be official members of the drafting group, it is important for them to participate in the discussions and provide their input, as it is valuable in this endeavor.

4. Discussed Roofing Repair and the MWUA Roof Upgrade Program Implemented in Mississippi

Mr. Case said Hurricane Zeta hit the Mississippi Gulf Coast in November 2020. The hurricane was a significant event for the Mississippi Windstorm Underwriting Association (MWUA), as there were 25,000 residential property claims. Mr. Case said the best time to fortify a roof is when putting a new roof onto a structure.

Mr. Case said during the claims settlement process, the MWUA made $2,500 available to policyholders for reimbursement to upgrade to a fortified roof. He said surprisingly, Mississippi had very few policyholders take advantage of this offer. He said one of the reasons this may have happened was that it was at the height of the holiday shopping season, so availability of cash was an issue for most policyholders considering a 2–5% deductible they were already having to pay. Mr. Case said there was also the issue of the withholding of depreciation. He said these items likely contributed to the low take-up rate of the reimbursement offer.

Mr. Case said there were three hurricanes in Louisiana, one in Alabama, and one in Mississippi in 2020, and there are only a certain number of Insurance Institute Business & Home Safety (IBHS) certified roofers available on the Gulf Coast. He said Mississippi was in competition with two other states that had as much or more damage than Mississippi for these certified roofers, as well as other property claim experts. He said there was a waiting list to have a roof repaired as it was, and he believes there was some hesitancy for people to have to wait even longer for an IBHS certified roof.

Mr. Case said Mississippi applauds the efforts of the MWUA, as the idea was to mitigate homes for future events and help some policyholders back out into the admitted market.

5. Discussed Items to Help Insurers with Expedited Claims Processing

Lisa Brown (American Property Casualty Insurance Association—APCIA) said the APCIA Catastrophe Actions Toolkit is included as a part of the Working Groups materials. She said the APCIA has heard from its members regarding getting into a catastrophe area quickly to adjust and settle claims, which oftentimes results in some regulatory hurdles. She said these hurdles are outside the jurisdiction of the department of insurance (DOI), but it would like to help eliminate some of the barriers. She
said the toolkit includes a draft bulletin, and the APCIA is hoping to begin a dialog on how it can help state insurance regulators in the various states.

Ms. Brown said the APCIA has heard from its members that it has set up a mobile claims settlement location not knowing that specific permits were needed to do so. She said the APCIA has also had issues with companies needing to bring in a tanker truck with fuel to refuel claims adjuster’s vehicles at a claims settlement location, and it found that another permit was needed to do this, as well as issues with towing and salvage. She said the APCIA would like to be able to get authority for the DOI to make administrative pronouncements that fall outside of its jurisdiction or figure out ways for the DOIs to better coordinate with other state and local agencies that need to be involved. She said the draft bulletin in the toolkit is intended to address both pre-disaster preparation and recovery measures. She said the bulletin also addresses the DOI getting the claims related data and information the APCIA will inevitably need from the insurers following a catastrophic event. She said the APCIA would welcome the opportunity to work on these issues with the state insurance regulators.

Ms. Bach asked if this initiative relates to the growing offers that some insurers are notifying their policyholders about regarding the relationships they have with private firefighting agencies or providing loss mitigation in advance of a wildfire. Karen Collins (APCIA) said this is not part of the initiative being discussed today. She said the initiative the APCIA is discussing today relates to the state insurance regulator’s role in coordinating with state and local officials and what that process will look like in preparation, as well as the expedited claims processing.

Mr. Byrd asked regarding the obstacles that authorities put up for entries, how long these last. He said he assumes these are for downed power lines or items such as flooding that take longer to clear. Ms. Collins said the most recent feedback the APCIA has received is for the time immediately following a storm. She said the hurdles insurers are having are the types that are simple to overcome from a simple administrative perspective (e.g., a permit is needed that the insurer did not know about even though access to an area is ready and available). She said knowing about these items and solving them prior to a catastrophic event would help alleviate additional delays.

Ms. Hatchette said many catastrophic events are local, which causes another set of issues. She said she is happy to discuss the individual barriers that various localities might have in place. She said the DOI has a seat at the table with the emergency managers; it has been her experience that it is difficult dealing with localities, and she is not sure a bulletin will provide automatic access. Ms. Collins said the APCIA recognizes that at the local level, there is going to be a lot of variation, but the APCIA hopes to promote a standardized approach or a working model to the various emergency operations individuals and officials and educate them on where these benefits lie, might then allow the local level to overcome some of these barriers. Ms. Brown said the APCIA would like to know if there is any way that as an industry, it can help to make this process smoother for state insurance regulators and the insurance industry. She said part of the toolkit describes putting together a multi-agency response team, where state insurance regulators can talk to the transportation department, or whoever is overseeing the placement of a tanker truck and things like local event permits.

Mr. Bradner said he applauds this effort. He said he is Connecticut’s long-term recovery co-chair for FEMA’s Emergency Support Function (ESF) #14, and he encourages other states to get involved too. He said Connecticut developed a program working with its Department of Emergency Management and Homeland Security and its state and local police. He said they have a bulletin with a certification program where they can issue placards to companies and the companies can sign up well in advance of a disaster. He said they ask insurers to provide an updated list of all their emergency contacts on a yearly basis. He said the bulletin also tells insurers that if they need several placards assigned to them, they can ask for them and have them distributed now so they are ready in the event of a disaster. He said the local authorities are also familiar with the process. He said he is also the liaison for the DOI at the command center if there is an event; this allows him to quickly work with the authorities to get adjusters into the areas where they need to be.

Ms. Bach said a discussion regarding getting undisputed benefits into the hands of policyholders is related to the topic of expedited claims handling, and she would like for the Working Group to discuss this further. Commissioner Chaney said many states address the issues of pre-payment, partial payment, and additional living expenses in bulletins. He said the biggest hurdle is to be certain you have licensed adjusters and emergency orders in place to get people out into the field.

Having no further business, the Catastrophe Insurance (C) Working Group adjourned.
The Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met June 21, 2021. The following Working Group members participated: Mike Chaney, Chair, David Browning and Andy Case (MS); Katie Hegland (AK); Brian Powell (AL); Ken Allen, Giovanni Muzzarelli and Lynne Wehmuller (CA); George Bradner and Wanchin Chou (CT); Virginia Christy (FL); Colin M. Hayashida and Grant Shintaku (HI); Travis Grassel (IA); Reid McClintock, Judy Mottar and Julie Rachford (IL); Heather Droge (KS); Rich Piazza and Tom Travis (LA); Joy Hatchette (MD); Cynthia Amann, LeAnn Cox and Jo LeDuc (MO); Timothy Johnson (NC); Carl Sornson (NJ); Tom Botisko (OH); Andrew Schallhorn (OK); David Dahl, Ying Liu and Van Pounds (OR); David Buono (PA); Segun Daramola and Beth Vollucci (RI); Will Davis (SC); Eric Hintikka and Brian Ryder (TX); and David Forte (WA). Also participating were: Eric Dunning (NE); Maggie Dell (SD); Diane Dambach, Darcy Paskey and Mark Prodoehl (WI); and Donna Stewart (WY).

1. Discussed the Catastrophe Modeling Handbook

Commissioner Chaney said one of the Working Group’s charges is to consider edits to the Catastrophe Modeling Handbook (Handbook). He said the Working Group had plans to update the Handbook this year; however, the Climate and Resiliency (EX) Task Force recently sent a referral asking the Working Group to review the Handbook. The referral suggests some specific considerations for edits.

Aaron Brandenburg (NAIC) provided background regarding the history of the Handbook. He said the Handbook was last updated in November 2010. The narrative portion of the Handbook contains nine short sections, totaling approximately 33 pages. However, there are 18 appendices of 400 plus pages.

Mr. Brandenburg said the purpose of the Handbook is to explore catastrophe models in some detail and discuss issues that have arisen or can be expected to arise from their use. Additionally, the guidance is advisory only and not intended to be all-inclusive. The Handbook suggests areas and concepts that should be explored to become well informed about catastrophe models.

Mr. Brandenburg said Section One of the Handbook provides the purpose and background of the Handbook, as well as a brief overview of the Handbook. This section of the Handbook describes perspectives from insurers, catastrophe modelers, consumers, and state insurance regulators. While this section is written at a high level, the language is dated.

Mr. Brandenburg said Section Two provides an overview of earthquake and hurricane risks. One of the items the Working Group may want to consider is expanding the Handbook to add additional perils, as catastrophe models currently include additional perils.

Mr. Brandenburg said Section Three provides a general overview of catastrophe models. The three modules include scientific, engineering and insurance, and they provide a high-level overview of each module. The Handbook is not intended to detail all aspects of a catastrophe model but provide high-level information as it pertains to state insurance regulators.

Mr. Brandenburg said Section Four describes the model input that is entered into the models by insurers; this data is separated into exposure data and insurance data.

Mr. Brandenburg said Section Five describes the model output. The descriptions regarding output are brief and include just a few sentences for each output. The outputs include average annual losses (AALs), loss costs, distribution of losses, exceeding probability distribution, individual event losses, and historical event losses.

Mr. Brandenburg said Section Six describes the model validation and update and describes concepts, such as accuracy, comparison to historical information, input data provided by insurers, model updates, probabilistic range, real-time predictions, sensitivity, and stability.

Mr. Brandenburg said Section Seven discusses evaluating models. This section is a critical section to the Handbook. It includes general questions, questions specific to earthquakes, and questions specific to hurricanes. This section was last updated by state insurance regulatory actuaries in 2010. Mr. Brandenburg said this section will likely need to be reviewed to determine if it is
necessary to revise the questions. He said the Working Group may also want to consider if questions should focus on modelers and insurers. Currently, the questions are directed to modelers. Mr. Brandenburg said the Working Group may also want to consider which perils need to be added to the Handbook.

Mr. Brandenburg said Section Eight speaks to regulatory review and acceptance. This section includes a brief narrative on scrutinizing the process and results. It also discusses what to do with a modeler’s proprietary information and how state insurance regulators might obtain that information.

Mr. Brandenburg said Section Nine describes related activities and items to consider. This section includes actuarial standards for model use, pre-tax loss reserves for companies, and activities to consider, such as auditing company exposure data, types of education, and outreach that can be done.

Mr. Brandenburg said the appendices contain: 1) a definitions section that provides various terms related to catastrophe models; 2) model data sources and documentation published on the modelers; 3) types of output; 4) modelers’ contact information; 5) department of insurance (DOI) catastrophe contacts; 6) enacted legislation; 7) information from the Florida Commission on Hurricane Loss Projection Methodology, the California Earthquake Authority (CEA), etc.; 8) published interrogatories; and 9) state circular letters. These items are out now out of date. The Working Group may want to consider making this a living document with linked data.

Mr. Brandenburg said the Climate Risk and Resiliency (EX) Task Force asked that the purpose of the Handbook be revisited to determine its practical use within the regulatory toolkit. The Task Force also asked the Working Group to coordinate with the Catastrophe Risk (E) Subgroup. Mr. Brandenburg said he believes these were items the Working Group was planning to do in terms of discovering why the Handbook is not more widely used and how it might have better utility for state insurance regulators. The Task Force also recommended that the Working Group review Section Seven of the Handbook and consider adding to the existing questions, as well as possibly revising the existing questions.

Mr. Brandenburg said Risk Management Solutions (RMS) and the Center for Insurance Policy and Research (CIPR) collaborated on the white paper, Application of Wildfire Mitigation to Insured Property Exposure. He said the Task Force suggested that the Working Group consider including the questions found in this white paper related to wildfire, and he also suggested that the Working Group consider questions specific to additional perils for which there are catastrophe models in use today, including but not limited to, flood. He said the Task Force suggested that the questions be denoted to clarify which questions should be directed to insurers versus catastrophe modelers. He said the Task Force also recommended exploring which catastrophe modelers have included climate data in their models.

Mr. Brandenburg suggested that state insurance regulators: 1) determine why state insurance regulators are not using the Handbook; 2) discuss what is missing from the Handbook; and 3) discuss what would improve the Handbook’s usefulness.

Mr. Brandenburg said considerations for the Working Group would be to: 1) gather state insurance regulator interest on what is needed; 2) incorporate information from the Application of Wildfire Mitigation to Insured Property Exposure white paper, including what information should be obtained from the insurer and the catastrophe modeling vendor; 3) edit “Questions to Insurers/Modelers”; 4) review the American Academy of Actuaries (Academy) guidance and education on catastrophe models; 5) explore climate models; and 6) determine future updates and how to better educate state insurance regulators and ensure that they have the information needed.

Mr. Botsko said he chairs the Property and Casualty Risk-Based Capital (E) Working Group and Mr. Chou chairs the Catastrophe Risk (E) Subgroup. He said they have been in discussion about adding perils to the risk-based capital (RBC) calculation. He said he believes the tasks of both groups run parallel to some extent, and he believes the groups should coordinate about some of the things the Catastrophe Risk (E) Subgroup is considering as they add perils to the RBC calculation and how they are going to consider the validity of these models, as the models for wildfire are relatively new. He said convective storms is another peril the Catastrophe Risk (E) Subgroup is considering adding to the calculations. He said discussion about the process of how the Subgroup is going to look at the models, and the things that are going to be considered is important. The discussion will not necessarily be about approving the models, but about the process of getting the models accepted for the new perils. Commissioner Chaney suggested that it would be helpful for a couple of members to serve on the group drafting the updates for the Handbook.

Commissioner Chaney said in review, the Working Group will need to: 1) explore the catastrophe models, the way they are being used, and items that may have already been an issue or can be expected to be an issue at some time in the future; 2) add
the wildfire peril, and possibly flood and convective storms, as the Handbook is limited to earthquake and hurricane; 3) review guidance developed by the Academy; 4) coordinate with the Catastrophe Risk (E) Subgroup; and 5) consider alternative formats for the Handbook to facilitate the ability to more easily and more frequently update the Handbook.

Commissioner Chaney said he believes forming a drafting group to update the Handbook is the best way to move forward with the updates. He said the first task of the drafting group would be to review the materials included in the handouts for today’s call, which includes: 1) the Application of Wildfire Mitigation to Insured Property Exposure white paper; 2) Actuarial Standard of Practice (ASOP) 56; and 3) the Academy research. He said Working Group members may want to include in-house actuarial staff on this project to provide their expertise in this area.

Mr. Chou said a high-level overview of the catastrophe model can be educational and useful for state insurance regulators. He said the Catastrophe Risk (E) Subgroup and the Catastrophe Insurance (C) Working Group likely need to discuss the purpose of the Handbook and discuss how it can be used more effectively. He said reviewing the model itself is a complicated process. He said discussion should encompass the educational and credential parts. He said when reviewing a model, the right questions should be asked.

Commissioner Chaney said there are things happening with the climate that do not fit historic patterns, such as tropical depressions intensifying over land. He said it is going to be important to look at catastrophe models and see what needs changing.

Dennis Burke (Reinsurance Association of America—RAA) asked if the purpose of the Handbook to focus on the role of the catastrophe model helping to identify catastrophic loss is to figure out the impact on the prospect of policy and rates that will be charged, or is the catastrophe model also opening into the climate model 20, 30, 40 or 50-year analysis. He asked if it is still focused on loss costs prospective policies. He mentioned not just loss costs, but also things like preference of the warm sea surface temperature model, as several states would not allow the use of warm sea surface temperature. He said state insurance regulators need to be looking at risk and deciding what to do about the risk that is five, 10, 20 or 30 years down the road; therefore, it is important to have the Catastrophe Risk (E) Subgroup involved, because this will affect the surplus. Commissioner Chaney said the Handbook is meant to be a live tool that state insurance regulators can use consistently.

NAIC staff will follow-up with Working Group members to find drafting group volunteers.

Having no further business, the Catastrophe Insurance (C) Working Group adjourned.
The Pet Insurance (C) Working Group conducted an e-vote that concluded August 13, 2021. The following Working Group members participated: Don Beatty, Chair (VA); Kendra Zoller, Vice Chair (CA); Jimmy Harris (AR); Kris Fabian (CT); Warren Byrd (LA); Sheri Cullen (MA); Shirley Corbin (MD); LeeAnn Cox (MO); Michael McKenney (PA); Kathy Stajduhar (UT); and David Forte (WA).

1. **Adopted its Aug. 4, 2021 Meeting Minutes**

The Working Group considered adoption of its Aug. 4, 2021 meeting minutes. During its Aug. 4, 2021, meeting, the Working Group took the following action: 1) adopted a definition of wellness program to include in Section 3 of the draft model; and 2) adopted the entire Pet Insurance Model Act as drafted.

A majority of the Task Force members voted in favor of adopting the Task Force’s Aug. 4, 2021 (Attachment Four-A) The motion passed.

Having no further business, the Pet Insurance (C) Working Group adjourned.
The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met Aug. 4, 2021. The following Working Group members participated: Don Beatty, Chair, Jessica Baggarley, and Phyllis Oates (VA); Kendra Zoller, Vice Chair, and Risa Salat-Kolm (CA); Katie Hegland (AK); Jimmy Harris (AR); Kristin Fabian (CT); Angela King (DC); Warren Byrd and Tom Travis (LA); Sheri Cullen (MA); Shirley Corbin and Rasheda Chairs (MD); Michael McKenney (PA); Matt Gendron and Beth Vollucci (RI); Kathy Stajduhar (UT); Mary Block and Anna Van Fleet (VT); and David Forte, John Haworth, and Eric Slavich (WA). Also participating were: Marcia Kramer (KS); Brock Bubar (ME); Joseph Sullivan (MI); Chris Aufenthie (ND); Maggie Dell (SD); and Jody Ullman (WI).

1. **Adopted its July 29 Minutes**

The Working Group met July 29 to discuss language related to wellness plans in the draft Pet Insurance Model Act.

Mr. Byrd made a motion, seconded by Ms. Corbin, to adopt the Working Group’s July 29 minutes (Attachment Four-A1). The motion passed unanimously.

2. **Discussed the Definition of Wellness Plans in the Draft Pet Insurance Model Act**

Mr. Beatty said on its last call the Working Group adopted a new section addressing wellness programs. He said there was discussion about adding a definition of wellness programs to Section 3 – Definitions. He said Rhode Island has since submitted a revised definition. Mr. Gendron said the definition is meant to address two issues, the first being language clarifying that states have different definitions for transacting insurance. He offered language that would allow for three ways states define insurance, related to indemnification, determinable contingencies, and fortuitous events. He said states should be able to insert their own definition for insurance within this section. The second edit dealt with two-party contracts. Mr. Gendron said the new language clarifies that the definition is not meant to classify a contract between a service provider and a pet owner that only involves the two parties as insurance. Mr. Forte said the language would help clarify that the business of insurance is separate from wellness programs but if wellness vendors venture into insurance, then they fall under insurance law.

Birny Birnbaum (Center for Economic Justice—CEJ) said the model should define pet insurance as not including service providers only including two parties. He said services should not be listed in the model because there are pet insurers that provide those services. He said the model should define what pet insurance does not include. The key is whether a product or service triggers the definition of insurance within a state. He also noted that “service provider” should read “non-insurer service provider.”

Isham Jones (American Veterinary Medical Association—AVMA) said the list of services should be noted by saying “including, but not limited to.” Cari Lee (North American Pet Health Insurance Association—NAPHIA) agreed with this suggestion. Mr. Byrd said it is redundant to say “not limited to.” Mr. Beatty agreed with not including the additional language.

Mr. McKenney said the Working Group is treating wellness like service contracts. Mr. Birnbaum said there is a parallel with auto service contracts and travel insurance, and that is why pet insurance should be defined instead of wellness programs. Mr. Byrd said the list includes things done normally that are not fortuitous. Mr. Birnbaum said some are services, but some are preventative and are meant to avoid losses. For instance, a blood test might be part of a service with a condition and would not be non-insurance.

Mr. Gendron said if the language related to wellness services referred to a person, he believes it would all be insurance, and he would support Mr. Birnbaum’s definition. Lisa Brown (American Property Casualty Insurance Association—APCIA) said if the pet were human, these items would be covered under a health policy, but the policy is not health insurance. She also noted auto insurers do not pay for maintenance, but a consumer can purchase a maintenance contract. She said a wellness program for pet insurance is like a service contract.

Mr. Gendron noted that language previously adopted created the linkage between insurance and a wellness program by listing requirements for a wellness program to be marketed and sold alongside a pet insurance policy by a licensed insurance entity.
Mr. Gendron made a motion, seconded by Mr. McKenney, to adopt the following language to be added to the Definitions section of the model:

“Wellness program” means a subscription or reimbursement-based program that is separate from an insurance policy, that provides goods and services to promote the general health, safety, or wellbeing of the pet. These goods and services include wellness exams, fecal tests, blood tests, vaccinations/titers, preventive medications for fleas, ticks, and heartworm, dental cleaning, spay and neuter procedures, nail trimming, grooming, and licensing tags. If any wellness program [insert state trigger for insurance contracts, which might include [undertakes to indemnify another], or [pay a specified amount upon determinable contingencies] or [provides coverage for a fortuitous event]], it is transacting in the business of insurance and is subject to the insurance code. This definition is not intended to classify a contract directly between a service provider and a pet owner that only involves the two parties as being “the business of insurance,” unless other indications of insurance also exist.

The motion passed unanimously.

Mr. Gendron made a motion, seconded by Ms. King, to adopt the entire Pet Insurance Model Act as drafted. The motion passed unanimously.

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

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The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met July 29, 2021. The following Working Group members participated: Don Beatty, Chair, Jessica Baggarley, and Phyllis Oates (VA); Andrew Gulcher (CA); Katie Hegland (AK); Jimmy Harris (AR); Kristin Fabian (CT); Warren Byrd (LA); Sheri Cullen (MA); Rasheda Chairs and Linas Glemza (MD); Jo LeDuc and Patrick Lennon (MO); Michael McKenney (PA); Matt Gendron (RI); Jamie Gile, Mary Block, and Anna Van Fleet (VT); and David Forte and Eric Slavich (WA). Also participating were: Linda Grant (IN); Heather Droge, Tate Flott, and Shannon Lloyd (KS); Brock Bubar and Sandra Darby (ME); Christine Peters (MN); Chris Aufenthie, Chrystal Bartuska, and Ross Hartley (ND); Maggie Dell (SD); and Jody Ullman (WI).

1. Adopted its July 22 Minutes

The Working Group met July 22 to discuss language on waiting periods, free look periods, and wellness plans in the draft Pet Insurance Model Act.

Mr. Byrd made a motion, seconded by Mr. Forte, to adopt the Working Group’s July 22 minutes (Attachment Four-A1a). The motion passed unanimously.

2. Discussed Adding Wellness Plans Language to the Draft Pet Insurance Model Act

Mr. Beatty said Washington submitted comments to add language to Section 7 regarding wellness programs. Mr. Forte said the name of the section should be changed to Policy Conditions in order to address policy issues beyond pre-existing conditions and waiting periods. He said there are five issues that he would like to see addressed in this section. He said those issues are: 1) the overlap between insurance policies and certain wellness programs, 2) prescriptive and wellness elements that are included within an insurance policy, 3) insurance companies marketing supplemental wellness programs that are not part of the insurance policy, 4) non-insurance entities providing wellness programs, and 5) insurance policy eligibility for consumers being contingent on participation in a partnering wellness program. Mr. Forte said Washington is proposing a definition in Section 3 of “wellness program” in an attempt to separate insurance from non-insurance wellness products. He said Washington is proposing three new subsections in Section 7 that would read: (C) A pet insurer must not require a veterinary examination of the covered pet for the insured to have their policy renewed; (D) If a pet insurer includes any prescriptive, wellness, or non-insurance benefits in the policy form, then it is made part of the policy contract and must follow all applicable laws and regulations in the insurance code; and (E) An insured’s eligibility to purchase a pet insurance policy must not be based on participation, or lack of participation, in a separate wellness program.

Birny Birnbaum (Center for Economic Justice – CEJ) said regulators should focus on what is and is not insurance and this issue could be solved by a clearer definition of pet insurance. He said the comments submitted by CEJ and Center for Insurance Research (CIR) give a new proposed definition of pet insurance. Mr. Forte said the concern with this definition is that it expands the definition of insurance to include things that Washington would not view as insurance such as maintenance and preventative care. Mr. Birnbaum said the definition should be broad to provide uniformity across the states and to give consumers what they would expect from an insurance policy.

Isham Jones (American Veterinary Medical Association – AVMA) asked if the list of services in Washington’s proposed definition of wellness program is meant to be a finite list. Mr. Forte said the list was not meant to be finite.

Mr. McKenney said there are currently many wellness programs that are not written by an insurance company that should not now be classified as insurance. He said he does support the language proposed by Washington with the exception of the last sentence in the definition of wellness program. Mr. Forte said the intent of that sentence is important to determine if a product aligns with a state’s insurance code, but that the sentence could be re-worded. Mr. McKenney asked for clarification on the term “determinable contingency.” Mr. Gendron said at least 15 states use this term as a statutory trigger for insurance. He said it would make sense to have that term in the definition, but also add in a term to refer to the two-party contracts between a veterinarian and consumer that are not considered insurance. Mr. Forte said if the term adds confusion for certain states then the term can be removed from the definition. Mr. Birnbaum said the type of two-party contracts being discussed is referred to...
as a fee waiver. He said language addressing this exists in Model #632-1 Travel Insurance Model Act, and this working group should not try to re-invent the wheel but instead look to Model #632-1 for this language.

Mr. McKenney made a motion, seconded by Mr. Forte, to rename Section 7 to “Policy Conditions” and adopt subsections 7C, 7D, and 7E as proposed by Washington. The motion passed unanimously.

Mr. Beatty said in June, the North American Pet Health Insurance Association (NAPHIA) had submitted comments to add a new section to the model to address the sales practices of wellness programs. He said Mr. Forte had submitted a modified version of those comments for consideration to the working group. Mr. Forte said Washington removed sections of the language that directed what wellness programs could do, and focused on what insurance entities can do with insurance policies. He said this language will help a consumer understand what is part of the insurance policy when a policy and wellness program are marketed together. Cari Lee (NAPHIA) said this language is supported by NAPHIA. Mr. Birnbaum said he would not support this language.

Mr. Gendron said he does not agree with the proposed language. He said in part A, the structure and design of many wellness programs sold along side insurance policies is that of an insurance product because it indemnifies costs that are incurred at 3rd party vendors. He said in part B, he does not have regulatory authority to take action against companies selling a non-insurance wellness product. He said he does not support language that would add anything to existing rules of the Unfair Trade Practices Act. Mr. McKenney said in Pennsylvania’s Unfair Insurance Practices Act there is reference to anything of value in an insurance policy, so there is an overlap with non-insurance benefits. Mr. Forte made a motion, seconded by Mr. Byrd, to include the proposed language as a new section in the model. The motion passed, with Rhode Island opposing.

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

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The Pet Insurance (C) Working Group met July 22, 2021. The following Working Group members participated: Don Beatty, Chair (VA); Kendra Zoller, Vice Chair, Andrew Gulcher, and Risa Salat-Kolm (CA); Katie Hegland (AK); Crystal Phelps (AR); Kristin Fabian (CT); Angela King (DC); Warren Byrd (LA); Sheri Cullen (MA); Shirley Corbin (MD); LeAnn Cox and Jeana Thomas (MO); Michael McKenney (PA); Matt Gendron and Beth Vollucci (RI); Jamie Gile and Mary Block (VT); and David Forte, John Haworth, and Eric Slavich (WA). Also participating were: Jimmy Gunn (AL); Linda Grant (IN); Vicki Schmidt (KS); Heather Droge, Tate Flott, and Brenda Johnson (KS); Daniel Lawson (ME); Sandy Anderson (MN); Chris Aufenthie, Chrystal Bartuska, and Janelle Middlestead (ND); Maggie Dell (SD); and Jody Ullman (WI).

1. **Adopted its July 8 Minutes**

The Working Group met July 8 to discuss language on waiting periods and free look periods in the draft Pet Insurance Model Act.

Mr. Forte made a motion, seconded by Mr. Gendron, to adopt the Working Group’s July 8 minutes (Attachment Four-A1a1). The motion passed unanimously.

2. **Discussed the Issue of Waiting Periods in the Draft Pet Insurance Model Act**

Mr. Beatty said the North American Pet Health Insurance Association (NAPHIA) submitted new proposed language that would: 1) change the language in Section 7B; 2) add three additional disclosures in Section 4; and 3) add a new definition for “orthopedic” in Section 3. Cari Lee (NAPHIA) said the submitted language was revised after discussion with the American Veterinary Medical Association (AVMA) and the revised language addressed concerns with the definition of “orthopedic” and concerns that waiting period requirements are clearly and prominently disclosed to consumers. Isham Jones (AVMA) said while there is still concern about the 120-day waiting period for orthopedic conditions, overall, the AVMA would be supportive of the proposed language.

Birny Birnbaum (Center for Economic Justice—CEJ) said he opposes any waiting period. He said the proposal of using three different waiting periods in one policy would be confusing to consumers. He said the waiting periods do not serve as a tool for adverse selection. He said the industry claims that waiting periods lead to reduced claims and lower premiums for all consumers but that the reduced claims are due to reduced coverage. He also said the use of different waiting period and preexisting condition options is too complex and that disclosures would not help alleviate confusion for consumers. Brendan Bridgeland (Center for Insurance Research—CIR) agreed with Mr. Birnbaum and said the language around waiting periods for accidents and specific conditions like “orthopedic” is too complex for the average consumer.

Mr. McKenney asked NAPHIA to explain the need for a 14-day waiting period for accidents. Ms. Lee said one reason for a specific waiting period for accidents is that some consumers will buy pet insurance after their pet has been in an accident and try to get coverage for the treatment needed due to that accident.

Mr. Forte asked what conditions insurers are seeing claims for that would necessitate a 120-day waiting period. Ms. Lee said hip dysplasia and other orthopedic conditions take time to manifest and diagnose, and she said these conditions are some of the costliest claims they cover. Dr. Jules Benson (NAPHIA) said the waiting period helps protect the insurers from conscious or unconscious adverse selection, but the insurers do see the need to cover these conditions when the develop in later policy years. Mr. Byrd asked why the policies are not priced based on the loss cost of these conditions. Ms. Lee said the waiting period is a tool to keep the price down for all consumers. She said underwriting this risk is costly and takes enough time that it would likely put off the customer from purchasing the product at all. Dr. Benson said the underwriting would still need to rely on the provided medical records.

Mr. Gendron said the waiting period is similar to a personal property floater that requires an appraisal, inspection, receipt, or some other method of verifying the items value before it is insured. He said the waiting period and veterinary exam are ways of getting the policies out to consumers without adding an additional cumbersome step.
Mr. Gendron made a motion, seconded by Mr. Byrd, to: 1) change the name of Section 7 – Pre-existing Conditions and Waiting Periods to Section 7 – Pre-Existing Conditions and Waiting Periods; 2) delete the current language in Section 7B and replace it with the proposed new language from NAPHIA’s submitted comments; and 3) insert in Section 4 the three additional disclosures from NAPHIA’s submitted comments; and 4) insert in Section 3 the definition of “orthopedic” from NAPHIA’s submitted comments. Mr. Forte made a substitute motion, seconded by Mr. McKenney, to adopt the previous motion with the following change to the proposed language in 7B: remove the 14-day waiting period for accidents and have only a 30-day waiting period for illnesses and orthopedic conditions. The motion passed, with Rhode Island opposing.

Mr. Gendron said with the new adoptions to Section 7 on waiting periods, the definition of “waiting period” in Section 3 should be changed. He said the definition should make it clear that the waiting period does not apply to policy renewals. He suggested removing the last sentence of the definition and replacing it with: “Waiting periods may not be applied to renewals of a policy.” Ms. Lee asked how this language would apply if a consumer increased his or her coverage in subsequent policy years. Mr. McKenney agreed that a consumer could buy an accident-only policy and then at renewal add illness, which would change the coverage of the policy. Ms. Fabian asked how it would be treated if another pet was added to the policy at renewal. Lisa Brown (American Property Casualty Insurance Association—APCIA) suggested using the term “coverage” instead of “policy” in the proposed language.

Mr. Gendron made a motion, seconded by Mr. Forte, to change the definition of “waiting period” in Section 3 to read “means the period of time specified in a pet insurance policy that is required to transpire before some or all of the coverage in the policy can begin. Waiting periods may not be applied to renewals of existing coverage.” The motion passed unanimously.

Ms. Lee said NAPHIA cannot support the model with the current language for waiting periods. Mr. McKenney asked if NAPHIA disagreed with the waiting period length for orthopedic conditions, accidents, or both. Ms. Lee said both waiting periods are important to the way NAPHIA companies are writing their policies. She said if the Working Group could offer more flexibility on the waiting periods, NAPHIA would be more likely to support the model. Mr. Forte said without data to support the need for longer waiting periods, it is difficult to see why those specific long waiting periods are needed.

Mr. Gendron asked, in NAPHIA’s proposed language, what is being covered if there is a 14-day waiting period for accidents and a longer waiting period for illnesses and orthopedic conditions. Ms. Lee said the premium reflects the waiting periods, so the consumer is not paying for coverage he or she is not receiving. Mr. McKenney asked if the renewal policies are more expensive because they do not have the waiting period. He also asked if a consumer initiates a veterinary exam to waive the waiting period, would the premium increase since there is no waiting period and there would be more days of coverage. Ms. Lee said she would have to get back to the Working Group on those questions.

Mr. Gendron said if the Working Group is going to revisit the waiting period issue, he would like to include a look-back period, of no more than 72 hours, for a veterinary examination that waives the waiting period.


Mr. Gendron said during the Working Group’s July 8 meeting, there was discussion on whether the free-look period should be included in the model and concern about the length of time of the free-look period. He said to address concern about the length of time of the free-look period, the language should be changed from “not less than 30 days” to “15 days.” He said there should also be language stating that the policy can be returned during the free-look period “unless the insured has submitted a claim to the insurer that has been paid.”

Mr. Gendron made a motion, seconded by Mr. McKenney, to change the language in 4G(2)(a) and 4G(2)(c) to reflect a 15-day free-look period. Mr. Byrd said actuaries in Louisiana have expressed that any length of free-look period is not actuarily sound. The motion passed, with Louisiana opposing.

4. Discussed the Issue of Wellness Plans in Pet Insurance

Mr. Beatty said the Working Group should recommend to the Property and Casualty Insurance (C) Committee that the Working Group should draft a white paper on the use of wellness plans in pet insurance, including how wellness plans are marketed and what defines the difference between wellness plans and insurance.

Ms. Zoller said she had submitted language for additional disclosures on the marketing of wellness plans and the exclusion of wellness care within the pet insurance policy.

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Mr. Forte said pet insurance needs to be well defined. He said wellness plans that are a subscription service between a veterinarian and consumer and do not include insurable items would not be regulated by state insurance departments. He said an insurance policy should not be affected by a wellness plan and that the wellness plan should be a stand-alone product.

Mr. Byrd said the greater the linkage between the wellness plan and how it is marketed, sold, and billed by an insurance company, the more it crosses over into a product that would be regulated by state insurance regulators. He said wellness plans sold and billed by veterinarians are fine, but when the wellness plan is billed on the same invoice as an insurance policy, that would create linkage. Mark Cushing (Mars Veterinary Health—MVH) agreed that veterinarian-based wellness plans are not a regulated insurance activity.

Mr. Bridgeland said it is important to define pet insurance within the model to make a clear line between insurance and wellness plans. He said the language in the model would be more effective than a white paper. Mr. Beatty said a white paper may lead to an amendment of the model, but it would bring jurisdictions together to analyze an issue and make suggestions on how to deal with the issue.

Ms. Lee said NAPHIA previously submitted comments on wellness plans that address, among other things, the marketing concerns that some Working Group members have expressed.

Having no further business, the Pet Insurance (C) Working Group adjourned.
The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met July 8, 2021. The following Working Group members participated: Don Beatty, Chair (VA); Kendra Zoller, Vice Chair (CA); Katie Hegland (AK); Crystal Phelps (AR); Kristin Fabian (CT); Angela King (DC); Warren Byrd and Tom Travis (LA); Sheri Cullen (MA); Rasheda Chairs and Shirley Corbin (MD); LeAnn Cox, Jo LeDuc, and Jeana Thomas (MO); Erin Summers (NV); Michael McKenney (PA); Matt Gendron and Beth Vollucci (RI); Kathy Stajduhar (UT); Jamie Gile and Mary Block (VT); and David Forte, John Haworth, and Eric Slavich (WA). Also participating were: Vincent Gosz (AZ); Katie Deaver (ID); Linda Grant (IN); Tate Flott (KS); Brock Bubar (ME); Sandy Anderson and Christine Peters (MN); Chris Aufenthie (ND); Tracy Burns (NE); and Maggie Dell (SD).

1. **Adopted its June 24 Minutes**

The Working Group met June 24 to discuss comments received on Section 7 of the draft Pet Insurance Model Act. The Working Group also discussed the use of wellness products in pet insurance.

Mr. Byrd made a motion, seconded by Mr. Forte, to adopt the Working Group’s June 24 minutes (Attachment Four-A1a1a). The motion passed unanimously.

2. **Discussed the Issue of Waiting Periods in the Draft Pet Insurance Model Act**

Mr. Beatty said the North American Pet Health Insurance Association (NAPHIA) submitted proposed language that would add: 1) a new section to the draft model (Section 8); 2) an additional disclosure in Section 4; and 3) a new definition for “musculoskeletal” in Section 3.

Mr. Gendron said Rhode Island had reviewed the proposed language and did not fully agree with all aspects of the language, but he said some aspects of the language did make sense to address in the model. He said it did make sense that certain conditions would require different lengths of waiting periods. He also said it made sense to add the definition of “musculoskeletal.” Cari Lee (NAPHIA) said all NAPHIA member companies are currently offering some type of waiting period for the following reasons: 1) to eliminate adverse selection; 2) to reduce the cost of the policy; and 3) to give consumers different options in the market. Ms. Lee said the NAPHIA proposal would have limits of 14-day waiting periods for accidents, 30-day waiting periods for illnesses, and 120-day waiting periods for musculoskeletal conditions. She said ideally, they would like to see 180-day waiting periods for musculoskeletal conditions. Dr. Jules Benson (Nationwide Insurance) said these musculoskeletal conditions can be costly, require chronic treatment and develop over a long period of time. He said with the timing of the presentation of musculoskeletal conditions, a 180-day waiting period would help control cost for everyone. He said a 180-day waiting period would allow more insurers to be involved in pet insurance and offer more choice for consumers looking for different pricing on policies. Ms. Lee clarified that the proposed language does include the ability for consumers to waive waiting periods, which is a practice in the industry currently. Mr. Byrd agreed that 180 days would be excessive for a waiting period from a consumer standpoint. He asked why a veterinary examination is not mandated by companies prior to the insurance being effective. Ms. Lee clarified that the proposed language does include the ability for consumers to waive waiting periods, which is a practice in the industry currently. Mr. Gendron asked if industry has data on how often musculoskeletal conditions develop in dogs. Dr. Benson said the data may be skewed due to adverse selection, but pet owners tend to seek treatment for these conditions more often than other conditions. He said the waiting period is a protection against unreasonable loss for the insurer.

Mr. Gendron said as a state insurance regulator, the 180-day waiting period is concerning for a one-year policy and the fact that consumers may not fully understand the disclosures they are presented with. Dr. Benson said if the waiting period is too restrictive, some insurers may opt to not offer coverage at all for certain conditions that would be too costly. Ms. Lee said the ability to have different length waiting periods provides variation in the market and drives competition and choice for consumers. Mr. Byrd agreed that 180 days would be excessive for a waiting period from a consumer standpoint. He asked why a veterinary examination is not mandated by companies prior to the insurance being effective. Ms. Lee said some companies do require an exam, but many do not in order to keep costs down for consumers and to avoid administrative costs for the pet insurer. She said that after a waiting period has been met in the initial policy year, there is no waiting period requirement in subsequent renewals. Mr. Byrd asked if a shorter waiting period was more likely to result in a required veterinary examination before the policy was issued. Ms. Lee said a shorter waiting period was more likely to result in an insurer excluding coverage for the condition.
Mr. McKenney said there is nothing keeping a company from writing a policy of less than one year, and it is concerning for a company to have the ability to implement a waiting period that could be almost as long as the policy period. He said it is also concerning since the industry wants the ability to write policies that do not renew, and the replacement policy would make the condition that first required a waiting period a preexisting condition. He said it would be confusing to consumers to have a policy with several different waiting periods that has coverage kick in at different times after policy inception.

Dr. Gail Golab (American Veterinary Medical Association—AVMA) said the term “musculoskeletal” should not be used in its current definition. She said the use of this term could cause issues of interpretation of the language. She said it would be best to get a different descriptor to address the issue these type of conditions. She said the AVMA and NAPHIA are working towards language that is agreeable.

Birny Birnbaum (Center for Economic Justice—CEJ) said he is opposed to any waiting period. He said in other lines of insurance, the waiting period is there to ensure that a condition continues for a minimum length of time, and it is not meant to replicate a preexisting condition exclusion. He said there should not be a waiting period for accidents. He said there is no evidence that waiting periods empower consumer choice and that waiting periods are not a tool for adverse selection like preexisting condition exclusions.


Mr. Byrd and Mr. Forte said they would oppose a free look period. Mr. Birnbaum said: 1) free look periods are a common feature in other lines of insurance; 2) free look periods cannot be invoked if a claim has been made; 3) no evidence has been offered that a free look period has large administrative costs; and 4) industry would not be willing to offer the free look period if there was a significant cost. Brendan Bridgeland (Center for Insurance Research—CIR) said the free look period is not free insurance for consumers. He said after talking with representatives from NAPHIA, he understands that there is not a hidden or significant cost for free look periods. Mr. Forte said there is an administrative cost to write a policy and in property/casualty (P/C) insurance, there is already a mechanism to return a policy and get back unearned premium. Mr. McKenney agreed that P/C products have a mechanism for pro-rata premium returns. He said insurers charge a cancellation fee for consumer-driven cancellations, and if industry is saying there is no cost to writing and cancelling policies with the free look period, then no line of insurance should have cancellation fees.

Mr. Forte made a motion, seconded by Mr. Byrd, to remove any allowance of a free look period in the model. The motion did not pass, with Arkansas, Louisiana, Pennsylvania, Utah, and Washington voting in favor, and Alaska, California, Connecticut, District of Columbia, Missouri, Nevada, Rhode Island, and Vermont voting against.

Mr. McKenney said the language in the current draft of the model says free look periods must be no less than 30 days, which could allow for up to a 364-day free look period. He suggested that the language should reflect a maximum of 30 days for a free look period. Mr. Gendron agreed with changing the language to make the free look period a maximum of 30 days. Ms. Summers said there should be a minimum length of the free look period as well. Mr. Byrd said if the free look period is not required by the language in the model, then a minimum length requirement would not be necessary. Mr. Beatty said the discussion of whether the current language mandates a free look period and any changes to the language would be continued during the Working Group’s next meeting.

Having no further business, the Pet Insurance (C) Working Group adjourned.
The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met June 24, 2021. The following Working Group members participated: Don Beatty, Chair (VA); Kendra Zoller, Vice Chair, Andrew Gulcher and Risa Salat-Kolm (CA); Jimmy Harris (AR); Kristin Fabian (CT); Angela King (DC); Warren Byrd (LA); Sheri Cullen (MA); Rasheda Chairs (MD); Carrie Couch, LeAnn Cox and Jo LeDuc (MO); Erin Summers (NV); Michael McKenney (PA); Matt Gendron and Beth Vollucci (RI); Kathy Stajduhar (UT); Rosemary Raszka (VT); and David Forte, John Haworth and Eric Slavich (WA). Also participating were: Ken Williamson (AL); Heather Droge (KS); Brock Bubar (ME); Tracy Burns (NE); Maggie Dell (SD); and Jody Ullman (WI).

1. **Adopted its June 10 Minutes**

The Working Group met June 10 to discuss comments received on Section 3 and Section 4 of the draft Pet Insurance Model Act.

Mr. Byrd made a motion, seconded by Mr. Forte, to adopt the Working Group’s June 10 minutes (Attachment Four-A1a1a1). The motion passed unanimously.

2. **Discussed Section 7 of the Draft Pet Insurance Model Act**

Mr. Beatty said the Working Group would continue to discuss comments received on open issues in the draft model.

Justin Liby (Companion Protect) said with respect to Section 7B, Companion Protect would support the industry being allowed to use both preexisting condition exclusions and waiting periods in tandem. He said both features address the issue of adverse selection; they work in different ways. He said the waiting period prevents a claim from being covered under the insurance agreement portion of an insurance policy and is designed to identify those conditions that are likely to become a preexisting condition. He said a preexisting condition exclusion only applies after a claim is determined to be covered under the insuring agreement and may not be limited to a specific time period. He said Companion Protect would be opposed to a cap on the duration of a waiting period. He said that if there is appropriate disclosure of the duration of the waiting period and what it applies to, then consumers can choose the best product for themselves at the right price. Mr. Byrd asked for an explanation on why a company would oppose a cap on the length of the waiting period. Mr. Liby said Companion Protect would like the ability to be more creative and deliver a product to the marketplace that a consumer might want.

Jack Chaskey (Companion Protect) said the products would be filed for approval with state insurance regulators, and the related pricing would be commensurate with the relative waiting period. Mr. McKenney said many states do not have prior approval authority. Ms. Cox asked if any states had specific statutes or regulation that speak directly to the time frames for waiting periods. Mr. Byrd said the National Flood Insurance Program (NFIP) has a mandatory 30-day waiting period for flood insurance. Mr. Gendron said he would have a problem with a waiting period longer than 30 days. He said it would make more sense for the company to exclude the condition entirely rather than have a long waiting period. He said he is in favor of allowing both preexisting condition exclusions and waiting periods in a policy with reasonable restrictions. Mr. Byrd said a 30-day waiting period would be reasonable for both the insurer and the insured. Dr. Gail Golab (American Veterinary Medical Association—AVMA) said it is a complex issue because of the many different animals that could be covered under a policy, and certain conditions would manifest at different times for those different animals. She said a 30-day waiting period would be reasonable.

Mr. Gendron asked if there would be any concern with including a provision that with an inspection from a veterinarian, a waiting period could be waived. Dr. Golab said she would like to see specific language on that provision but agrees with the concept. Brendan Bridgeland (Center for Insurance Research—CIR) said he would not be in favor of the proposal to have no cap on waiting period durations. Birny Birnbaum (Center for Economic Justice—CEJ) said it is unclear why a waiting period is needed at all if there are preexisting condition exclusions in the policy. He said a waiting period would be problematic for consumers who would have an expectation when they purchased a policy that anything that is not a preexisting condition would be covered. Mr. Birnbaum said it is unrealistic to expect consumers to understand all the features and limitations of a product as complex as pet insurance. Cari Lee (North American Pet Health Insurance Association—NAPHIA) said the Working Group
will be presented with language that would be a middle ground in the discussion on waiting periods. She said waiting periods assist with the issue of adverse selection and allow all policyholders to be held to the same standards. Mr. Forte said he agrees with Mr. Gendron that waiting periods and pre-existing condition exclusions can be applied together with certain parameters. He said is comfortable with a 30-day waiting and that he would not be comfortable with the unlimited time frame.

Mr. Beatty said in Section 3G, there was a suggestion to change “treatment provided by a veterinarian” to “treatment provided, prescribed or suggested by a veterinarian.” There was no motion to adopt this change.

Mr. Beatty said in Section 4G (2), there was a suggestion to change “owner” to “insured.” Mr. Gendron asked if this change would bring a need to address insurable interest. Dr. Golab said it is not uncommon in the dog performance world to have a single animal with multiple owners, so there may be some advantage to referring to the insured instead of the owner. Mr. Byrd made a motion, seconded by Mr. Forte to adopt this change. The motion passed unanimously.

Mr. Beatty said the Working Group had previously discussed free look periods and that discussion is still an open topic. Mr. Birnbaum said there should be a provision that specifies that if a consumer is looking to return a policy, the insurer needs to provide clear instructions and the process should not be difficult for the consumer. Mr. Byrd said actuaries in Louisiana still take issue with providing insurance without a premium payment. Mr. Forte said actuaries in Washington also have an issue with this since there is a cost associated with administering the policy, and when consumers return the policy during the free look period, the cost is passed on to other consumers. Mr. McKenney said that since enough states take issue with the free look period, it should not be required, and it should be left to a state-by-state basis. He said the language says “not less than 30 days,” so technically the law is saying companies implement a 364-day free look. Mr. Birnbaum said the Travel Insurance Model Act (#632) incorporates a free look provision that should provide guidance for this model. He said the free look provision does not provide free coverage since the policy can only be returned if a claim has not been made. Mr. McKenney asked if the travel insurance free look period expires before the coverage takes effect. Caren Alvarado (Crum & Forster) said Model #632 states that if there is a free look period and if there is going to be a refund had there not been a claim paid, then the entire cost of the travel protection plan would be refunded.

3. Discussed Pet Wellness Products

Ms. Lee said NAPHIA submitted language for the Working Group’s consideration based on some of the concerns expressed over the last few meetings regarding wellness. She said NAPHIA members are licensed insurance entities, and none of the members sell stand-alone wellness products. She said currently, NAPHIA members are selling wellness products as endorsements to insurance policies, or they are sold alongside a policy as a separate product. Ms. Lee said NAPHIA’s proposed language clarifies that: 1) the purchase of wellness products is not a requirement to purchase pet insurance; 2) the cost of the wellness product should be separate and identifiable; 3) the terms and conditions should be separate from the policy and be available to the consumer prior to enrollment; 4) the wellness product should not duplicate the pet insurance policy benefits; and 5) the advertisement of wellness products should not be misleading. She said NAPHIA included language that specifies that advertisements should delineate between a wellness product and a pet insurance product, and that the wellness product should not use language that would apply to an insurance policy such as “premium” and “policy.” She said NAPHIA included language on disclosing the costs for the wellness product and which of the costs are for the pet insurance product.

Mr. Forte after reviewing the language, he believes it aligns with the view that wellness products should be distinct and different from insurance. He said if it is part of the policy, it would be considered insurance, and if it is separate from the policy, then it should have no influence on eligibility of the policy. He said the Working Group has heard reports that if a consumer does not pay a non-insurance company’s wellness plan, their insurance policy that is in partnership with the wellness company would then also be cancelled. He said there should not be a requirement to buy both the wellness product and insurance policy. Mr. McKenney said wellness products often include insurance benefits such as a death or burial benefit, or chiropractor benefits. He said the language about wellness products in the model should be carefully crafted so that companies are not issuing wellness products that do have insurance benefits but are not considered insurance products and, therefore, not regulated and not collecting premium tax.

Mr. Beatty suggested that the Working Group should draft language that states, “The wellness product can be a wellness product, but it cannot include anything that meets the definition of insurance under the specific state insurance code.” Mr. Birnbaum said the proposed language seems to be defining an insurance benefit as insurance if it is included in the policy and not an insurance benefit if it is a stand-alone product. He said this is confusing to consumers and an arbitrary distinction that promotes a lack of consistent regulation for consumer protection. Mr. Birnbaum suggested that wellness products should be defined as any product, service, or benefit related to promoting and maintaining the health and wellness of the pet. He said
these services—including wellness exams; blood tests; vaccinations; preventive medications for fleas, ticks, and heartworm; dental cleanings; spaying and neutering; and nail clippings—should all be a part of the insurance package. Mr. Bridgeland agreed with Mr. Birnbaum’s view of the wellness product offerings. He said he does not like the use of the word “complementary” in the NAPHIA language because it is too close to the word “complimentary” and could be confusing to consumers that might expect something that is being provided for free. Mr. Gendron said one issue with the language is that it seems to be attempting to give state insurance regulators authority over non-insurance products and may preempt the authority of state attorneys general with regard to unfair trade practices. Allison Osterberg (Banfield Pet Hospital—Banfield) said Banfield does sell wellness plans that are not insurance. She said it is a bundle of set services offered by their veterinarians, and the product does not need a triggering event to be used. She said it is common in the veterinary industry to sell prepackaged services for specific clinics or pet hospitals. The Working Group agreed to continue discussion of wellness products in their next meeting.

Having no further business, the Pet Insurance (C) Working Group adjourned.
The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met June 10, 2021. The following Working Group members participated: Don Beatty, Chair (VA); Kendra Zoller, Vice Chair, Andrew Gulcher and Risa Salat-Kolm (CA); Katie Hegland (AK); Jimmy Harris (AR); Kristin Fabian and George Bradner (CT); Angela King (DC); Tom Travis and Warren Byrd (LA); Rasheda Chairs and Shirley Corbin (MD); Erin Summers (NV); Michael McKenney (PA); Matt Gendron (RI); Kathy Stajduhar (UT); Anna Van Fleet (VT); and David Forte and Eric Slavich (WA). Also participating were: Brenda Johnson and Sharil Sivertson (KS); Brock Bubar (ME); Chris Aufenthie (ND); Tracy Burns (NE); Maggie Dell (SD); and Jody Ullman (WI).

1. Adopted its May 19 Minutes

The Working Group met May 19 and took the following action: 1) discussed Section 3, Section 4 and Section 7 of the draft Pet Insurance Model Act; and 2) discussed issues with standalone and endorsement wellness products.

Mr. Forte made a motion, seconded by Mr. Bradner, to adopt the Working Group’s May 19 minutes (Attachment Four-A1a1a1). The motion passed unanimously.

2. Discussed Section 3, Section 4 and Section 7 of the Draft Pet Insurance Model Act

Mr. Beatty said the Working Group would discuss comments received on the remaining open issues in the draft model. Ms. Zoller said California submitted a new proposed definition for “pet insurance” because the Working Group had not come to an agreement on the language about veterinary expenses within the definition. She said the definition reflects how pet insurers are currently defining the product and what the product is currently offering. The language reads, “‘Pet Insurance’ means an individual or group property insurance policy that provides coverage for accidents and illnesses of pets.” Ms. Van Fleet said Vermont approves of the proposed definition. Mr. Forte said the Working Group had previously discussed removing the reference to group policies, as the industry had reported that the policies are not true group policies. He said group policies are not offered on property/casualty (P/C) insurance products. He recommended that the definition not refer to individual or group polices. Ms. Zoller agreed to this change in the proposed definition. Birny Birnbaum (Center for Economic Justice—CEJ) said preventative care should be part of the definition. Brendan Bridgeland (Center for Insurance Research—CIR) said including the word “property” in the definition would be a complication if pet insurance is in the future designated as a different type of insurance. Ms. Zoller said the addition of “property” would help consumers understand what type of insurance they are buying. Cari Lee (North American Pet Health Insurance Association—NAPHIA) said the term “veterinary expenses” is still misleading to consumers. Mr. Forte said the use of the term “eligible expenses” would be confusing, as that term is used in health insurance, but property insurance would use the term “covered expenses.”

Mr. Forte made a motion, seconded by Ms. Van Fleet, to adopt a definition that states, “‘Pet Insurance’ means a property insurance policy that provides coverage for accidents and illnesses of pets.” The motion passed unanimously.

Justin Liby (Companion Protect) said the use of the term “coverage is afforded” is concerning because if a claim is paid but the condition should have been excluded, the current language would require the insurer to continue covering that condition, and they would not be able to apply a preexisting condition clause to that condition. He said the language should be replaced with “a claim was properly paid” in the definitions for “preexisting condition” and “waiting period.” Mr. Birnbaum and Mr. Bridgeland opposed this change. Mr. McKenney said it should not be based on whether a claim was paid because a company can open an investigation into the claim during the policy period and pay it after the policy period ends. He said it should be based on whether coverage applies to the condition. No motion was made to adopt this change.

Mr. Liby said Section 3I—Renewals should be removed from the draft model because the existing insurance codes and regulations already define what a renewal is, and the draft model definition could conflict with those existing definitions. Mr. McKenney said the purpose of this definition is to not allow a company to call a policy a renewal if it is going to exclude coverages that were included in the initial policy period. He said if the industry is going to exclude conditions in subsequent policy years, then it would have to issue a non-renewal and offer the customer a new policy with altered terms. Mr. Gendron said the conflicts of law doctrine would apply, as this definition would be more specific and more recent than the existing definitions. Mr. Bridgeland agreed that Section 3I should remain in the draft model. No motion was made to adopt this change.
Mr. Liby said in Section 4, the information in Subsection B is dealt with in Subsection C and Subsection D; therefore, Subsection B should be deleted. He said in Subsection D, the term “usual and customary” should be replaced with “prevailing veterinary service provider charges” because it captures the intent of the overall disclosure. Mr. Birnbaum opposed removing “usually and customary” because the proposed alternative inserts the words “veterinary service,” which could be a contradiction to the issues with the term “veterinary expenses” in Section 3—Definitions. Mr. Bridgeland opposed the removal of Subsection B because consumers should know how the insurers determine that payments are going to be made. No motion was made to adopt these changes.

Ms. Zoller said in several areas of Section 3 and Section 4, she suggested that requirements in the draft model to link to definitions and disclosures should also be required to be prominently displayed and in at least 12-point font size. Mr. Beatty said it makes sense for the information to be prominently displayed, but it is not clear what font size would be appropriate for a website. Mr. Birnbaum said the font size would vary depending on the tool being used to view the website. Mr. Gendron said the Federal Trade Commission (FTC) uses the term “clear and conspicuous.” Mr. Bridgeland suggested requiring that the links cannot be in a smaller font size than the rest of the website. Ms. Lee said NAPHLA agrees to the “clear and conspicuous” language. Mr. Gendron made a motion, seconded by Mr. McKenney, to use the term “clear and conspicuous link” in Section 3 and Section 4 of the draft model when talking about required links on insurers’ and insurers’ program administrators’ web pages. The motion passed unanimously.

Ms. Zoller proposed a change to Section 4(A)2 that requires a disclosure if the policy excludes certain preventative care and wellness services. Mr. Beatty suggested revisiting this suggestion after the Working Group has concluded its discussion on wellness products.

Ms. Zoller said there had been previous discussion on the marketing of pet insurance products, and she proposed a new disclosure stating, “an insurer shall not market or advertise pet insurance as health insurance for pets.” Mr. Forte said he understands the purpose of the proposal because many of the claims in Washington stem from confusion on the type of insurance the consumer is purchasing. He said if a new disclosure is adopted, he would like it to include clarifying language that pet insurance is property insurance. Mr. McKenney suggested that this language should be placed elsewhere in the law and should not be a required disclosure. Mr. Bridgeland agreed that the language should be a part of the law, but it does not need to be a separate disclosure. Ms. Lee said NAPHLA would support keeping the health language, as that is the way consumers tend to view pet insurance. Ms. Dell said using the health language could cause problems on the regulation side for enforcement of misrepresentation. Lisa Brown (America Property Casualty Insurance Association—APCIA) suggested that a potential disclosure should state that while the product covers some health concerns, it is a property insurance policy. Mr. Birnbaum said the purpose of the draft model is to get clear definitions and ensure that consumers know what they are purchasing, and it should not be used to memorialize what insurers are currently doing in the marketplace. He said he would support including the language proposed by California. Mr. McKenney asked if the states are getting complaints about the way the products are advertised. Ms. Zoller said the California complaints are not coded with that level of detail, but the complaints usually center around consumers not knowing exactly what they are purchasing.

Mr. Liby said Companion Protect would oppose the free look period that is mandated in Section 4 because the free look period tends to drive bad customer behavior. He said the free look period encourages consumers to buy a pet insurance product that they would not normally buy because they consider it a no regret decision, and they can cancel in 30 days if they do not have a claim. He said requiring a free look period leads to higher acquisition costs that insurers will never recover, and it leads to a higher volume of early terminations. He said Companion Protect proposes a required pro-rated premium refund if the policy is cancelled in the first 30 days. Mr. Gendron said free look periods are used in other lines with complex products, such as life insurance, annuities and travel insurance. He said he would like Companion Protect to submit data that supports its position. Mr. McKenney agreed with Companion Protect’s position that the free look period is not actuarially sound and passes on costs to all customers. Ms. Lee said NAPHLA would disagree with Companion Protect on this issue because the free look period is consumer friendly and allows the consumer to look at their policy in more detail and cancel that policy if it is not what the consumer thought it was. She said NAPHLA has not found that the free look period increases the cost of pet insurance in a significant way. Mr. Bridgeland said if the industry can include waiting periods in the policy, then the consumer should be allowed to have a free look period. Mr. Forte asked if NAPHLA could share its data on the minimal cost of free look periods. Ms. Lee said NAPHLA would share that data with the Working Group.

Having no further business, the Pet Insurance (C) Working Group adjourned.
The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met May 19, 2021. The following Working Group members participated: Don Beatty, Chair, Jessica Baggarley and Phyllis Oates (VA); Kendra Zoller, Vice Chair, and Andrew Gulcher (CA); Katie Hegland (AK); Kristin Fabian (CT); Angela King (DC); Warren Byrd (LA); Sheri Cullen (MA); Rasheda Chairs and Shirley Corbin (MD); LeAnn Cox (MN); Erin Summers (NV); Michael McKenney (PA); Matt Gendron (RI); Kathy Stajduhar (UT); Jamie Gile (VT); and John Haworth and Eric Slavich (WA). Also participating were: Linda Grant (IN); Brenda Johnson and Sharil Sivertson (KS); Sandra Darby, Brock Bubar and Frank Niles (ME); Chris Aufenthie (ND); Tracy Burns (NE); Maggie Dell (SD); and Jody Ullman (WI).

1. **Adopted its April 29 Minutes**

The Working Group met April 29 and took the following action: 1) discussed Section 3, Section 4 and Section 7 of the draft Pet Insurance Model Act; and 2) discussed issues with classifying pet insurance as a property/casualty (P/C) product.

Mr. Gendron made a motion, seconded by Mr. McKenney, to adopt the Working Group’s April 29 minutes (Attachment Four-A1a1a1a1). The motion passed unanimously.

2. **Discussed Section 3, Section 4 and Section 7 of the Draft Pet Insurance Model Act**

Mr. Beatty said the Working Group received comments from Companion Protect (Companion) regarding Section 3, Section 4 and Section 7 of the draft Pet Insurance Model Act. Justin Liby (Companion) said Companion would like to see some flexibility in terms of whether definitions in the draft model will be prescriptive required terms. He said Companion would like state insurance regulators to be able to approve the use of similar definitions. Birny Birnbaum (Center for Economic Justice—CEJ) said this approach would not provide the consistency sought in the draft model and would allow for different definitions in each state. He said for consumer protection purposes, he would like to see important terms defined in the draft model. Brendan Bridgeland (Center for Insurance Research—CIR) said it is important to have a common baseline to avoid consumer confusion.

Mr. McKenney said this proposed language would allow for non-uniformity, both across different states and within the state, because different language could be approved for individual insurers within the state. The Working Group did not vote to adopt this change.

Mr. Liby said Companion does not want to have to link to the definitions and disclosures on the main page of the insurance company website, as required in Section 3 of the draft model. He said there may not even be a reference to pet insurance on the main page of the website, and there are several pet insurance programs that have program administrators who maintain the website and market the products. He said Companion’s suggestion is to require the location of the link to the definitions to be within the marketing information for the applicable policy. He said many pet insurers offer more than one type of policy, and there may be some differences with respect to the required disclosures, so companies have different policies. Additionally, he said some program administrators may administer multiple policies for a single insurer, or they may work with multiple insurers. Mr. McKenney asked how this language would be applied to printed marketing materials, such as pamphlets in pet stores and veterinary offices. Mr. Liby said the intention of the language is limited to internet website presence. Mr. McKenney said the language as submitted is not clear in its reference to marketing material. Mr. Gendron said the current language does not require the links on the insurer’s main page if a program administrator’s web page is used. He said the purpose of the language is to make the information easily available to consumers. Ms. Zoller said Companion currently has a link for California customers on their main web page. Mr. Liby said that if Companion were to market a product for a different company, it would not want to place the link on the main web page. Ms. Zoller said the link is already buried on the web page, and the draft model should require the link to be more prominent. Mr. Byrd agreed that the link should be prominent on the main web page. Mr. Bridgeland said he would not be in favor of the proposed change. He said some companies currently have the information available on their web page, but there is no link, and the information can only be accessed through a Google search. Lisa Brown (American Property Casualty Insurance Association—APCIA) said even if program administrators do not have links, they should still be able to link to definitions on the main page of their website. The Working Group did not vote to adopt the change.

Mr. Liby said Companion would support the new definition of “pet insurance,” as proposed by the North American Pet Health Insurance Association (NAPHIA) and the American Veterinary Medical Association (AVMA). That language reads, “Pet
Insurance’ means an individual or group insurance policy that provides coverage for expenses specified in the policy.” Ms. Zoller said the current definition that refers to veterinary expenses is not limiting the services that are covered. Kate Jensen (NAPHIA) said the proposed definition makes it clear that the definition of “pet insurance” is what is laid out in the specific policy that is purchased. She said this will encourage the consumer to understand what they have purchased and what is covered in the policy. Isham Jones (AVMA) said it is important that the consumer knows when going into a veterinary clinic what will and will not be covered under their pet insurance policy. Ms. Oates suggested the use of the term “eligible veterinary expenses.”

Mr. McKenney said it would make sense to use “eligible veterinary expenses” and keep the definition of veterinary expenses. Ms. Brown said the APCIA would support the proposed definition of “pet insurance” from NAPHIA and the AVMA. She said if the Working Group adopts the use of eligible veterinary expenses, then there should be an added clause of “as specified in the policy.” Ms. Jensen said by limiting the definition to veterinary expenses, no matter how it is defined, companies would be limited in what they could offer consumers in terms of coverage in the future. She said NAPHIA would like to see flexibility with this definition. Mr. Birnbaum said the proposed definition from NAPHIA and the AVMA does not make it clear that it is for pet insurance. Ms. Jensen said the definition is broad because there is no standard policy in pet insurance, and industry does not want the definition to be limiting. She said the definition could be reworked to include the word “pet.” Ms. Brown said there are companies that are currently offering coverage for services outside of veterinary offices, and companies should be able to continue to write those policies or policies for other products that consumers may request in the future. Mr. Gendron said there may be an unintended consequence of trying to define what “pet insurance” is if the intent is to exclude wellness coverage offered by veterinarians as insurance. He said the discussion on wellness products would help inform the discussion on the definition of “pet insurance.”

3. Discussed Issues Related to Pet Wellness Products

Ms. Zoller said the Working Group should consider addressing, within the draft model, the wellness plans that most pet insurers are now selling alongside their insurance policies. Mr. Gulcher said California has seen several add-on products to traditional insurance, such as wellness products and health savings accounts (HSAs), that have been confusing to consumers. Ms. Zoller said with some of these products, the consumers pay money and then lose that money if they do not use the benefits. Mr. Gulcher said there are regulatory questions of how the money is being handled by the insurance companies and the verbiage used to describe wellness products and HSAs. Mr. Beatty asked if these products met the definition of “pet insurance” in California. Mr. Gulcher said the definition is broad because there is no standard policy in pet insurance, and industry does not want the definition to be limiting. Ms. Oates said the definition could be reworked to include the word “pet.” Mr. Brown said there are companies that are currently offering coverage for services outside of veterinary offices, and companies should be able to continue to write those policies or policies for other products that consumers may request in the future. Mr. Gendron said there may be an unintended consequence of trying to define what “pet insurance” is if the intent is to exclude wellness coverage offered by veterinarians as insurance. He said the discussion on wellness products would help inform the discussion on the definition of “pet insurance.”

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Mr. McKenney said it would make sense to use “eligible veterinary expenses” and keep the definition of veterinary expenses. Ms. Brown said the APCIA would support the proposed definition of “pet insurance” from NAPHIA and the AVMA. She said if the Working Group adopts the use of eligible veterinary expenses, then there should be an added clause of “as specified in the policy.” Ms. Jensen said by limiting the definition to veterinary expenses, no matter how it is defined, companies would be limited in what they could offer consumers in terms of coverage in the future. She said NAPHIA would like to see flexibility with this definition. Mr. Birnbaum said the proposed definition from NAPHIA and the AVMA does not make it clear that it is for pet insurance. Ms. Jensen said the definition is broad because there is no standard policy in pet insurance, and industry does not want the definition to be limiting. She said the definition could be reworked to include the word “pet.” Ms. Brown said there are companies that are currently offering coverage for services outside of veterinary offices, and companies should be able to continue to write those policies or policies for other products that consumers may request in the future. Mr. Gendron said there may be an unintended consequence of trying to define what “pet insurance” is if the intent is to exclude wellness coverage offered by veterinarians as insurance. He said the discussion on wellness products would help inform the discussion on the definition of “pet insurance.”

Having no further business, the Pet Insurance (C) Working Group adjourned.
The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met April 29, 2021. The following Working Group members participated: Don Beatty, Chair, (VA); Kendra Zoller, Vice Chair, and Risa Salat-Kolm (CA); Katie Hegland (AK); Kristin Fabian and George Bradner (CT); Angela King (DC); Warren Byrd (LA); Rasheda Chairs and Shirley Corbin (MD); LeAnn Cox and Kendra Hetland (MO); Erin Summers (NV); Michael McKenney (PA); Matt Gendron (RI); Kathy Stajduhar (UT); Jamie Gile and Anna Van Fleet (VT); and David Forte, John Haworth and Eric Slavich (WA). Also participating were: Ken Williamson (AL); Brenda Johnson (KS); Sandra Darby, Lindsay Laxon and Frank Niles (ME); Chris Aufenthie (ND); Tracy Burns (NE); Maggie Dell (SD); and Jody Ullman (WI).

1. **Discussed Section 3, Section 4 and Section 7 of the Draft Pet Insurance Model Act**

Mr. Beatty said after the Working Group’s previous meeting on March 26, the North American Pet Health Insurance Association (NAPHIA) submitted comments that addressed language regarding renewals that had been adopted by the Working Group. Kate Jensen (NAPHIA) said NAPHIA members are concerned that the adopted language would limit the ability of consumers to choose a term-limited accident and illness policy for their pet. She said NAPHIA is concerned it will limit innovation and options for consumers to have products at a lower price point. She said NAPHIA prefers robust disclosures to consumers about policy renewals and how the policy works. Mr. McKenney said the language adopted into the model says if a succeeded policy excludes conditions that were covered in the previous policy, then it cannot be called a renewal. He said the NAPHIA letter indicated that there have not been complaints about limited term policies not covering pre-existing conditions in subsequent policies, but the industry has stated those policies are not yet available in the U.S.; therefore, there would be no complaint data. Mr. Byrd asked Ms. Jensen if the price point of the products that the industry offers will be determined by the experience of claims on these products. Ms. Jensen said there is a large gap in the price points of a policy that offers a lot of coverage and an accident-only policy. She said the industry does not want to lose the opportunity to innovate products that would be middle ground in terms of coverage and premium price.

Mr. Forte said he is concerned that a disclosure would not be sufficient to inform a consumer that conditions covered in the current policy period are likely to not be covered on the next policy with limited term policies. Mr. Bradner said the companies would have to issue non-renewals to the consumer and re-issue a policy with different terms and conditions. Mr. Forte said the consumer should know before purchasing a limited term policy that any subsequent policies will have different terms and conditions. Ms. Jensen said that any disclosure for this type of product would state very clearly that the policy is only for a limited term and that subsequent policies will have new pre-existing condition clauses and new waiting periods.

Brendan Bridgeland (Center for Insurance Research—CIR) said offering waiting periods for one-year limited-term policies could lead to confusion for consumers and companies. He said the Working Group should consider using a term other than “pre-existing condition” to avoid confusion for consumers that would be familiar with the concept in human health insurance. The language in Section 3—Definitions related to renewals remained unchanged.

Mr. Beatty said Mr. Bridgeland had submitted a drafting note related to Section 3E—Preexisting Condition. Mr. Bridgeland said the drafting note is to be used to provide guidance on what a verifiable source is. He said the drafting note would make clear that verifiable sources include business records from veterinarians, shelters, police and animal control, prior insurance claims, and any other written or electronic records. He said social media posts, especially those that include undated images, do are not necessarily indicate verifiable sources but could be used by companies investigating potential fraud. Ms. Jensen said NAPHIA does not believe a drafting note is necessary since the term “verifiable sources” means able to be checked for accuracy. She said if the Working Group feels a drafting note is necessary, the proposed language from NAPHIA clarifies that an insurer’s record would be a verifiable source.

Mr. Beatty said NAPHIA submitted additional comments on Section 7B and time limits on waiting periods. Ms. Jensen said NAPHIA strongly opposes any time limit on waiting periods and any language that would preclude the use of waiting periods and pre-existing condition clauses together. She said they oppose anything that would require companies to parse out premium for each waiting period. Ms. Jensen said NAPHIA included language that adds more detail to the waiting period disclosure. Mr. Byrd asked what time frame NAPHIA would suggest for the length of a waiting period. Ms. Jensen said the length of
waiting period varies by policy and carrier, and it also affects the premium price point. She said waiting periods are typically structured for different conditions based on how long those conditions would take to develop. She said NAPHIA does not have consumer complaint records relating to waiting periods because there is robust disclosure of these waiting periods to the consumers.

Mr. McKenney said the Working Group should look at reworking the language in Section 7B that states no premium will be charged during the waiting period. He said that at least some premium should be charged if only certain conditions are excluded during the waiting period.

Mr. Beatty said the Working Group had previously discussed removing “individual or group” from Section 3D—Pet Insurance. He asked if any Working Group member is opposed to this removal. No Working Group member was opposed.

Mr. Beatty said the Working Group had previously discussed changing Section 3G—Veterinary Expenses to Eligible Expenses. Mr. Gendron said he understands the idea behind changing the term to “eligible expenses,” but he said he is concerned about the unintended consequences of broadening the definition. Mr. Byrd suggested that the language could be changed to indicate that veterinary expenses means eligible expenses. Ms. Jensen said most consumers do think of pet insurance as covering anything that happens at the veterinarian, but that is not always the case.

Mr. Forte said Washington has requested adding a disclosure that premium may increase due to the age of the pet and where the consumer resides. He said those premium increases are the biggest complaint they get in Washington. He said he is hopeful an additional disclosure would clear up confusion for the consumers. Mr. Byrd agreed that this is an important issue. Mr. McKenney said he has seen very large rate increases from products where the premium does not increase as the pet ages. He said the insurers had failed to account for the increased risk as the pet ages and, therefore, had to drastically increase premium rates. Gavin Friedman (Trupanion) said consumers should know factors that may cause their premium to increase, as well as factors that will cause their premium to increase. Mr. Bradner said he is not concerned about this issue because policies such as homeowners insurance increase in premium price as the home ages. Mr. Forte said the complaint is due to the amount of increase in premium. Mr. Beatty said if there is no opposition, the additional disclosure will be left in the draft model.

Mr. Beatty said the Working Group had previously voted to remove the Licensing section of the draft model and replace it with a drafting note. Mr. Gendron said the Producer Licensing Uniformity (D) Working Group is currently looking at how to handle producer licensing of pet insurance. He said once that Working Group makes a decision on how the licensing is handled, a drafting note in this model would no longer make sense. Mr. Beatty agreed and said the drafting note would be removed from the model.

2. Discussed Issues Related to Pet Insurance as a P/C Product

Mr. Gendron said the Rhode Island Department of Business Regulation – Insurance Division has been looking into whether it makes sense to report pet insurance as an inland marine line of business. He said pet insurance does not look like other risks reported in the inland marine line or in property/casualty (P/C) insurance. He said pet insurance evolved from horse insurance, and while it makes sense to classify horses as property when they have a monetary value, it does not necessarily make sense for a household pet. He said the terms used in pet insurance are similar to human health insurance, it is marked like health insurance, and actually it operates like health insurance. Mr. Beatty said reclassifying pet insurance as health insurance would be difficult in the real world due to prior approval rates and other issues affecting both the insurance industry and state legislators. Mr. Byrd said he understands Mr. Gendron’s position, but he believes health insurance is for humans and pet insurance should continue to be classified as a P/C line of business. Ms. Zoller said another option is to have insurers stop marketing pet insurance as health insurance. Mr. Williamson agreed with Mr. Gendron and said he does not understand writing a health coverage on a property risk. Mr. McKenney said he agrees with both points, but it may be too late to try to reclassify pet insurance since there are adjudications dealing with pet insurance in the P/C market. He said if pet insurance is reclassified as health insurance, the industry would have to support that change.

Having no further business, the Pet Insurance (C) Working Group adjourned.
The Transparency and Readability of Consumer Information (C) Working Group of the Property and Casualty Insurance (C) Committee met July 20, 2021. The following Working Group members participated: Joy Hatchette, Chair (MD); Jimmy Gunn and Stephanie Tompkins (AL); Bobbie Baca (CO); George Bradner and Connor Huydic (CT); Julie Rachford (IL); Heather Droge (KS); Ron Henderson (LA); Jeana Thomas (MO); Kathy Shortt (NC); Chris Aufenthie and Janelle Middlestead (ND); Cuc Nguyen (OK); Jennifer Ramcharan (TN); and Marianne Baker and Laura Machado (TX). Also participating were: Michele McKenzie (ID); Linda Grant (IN); Karen Dennis (MI); Trisha Goldsmith (OR); Candy Holbrook (SD); Vicki Ayers (VA); Manabu Mizushima (WA); and Donna Stewart (WY).

1. Adopted its May 13 and Spring National Meeting minutes

The Working Group met May 13 and March 15. During its May 13 meeting, the Working Group took the following action: 1) heard reports from the three drafting groups formed to draft the various sections of a consumer disclosure regarding significant premium increases on property/casualty (P/C) insurance products; and 2) heard a presentation about VisibleThread’s language analysis platform.

Ms. Shortt made a motion, seconded by Ms. Droge, to adopt the Working Group’s May 13 (Attachment Five-A) and March 15 minutes (see NAIC Proceedings – Spring 2021, Property and Casualty Insurance (C) Committee, Attachment Four). The motion passed.

2. Received an Update from the Thresholds and Communications Standards Drafting Group

Mr. Bradner said the Thresholds and Communications Standards Drafting Group determined the following items regarding requirements for disclosures for premium increases: 1) a 10% threshold (any rate change greater than or equal to 10% on renewal) will trigger a notice; 2) the notice must be sent at least 30 days prior to the renewal; 3) the notice must include the new premium versus the old premium; 4) items affecting the premium increase should be listed by dollar amount; 5) the top reasons should be listed and should account for 80% of the premium increase, and the top five reasons for the premium increase should be listed; and 6) if an insurer already has an acceptable notification process in place and the state is in agreement with the process, the insurer could be allowed to continue the process in place; otherwise, these will be the minimum requirements.

Charles Angell (AL—Retired) said in the disclosure notice (Attachment Five-B), the second and third paragraphs apply only to policies that were capped. If an insured’s premium was not capped, these paragraphs would be deleted and replaced by a single sentence stating the renewal premium. He said the reasons for the premium increase would be listed in descending order with the largest impact being shown first and then at least 80% of the premium increase; this is for the uncapped premium.

Various suggestions were made regarding the last sentence, and the Working Group agreed upon: “Please call your agent or our Customer Service Representative at (xxx) xxx-xxxx with any questions.”

Birny Birnbaum (Center for Economic Justice—CEJ) suggested that there should be a mechanism in place to test the disclosure to see if it is effective for consumers. Ms. Hatchette said she does not know if the NAIC had a mechanism in place to do consumer testing. She said NAIC staff will follow up to see if there are any mechanisms in place to test this disclosure with consumers. Mr. Birnbaum suggested giving reasons that insureds might offer for premium increases, or at least provide some examples. Mr. Bradner said the Drafting Group would discuss this possibility.

Mr. Angell said a disclosure notice must include specific reasons for the premium increase, which will vary from insurer to insurer. He said he is not sure the NAIC would be able to do consumer testing. He asked if anyone had other ideas on how to do the testing. Mr. Bradner said that maybe the insurers could do a sampling of letters that would send and then these letters could be used to do surveys with the individuals that received the letters on their renewals.

Angela Nelson (Automobile Club of Missouri) said when consumer testing was done on the health side, a consumer information subgroup tested the summaries of benefits and coverage forms, which does have a lot of information and variability by plan. She said when thinking about the different cost sharing, there were enough common elements to where they could go forward with some clarifications that the Consumer Information (B) Subgroup filled in for the consumer to test.
Ms. Hatchette suggested that perhaps Lisa Brown (American Property Casualty Insurance Association—APCIA) would be able to get the NAIC some samples of reasons for premium increases so the NAIC would be able to simulate what a notice might look like to do some consumer testing. Ms. Brown said until these disclosures are required, it might be difficult to get responses from the insurers. Mr. Bradner agreed that this is only something that could work once a state tells an insurer this is wanted.

3. Received an Update from the Rate Checklist Drafting Group

Ms. Droge said many states do not currently have a rate checklist in place. She said Kansas and Connecticut both have rate checklists in place, and both states find them to be extremely helpful. Ms. Droge said the Rate Checklist Drafting Group believes that although this checklist should not be required, it should be included in the best practices document, as states that do not have something like this in place may find the checklist to be beneficial.

Ms. Droge said Kansas has been using its checklist for about nine years and has found it to be efficient, as the checklist has increased its productivity by reducing the number objections they send out to the insurers. She said the checklist includes items that Kansas thought were most important. Ms. Droge said the checklist has reduced the amount of correspondence going back and forth between insurers and the Kansas state insurance regulators.

Ms. Droge said the Drafting Group made the decision to recommend using the Kansas rate/rule filing checklist. She said the Drafting Group did decide to add a question about whether an insurer is using a rating model. Ms. Droge said the Drafting Group believes that there are times insurers are using rate models and do not include this fact in their rate filings. She said the Drafting Group thinks the additional questions regarding rate models will provide a little more feedback to the state.

Ms. Droge said the document will be distributed to the Working Group members and interested parties following this meeting.

4. Received an Update from the Consumer Education Drafting Group

Ms. Shortt said the Consumer Education Drafting Group began with a master document from which it could pull various pieces of consumer education pieces. She said the Drafting Group has broken into three smaller drafting groups to draft the topics of underwriting and rating, and factors affecting premium increases and discounts.

Ms. Shortt said the Drafting Group is currently working on automobile insurance and will work on consumer education regarding homeowners insurance once the automobile insurance piece is completed. She said each of these drafting groups has been meeting consistently and will continue meeting on a monthly basis until the work is completed.

Ms. Shortt said the Underwriting and Rating Drafting Group has completed its work, and it will be sent to Brenda J. Cude (University of Georgia) for a readability review. Ms. Shortt said once all of the work is completed and documents are in place for auto and homeowners insurance, the NAIC Communications department has agreed to put together some infographics, social media pieces, and consumer alerts to be used by the departments of insurance (DOIs).

5. Heard a Presentation Showing an Example of Before and After the Use of the VisibleThread Product

Sara Robben (NAIC) showed the Working Group an example of the product output from the VisibleThread product. The product produces a report in both Microsoft Excel and Microsoft Word that shows the number of long sentences that were used, the readability and grade level score for each sentence, and the number of passive voice sentences that are in the document. The product also provides suggestions of how to fix sentences to make them more readable.

Ms. Robben asked Working Group members to let her know if they would like contact from VisibleThread regarding the use of this product. Ms. Baker talked with VisibleThread, and she said the product seemed to be interesting. She said the VisibleThread contact indicated that they were interested in working with insurance companies, which was interesting to her. Ms. Baker said they asked her about policy forms, and she directed them to the System for Electronic Rate and Form Filing (SERFF) to look at various policy forms. She said she believes working with insurance companies on policy forms would have a huge impact.

Having no further business, the Transparency and Readability of Consumer Information (C) Working Group adjourned.
The Transparency and Readability of Consumer Information (C) Working Group of the Property and Casualty Insurance (C) Committee met May 13, 2021. The following Working Group members participated: Joy Hatchette, Chair (MD); Ken Allen (CA); Bobbie Baca (CO); George Bradner (CT); Brenda Johnson (KS); Ron Henderson (LA); Jeana Thomas (MO); Chris Aufenthie (ND); David Combs (TN); and Marianne Baker (TX). Also participating were: Renee Campbell (MI); Jana Jarrett (OH); and Bill Cole, Kristi Alma Jose and Donna Stewart (WY).

1. Heard a Presentation from VisibleThread

John Noland (VisibleThread) said insurers are endeavoring to use the plain language guidelines put into place by the various states. Insurers do not necessarily use the same vocabulary as their audience, as it is difficult for the human brain to forget what has already been learned regarding vocabulary. Mr. Noland said independently objective scoring of written content can be useful and instructive. He said this concept has been around for many years, and most people are familiar with Flesch-Kincaid readability scores and grade levels, which are available in Microsoft Word. However, multiple people throughout organizations do not consistently use these tools, as they are not easy for everyone to use.

Mr. Noland said VisibleThread makes it easy for people to see that there is a problem with content. He offered state insurance regulators the ability to use VisibleThread’s product to test a particular insurer’s content to learn more about the product. He said most communications distributed by insurers are not readable to the consumer. VisibleThread allows the content to be reviewed, audited and written in an understandable way.

Mr. Noland said an insurer’s legal and contracts office have to be shown some objective data that demonstrates that a policy is not readable. He said when a subject matter expert (SME) is shown that there is a challenge for the reader and an area needs attention, they are positive and supportive of change. He said it is important for the consumer to understand what they are reading.

Mr. Noland said VisibleThread allows documents, web pages and text to be analyzed. He said plain language supports compliance. Sentences should be kept relatively short, having no more than 20 words per sentence. Mr. Noland said it is important to write as simply as you can and keep to the grade level the state requires, which is either grade level five, six or seven. He said it is also important to not use passive voice or reduce it to below 5%.

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Mr. Noland said the VisibleThread product provides a score card. A document can be emailed and run through the program, and the guidelines can be sent back to the party sending the document. The program needs can be configured based upon audience type. Mr. Noland said VisibleThread would provide state insurance regulators with a link to where they can email documents to receive a score card.

Mr. Noland said VisibleThread can use the style guide of a particular company or the guidelines. The product has watch words, which are words that should be used in documents. VisibleThread provides guidance on best practices; these best practices will differ for organizations and states.

Rowland Bradley (VisibleThread) said each state has its own readability guidelines. Important paragraphs within an insurance policy do not meet readability guidelines. Ms. Hatchette said state insurance regulators constantly struggle with trying to ensure that complicated insurance terms are written in a manner that the average consumer can understand. Mr. Noland said the use of the VisibleThread program makes it easy to write things in plain language, and it is free for the state insurance regulators to try. VisibleThread allows the writer to use the system to more quickly edit and change documents. Mr. Noland said this product works for Spanish as well as English.

Mr. Noland said there are five basic steps to a better customer experience and a return on investment. The steps include: 1) identifying a champion; 2) creating a baseline with a content audit; 3) making the style guide and terminology list accessible; 4) supporting writers to score content for quality; and 5) measuring and improving. Mr. Noland invited state insurance regulators to reach out to VisibleThread if they want to subjectively look at things a department of insurance (DOI) is writing. Peter Kochenburger (University of Connecticut School of Law) asked if there was any research as to whether a person would be more likely to understand their policy if it is written at a lower grade level. Mr. Noland said it is difficult to track whether
someone understands what they read because there are many factors in play, such as how stressed a person is when reading the policy. He said VisibleThread has been able to see successes with some insurers where they have done some great design work to either simplify the policy visually or break down some of the insurance jargon into subsets in the structure of the documents. Mr. Noland said the Center for Plain Language has some good examples. He said the complexity of the writing also comes into play in letters a consumer receives from the insurer or in the frequently asked questions (FAQ) insurers provide on the internet.

Mr. Bradley said people simply scan documents rather than read documents in today’s world, so a simpler design can help too.

2. Heard an Update from the Thresholds and Communications Standards Drafting Group

Mr. Bradner said the Thresholds and Communications Drafting Group has spent a couple of meetings discussing when a notice of premium increase should be sent to a policyholder. He said the drafting group is focusing on personal lines of business. Mr. Bradner said a 10% or greater change in premium upon renewal would trigger a notice being sent to the policyholder. He said the renewal should be sent at least 30 days prior to the renewal date, and the notice must include the new premium amount versus the old premium amount. He said the notice should list the items that affected the premium increase, and a dollar amount should be listed for each one of the items identified, so a policyholder can see the actual dollar impact that occurred for each item. He said the drafting group decided that 80% of the rate increase should be shown, and the top five reason most affecting the premium should be listed. He said if an insurer already has an acceptable notification process and the state agrees with the process, the state could allow the insurer to continue whatever process they had in place. He said if an insurer had no process in place, the items just discussed would be the minimum requirements a state DOI would expect. He said the next item the drafting group will discuss is rate capping.

Mr. Bradner said this will only apply to increases due to items such as an insurer changing a tiering band, or a youthful driver being added, accidents, etc.

3. Heard an Update from the Rate Checklist Drafting Group

Sara Robben (NAIC) said Kansas sends out a rate checklist to insurers that collects information from an insurer. Part of what is asked for on the rate checklist are items that will help the DOI explain rate changes to a consumer if the consumer happens to call the DOI. The form used by the Kansas DOI asks the insurer to provide talking points to explain the rate increase. Kansas also asks for histograms. Kansas rejects a filing if the insurer does not return the checklist with the filing.

Ms. Robben said Connecticut also has a couple of checklists the Rate Checklist Drafting Group is looking at. Mr. Bradner said Connecticut sends a detailed actuarial checklist to insurers. The questions on the checklist reflect the answers to questions the actuary wants to see when they are reviewing a filing. Mr. Bradner said the checklist was published in December 2020, and it is required on all personal lines filings. He said the checklist is used occasionally on commercial lines filings if there is a sizeable rate increase.

Mr. Bradner said the other checklists Connecticut uses are product oriented and more geared toward some of Connecticut’s statutes and regulations for a line of business that the examiner will be looking for.

Some of the states on the drafting group do not have rate checklists they use in their state, so if any of the states on this call have a rate checklist, the Working Group requests that a copy be sent to Heather Droge (KS). The drafting group is at a point to start writing up a checklist to be used in a best practices document.

4. Heard an Update from the Consumer Education Drafting Group

Ms. Robben said Kathy Shortt (NC) is the chair of the Consumer Education Drafting Group. She said Ms. Shortt initially created an outline of some of the various topics for the drafting group to consider for a consumer education document. She said the topics included everything from Ratemaking 101 to information about auto, homeowners and general terminology. The drafting group also discussed the types of information to include, and the drafting group discussed the various formats in which the information could be distributed. Ms. Robben said much of the information the drafting group wants to include in a consumer education document can be found in various other publications. NAIC staff has begun gathering information from various states, as well as from various insurers. The documentation collected includes information on how to deal with items such as credit, credit information, insurance scores, etc., as well as changes a consumer can make to mitigate insurance costs. Ms. Robben asked for Working Group members to send information they might have available to the drafting group.

Having no further business, the Transparency and Readability of Consumer Information (C) Working Group adjourned.
FINAL VERSION of DISCLOSURE NOTICE

Instructions to Insurers:

- Each insured receiving at least a 10% premium increase at renewal must receive a Disclosure Notice.
- This notice must be sent to the insured at least 30 days prior to the renewal date. It may be included with the renewal notice or may be sent in a separate mailing, or by email if the insured has elected to receive email notifications.
- The Disclosure Notice must include a listing of the rating factors/characteristics, and the dollar impact of each rating factor/characteristic on the premium increase, such that at least 80% of the uncapped premium increase is explained.
  - The rating factors should be listed in descending order of dollar impact.
  - Note that a “change in underwriting tier” is not acceptable as a rating factor to be listed. All rating factors/characteristics listed must be such that the insured can understand its content and determine if they have the ability to mitigate the increase caused by that rating factor. If multiple rating characteristics define the underwriting tier, then the premium increase caused by each of those rating characteristics must be considered separately.
- If an insurer already has a notification process acceptable to the State’s regulator, the insurer could be allowed to continue to use the process that is in place.
- The following Disclosure Notice is the minimum required notice. Insurers are permitted to provide additional information if so desired.

DISCLOSURE NOTICE

Your current premium is $1,175.

According to our current rating plan filed with your state, your renewal premium would be increased to $2,121. However, your renewal premium has been limited to $1,257 rather than charging the entire premium increase at this time. We are phasing in the remaining premium increases for your policy over the next X policy renewals.

Your future renewal premiums may also be increased or decreased by coverage changes you choose to make, by changes in your personal risk characteristics that occur during this time frame, and by future rate change filings made by our company with your state.

Here are the major reasons for this increase in your premium, along with the dollar impact of each of those reasons:
Reasons for your premium increase and the dollar impact

- Reason 1 raised your premium $A
- Reason 2 raised your premium $B
- Reason 3 raised your premium $C
- Reason 4 raised your premium $D
- Reason 5 raised your premium $E

Please call your agent or our Customer Service Representative at (xxx) xxx-xxxx with any questions.
How to Buy Title Insurance in [Insert State]

This guide:
• Covers the basics of title insurance.
• Explains the need for title insurance.
• Offers tips to shop for title insurance and closing services.
• Gives you questions you should ask before you buy title insurance.

[Name]  [DOI Logo]
[Superintendent of Insurance]

[DOI Website Address]

Drafting Note: This template has been developed for state departments of insurance who are interested in providing a consumer education publication regarding title insurance. The template was developed as a comprehensive guide that can be edited/personalized to meet the individual needs of a state.

DRAFT: 3-23-215-25-21
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Disclaimer:

The information included in this publication is meant to serve as a guide and is not a substitute for legal or professional advice. Please contact a professional if you have any questions.

DRAFT: 3-23-215-25-21
Introduction

A real estate transaction may be one of the largest investments you’ll ever make. Because the decisions you make when you buy or refinance a home can have effects for years to come, it’s important to take time to learn about the process so you can make good decisions.

You may want to hire a licensed professional to help you with the many steps to buy or refinance a home or piece of property. Before you agree to do business with anyone, however, be sure the individual is qualified and licensed.

Buying or Refinancing a Home or Property

So you’re ready to buy or refinance a home or piece of property. Now what?

If you’ve found the perfect home or property and the seller has accepted your offer, the next steps will most likely be:

- You’ll get a loan from a mortgage lender.
- A professional will inspect and appraise the home or property.
- You’ll choose an individual or business, known as a closing agent, to organize and finalize your real estate transaction.
- You’ll choose a “closing date” to sign paperwork and take ownership of your new home.
- You’ll buy homeowners insurance through a licensed property and casualty insurance agent.
- You’ll decide if you need flood and/or earthquake insurance, which you can buy through a licensed property and casualty agent.
- You’ll decide if you’ll need title insurance, which you can buy through a licensed title agent or company.
- A professional may “survey” the property. A survey is a professional drawing of the property’s boundaries. It also shows where a home is located on the property.
- You may be able to buy a home warranty that covers the mechanical breakdown of individual parts of a home, such as the electrical and plumbing systems. A warranty doesn’t cover the home’s structure, may or may not cover appliances, ends at a specific point in time (for example, one year) and has exclusions and limitations that you should review. Home warranties might not be regulated as insurance in your state.
- A final walk through of the home you’re buying will be scheduled.
- You’ll sign legal paperwork to finalize your new loan.

If you’re refinancing your home or property:

- You’ll get a new loan from a mortgage lender.
- A professional may inspect and appraise your home or property.
- You’ll give the lender information about your homeowners, flood and/or earthquake insurance coverage.
- You’ll decide if you need title insurance, which you can buy from a licensed title agent or company.
- A closing date will be selected.
- You’ll sign legal paperwork to finalize your new loan.

When you buy or refinance a home or piece of property, you’ll need to decide whether to buy title insurance.

What is title insurance? Why do you need it? This guide will answer those questions and more.
What is Title Insurance, and What Does it Cover?

A title documents your legal ownership or interest in property.

Title insurance is an insurance policy that covers past title problems that come up after you buy or refinance a property.

Lost, forged or incorrectly filed deeds, property access issues and liens on a property are just a few of the title problems that could come up after you buy or refinance a home or piece of land.

For example, if you received a letter telling you there’s an unpaid mortgage on the property you just bought, you could submit a claim to your title insurance company. The title insurance company would pay the legal costs to settle the dispute and/or to resolve the problem.

Without title insurance, you might have to pay all of the legal costs to settle the dispute. And if you lose the dispute, you could lose money, the equity you have in your home, and possibly ownership.

Two Types of Title Insurance—Owner’s and Lender’s Policies

There are two types of title insurance policies:

- An Owner’s Policy
- A Lender’s Policy

An owner’s policy protects you for the full price you paid for the home plus legal costs if a past title or ownership issue comes up after you buy your home. An owner’s policy is issued for the amount you paid to buy your home, and the policy will cover you as long as you own an interest in the property. You are not required to purchase an owner’s policy, but if you choose not to, you may lose the money you’ve paid for your home.

If a basic owner’s policy doesn’t cover a specific title issue, often you can add coverage, known as a policy endorsement. For example, if you’re buying a new home and the owner’s policy doesn’t cover claims (often known as a mechanic’s lien) filed by a contractor, you can add a policy endorsement to ensure you are covered. Some endorsements are free while others can be added for an additional fee.

An enhanced owner’s policy, which has a higher level of coverage than a standard owner’s policy, also may be available in your area. Enhanced owner’s policies cost about 20% more than a standard owner’s policy, but they cover extra risks. An enhanced owner’s policy also may continue to provide coverage after a property has been transferred.

If you borrow money to buy your home or property, your lender is likely to require you to buy a lender’s policy. A lender’s policy only protects the lender if a title or ownership problem comes up after the property is purchased. A lender’s policy is issued for the amount of the mortgage, and the coverage goes down as you pay down your loan. Unlike an owner’s policy, the lender’s policy ends when you pay off your mortgage. You may be expected to pay the premium for a lender’s policy.

Because a lender’s policy only protects the lender from title problems, you’ll also need an owner’s policy if you want to protect yourself.

What Doesn’t Title Insurance Cover?

Title insurance policies do not cover ownership issues that come about after you’ve bought a home.

For example, if your neighbor builds a fence on your property after you’ve bought your home, your title insurance policy will not cover the costs to settle the dispute.
Also, most title insurance policies don’t cover issues such as easements, boundary line disputes, zoning violations and air or mineral rights.

Your title insurance policy may spell out other issues that won’t be covered. And if there’s a title issue specific to the home you’re buying or refinancing, your title policy may not cover it. Ask for a list of what will and will not be covered, and be sure to read your policy.

Who Sells Title Insurance?

Only licensed title insurance companies, agencies and agents can sell title insurance in [INSERT STATE].

Drafting Note: If a state permits other individuals and entities to sell title insurance, this sentence should be amended to include those parties.

You can buy title insurance directly from a title insurance company or a title agent who sells title insurance for a company.

The Right to Choose Your Own Title Agent/Company

You have the right to shop for and choose your provider of title insurance and settlement services

A good time to shop for title insurance is when you choose a real estate agent, and a lender has prequalified you for a loan. You’ll have an idea of the price you can pay for a home/property and a title insurance agent or company can use that information to estimate your title insurance costs.

There are several ways you can find a title insurance agent or company:

- You can ask the sellers who they used when they bought the home.
- You can check the [INSERT NAME OF DOI] website, [INSERT WEB ADDRESS].
- You can check online for title insurance agents, agencies and companies in your area.
- You can ask for recommendations from your real estate agent, attorney, mortgage lender, financial institution or builder.

If your real estate agent, attorney, builder or lender offers to arrange title insurance for you, or suggests you use a specific title agent or company, ask if they have a business arrangement with the title company or agent they’re recommending and if they’ll make money from the referral. Federal law requires real estate professionals, title agents and lenders to tell you about any business arrangements they may have.

Also, beware of statements such as:

- “Everyone charges the same price.”
- “We’ll give you a discount on something else if you use our title agent.”
- “If you choose another title agent, your purchase may be delayed.”

These types of statements may be used to convince you to give up your right to choose a title agent or company, and you may pay more for title insurance than if you had shopped around.

Who Pays for Title Insurance?

If you’re buying a home, who pays for title insurance depends in part on local custom. It may be something, however, that you can negotiate with the seller of the property. When buying a home, be sure to ask your real estate agent what the custom is in your area and if you’ll likely be the one to pay for title insurance.
If you’re refinancing your home, it’ll be your responsibility to buy and pay for the title insurance policy.

A title insurance policy is paid for with a one-time premium payment.

What Does Title Insurance Cost?

The cost of title insurance is usually tied to the value of the home.

If you’re buying an owner’s policy, the price of your policy will depend on the home’s selling price.

The price of title insurance also can include more than just insurance. One cost included in the price is a title search. When a title search is conducted, a title agent or company reviews local records, such as deeds, mortgages, wills, divorce decrees, court judgments and tax records looking for any title issues with the property. In [INSERT STATE NAME], a title search must be done before a company can issue a title insurance policy.

If you’re buying a lender’s policy, the price of title insurance will depend on your loan amount.

Ask if You’re Eligible for Discounts

When you buy title insurance, ask if you’re eligible for any discounts.

If there was a previous title policy on the home (because the home changed owners or you’re refinancing), you may get a discount known as a “reissue rate.”

If you decide to buy both an owner’s and lender’s policy, you may get a discount if you buy both policies together.

The Difference Between Title and Homeowners Insurance

Title insurance is different from homeowners insurance.

- Title insurance protects you against past title problems. Homeowners insurance protects you against future issues that cause damage to your home or personal property. Homeowners insurance also limits your personal legal responsibility (or liability) if someone is injured while they’re on your property.
- Licensed title agents and companies sell title insurance. Insurance agents licensed to sell property, and casualty insurance sell homeowners insurance.
- You pay the premium for title insurance with a one-time payment, when you buy or refinance a home. A homeowners insurance policy is paid for on an ongoing basis and is up for renewal each year.
- Homeowners insurance does not protect your ownership in the property and does not replace the need for title insurance.

Questions to Ask Before You Buy Title Insurance

When you shop for title insurance, be sure to ask the title agent or company the following questions:

- How long have you been licensed to sell title insurance in [INSERT STATE]?
- What title insurance company do you sell policies for?
- Are title insurance premiums regulated in [INSERT STATE]?
- Are any discounts available?
- Are you related or affiliated in any way with my real estate agent, mortgage lender, builder, or attorney?
- Will anyone be paid a referral fee or commission or be compensated if I buy title insurance from you or a company you represent?
- In addition to title insurance premiums, what other fees and charges will I pay?
- What policy endorsements are available?
- Do you charge a cancellation fee if I don’t buy title insurance from you after you do a title search?
• Will I need to pay for a survey before you can sell me title insurance?

The Real Estate Closing

The last step to buying or refinancing a home / property is known as the closing.

Shortly after the seller accepts your offer to buy their home or the lender approves your refinancing, a closing date will be set.

A closing can be done in person, electronically or by mail. As part of the closing, you’ll be asked to sign the legal paperwork required to finalize the real estate transaction. On the day of the closing, you (as well as the seller) will be expected to pay any money owed.

If an in person closing is scheduled, expect the closing to last an hour or two. In addition to you, the seller, real estate agent(s), attorney, title agent and lender may attend the closing.

Make sure you understand what you’re being asked to sign.

During the closing, you’ll be signing documents that are legal binding contracts. Take time to understand what they mean. If you don’t understand something, ask someone to explain it to you, or ask for time to contact a trusted friend, family member, attorney or advisor for help.

One document you’ll be asked to review and sign is the closing disclosure. The closing disclosure shows all of the money to be paid to complete the transaction. Some of the costs listed on the closing disclosure will include:

• Outstanding mortgages to be paid.
• Money to be exchanged between the buyer and seller.
• The amount of the new loan(s).
• Loan origination charges.
• Property appraisal fees.
• Credit report fees.
• Real estate agent fees.
• Tax preparation fees.
• Property taxes owed.
• Escrow funds.
• Title insurance premiums.
• Courier fees.
• Settlement or closing fees.
• Closing protection fees.
• Document or recording fees.

Federal law gives you the right to see the closing disclosure at least three business days before closing. It’s highly recommended that you ask for a copy of the closing disclosure ahead of time so you have a chance to review it and ask questions.

If everything isn’t in order by your scheduled closing date, your closing date may be moved to another date.

After the closing, you’ll be given copies of all the documents you signed.
Closing Agents

Closing agents handle real estate closings and coordinate all of the steps required to make the real estate transaction official. They’re responsible for getting mortgage and loan pay-off amounts from the seller’s lender(s) and the amount of property taxes owed. They also give instructions to the buyer and seller, hold money until the home’s title is transferred, prepare documents for the buyer and seller to sign, pay out money owed and file documents with the county recorder, who updates records to show a property has changed owners.

Some title agents do more than just sell title insurance. They also conduct real estate closings by serving as a closing agent. Their responsibilities as a closing agent are separate from what they do as a title agent.

Other professionals, such as attorneys, also can be closing agents.

Questions to Ask When You Choose a Closing Agent

When you choose a closing agent, be sure to ask the following questions:

- Can you give me a list of all the fees and charges I would pay if you were my closing agent?
- What fees and charges are negotiable?
- Are your closing staff licensed title insurance agents?
- How and when do you conduct closings?
- Who will handle my closing?
- When will you give me a copy of the settlement statement?
- Do you have references or testimonials available?
- Do you offer closing protection coverage?
- How much does closing protection cost?

Closing Protection Letters

Title insurance doesn’t protect the lender or buyer against mistakes made during the closing, or if money is stolen or paid to the wrong parties. For an added fee, title insurance agents and companies that conduct real estate closings offer closing protection letters. If you buy a closing protection letter, the title insurance company will reimburse you for any money you lose from negligence, fraud, theft of funds or errors the closing agent made. Without this, you’d have to sue the agent to get back any money lost.

If you buy closing protection coverage, be sure to ask for a copy of the closing protection letter for your records.

Drafting Note: States who do not require closing protection should delete this section.

Shop Around for Title Insurance and Closing Services

As rates and fees for title insurance and closing services may vary, you should shop for title insurance and closing services. Use the chart that follows to learn how much you’ll be charged for certain rates, fees and services.
### Cost Comparison Chart

<table>
<thead>
<tr>
<th></th>
<th>Company Name</th>
<th>Company Name</th>
<th>Company Name</th>
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</thead>
<tbody>
<tr>
<td><strong>Title Insurance</strong></td>
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<tr>
<td>Premium Price (Lender's Title Policy)</td>
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<tr>
<td>Premium Price (Owner's Title Policy)</td>
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<td>Endorsement Price</td>
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<td>Title Search Fee</td>
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Beware Of Real Estate Wire Fraud Schemes

Money often needs to change hands quickly in a real estate transaction. One way to move money quickly is to have a financial institution wire it. Your real estate broker or agent, the title and closing agent, or an attorney will give you the details you need for a wire transfer.

Criminals can hack into professionals’ email systems to send emails that look as though they are coming from someone you’re working with. The emails can have fake instructions about wiring money for your upcoming closing. If you follow these instructions, your money will go to the scammer’s bank account. If that happens, you could lose your money.

To avoid being a victim of real estate wire fraud, you should:

• Call or personally meet with the professionals who will conduct the closing to learn how the closing will take place and how funds will be transferred.
• Get the names, telephone numbers, and mailing and email addresses for all of the professionals who will be involved with your closing.
• Be suspicious of all telephone or email messages about a change in the closing process. If you get such a message, call the professional you’re working with. Use the contact information they gave you, not the contact information in the message.
• Carefully examine all email addresses and telephone numbers associated with a message about your closing to verify the message really came from an individual you’ve been dealing with.
• Never respond to a message or click on a link if you’re asked to verify or provide bank account information.

What To Do If You Believe You’re The Victim of a Real Estate Wire Fraud Scheme

Report suspected wire fraud immediately!

If you suspect you’re the victim of real estate wire fraud, it’s important to immediately report your suspicions and take the following steps to increase the chances of recovering your money:

1) Contact your bank or wire transfer company to report your suspicions and ask for a wire recall.
2) Ask your bank to notify the financial institution that received your funds.
3) Call your local Federal Bureau of Investigation (FBI) office and report the crime.
4) File a report with the FBI’s Internet Crime Complaint Center by visiting www.ic3.gov

Drafting note: States who have Fraud units who investigate real estate wire fraud may wish to add a Step 5. Consumers should contact the Department of Insurance.

Final Tips to Remember

• Deal only with licensed professionals who’re in good standing in [INSERT STATE].
• As soon as you make an offer on a house or choose a lender to refinance with, start shopping for title insurance.
• Decide up front who’ll pay for the title insurance policies.

DRAFT: 3-23-215-25-21
Whoever buys the title insurance policy has the right to choose the title agent or title company.
A professional who recommends a title insurance company or agent to you may receive a commission or referral fee.
Ask the seller which title insurance company they used.
Ask friends or family who recently bought a home if they would recommend their title agent/company.
If you buy an owner’s policy, be sure the coverage is equal to the price you paid for your home.
Comparison shop, and get at least three quotes before you buy title insurance and closing services.
Ask about available discounts.
Ask title and closing agents for an itemized list of their fees and charges.
Ask for a copy of the title commitment at least three weeks before your closing date.
Know exactly what your title insurance policy will cover.
If your title agent also will be the closing agent, ask if closing protection coverage is available.
Ask the closing agent for a settlement statement at least one business day before your scheduled closing.
Be suspicious of all communications relating there’s been a change to the closing process.
Knowledge is power, so don’t be afraid to ask questions!
Read and understand all documents before signing them.
Request copies of all documents.
Keep a copy of your title insurance policy for as long as you own your property.
Immediately report suspected real estate wire fraud.

How to File a Title Insurance Claim

If an issue arises about your home’s title, contact your title insurance company as soon as possible. If you don’t know the name of your title insurance company, check the paperwork you signed when you bought or refinanced your home. You also can contact your title agent or closing agent for help.

The [INSERT DOI NAME] is Here to Help

For more information about buying insurance, please visit [INSERT DOI WEBSITE ADDRESS], or call [INSERT TELEPHONE NUMBER].

As a consumer protection agency, the [INSERT DOI NAME] also can help if you believe an insurance agent or company has misled you or acted improperly.

To file a complaint, please visit our website at [INSERT WEB ADDRESS], or send a written complaint and any supporting documents to:

[DOI Logo]
[DOI Address]
[City, State  Zip Code]
[DOI Telephone Numbers]
[DOI Website]
[DOI Facebook / Twitter Contact Information]

Other Resources Available
To verify the license status of the professionals who will be helping you with your real estate transaction, please contact:

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<th>Agency Name</th>
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To find other useful information regarding the home buying process, please contact:

U.S. Department of Housing and Urban Development
451 7th Street S.W.
Washington, DC 20410
202-708-1112
www.hud.gov

Consumer Financial Protection Bureau
P.O. Box 4503
Iowa City, Iowa 52244
855-411-2372
855-237-2392 (Fax)
http://www.consumerfinance.gov

National Flood Insurance Program
500 C Street SW
Washington, DC 20472
800-621-FEMA
www.FloodSmart.gov

[OTHER SOURCE NAME & INFO]
The Casualty Actuarial and Statistical (C) Task Force met August 10, 2021. The following Task Force members participated: Grace Arnold, Chair, represented by Phil Vigliaturo (MN); James J. Donelon, Vice Chair, represented by Nichole Torblaa (LA); Lori K. Wing-Heier represented by Katie Hegland (AK); Jim L. Ridling represented by Daniel Davis (AL); Evan G. Daniels represented by Tom Zuppan (AZ); Ricardo Lara represented by Mita Sanandajifar and Lynne Wehmuller (CA); Michael Conway represented by Mitchell Bronson (CO); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by David Christhilf (DC); David Altmairer represented by Sandra Starnes (FL); Colin M. Hayashida represented by Randy Jacobson (HI); Doug Ommen represented by Travis Grassel (IA); Dana Popish Severinghaus represented by Reid McClintock (IL); Vicki Schmidt represented by Nicole Boyd (KS); Kathleen A. Birrane represented by Walter Dabrowski (MD); Eric A. Cioppa represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Chlorella Lindley-Myers represented by Cynthia Amann (MO); Troy Downing (MT); Mike Causey represented by Arthur Schwartz (NC); Chris Nicolopoulou represented by Christian Citarella (NH); Russell Toal represented by Anna Krylova (NM); Barbara D. Richardson represented by Gennady Stolyarov (NV); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by David Dahl (OR); Jessica K. Altman represented by James DiSanto (PA); Raymond G. Farmer represented by Will Davis (SC); Doug Slape represented by Miriam Fisk (TX); Michael S. Pieciak represented by Rosemary Raszka (VT); Mike Kreidler represented by Eric Slavich (WA); James A. Dodrill represented by Juanita Wimmer (WV); and Jeff Rude represented by Tana Howard (WY). Also participating was: Gordon Hay (NE).

1. Adopted its July 13, June 8, May 11, and March 9 Minutes

Mr. Vigliaturo said the Task Force met July 13, June 8, and May 11. During these meetings, the Task Force adopted responses to the Blanks (E) Working Group and a request for NAIC staff to gather information about statistical reports.

The Task Force also met May 20 and April 20 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss rate filing issues.

The Task Force held the following Predictive Analytics Book Club meetings: Sam Madden (Cambridge Mobile Telematics) presented on telematics in March and Radost Wenman (Pinnacle Actuarial Resources) presented on generalized linear models (GLMs) to generalized additive models (GAMs) in April. In June, the American Academy of Actuaries (Academy) arranged presentations for the NAIC’s Insurance Summit. Dorothy Andrews (Academy) and Hao Li (Verisk) presented on big data and modeling; Howard Kunst (CoreLogic) and Matt Chamberlain (Milliman) presented on catastrophe modeling; James Guszcza (Center for Advanced Study in Behavioral Sciences—CASBS at Stanford University), Dani Bauer (University of Wisconsin-Madison), and Birny Birnbaum (Center for Economic Justice—CEJ) presented on ethics in analytics, Ms. Andrews and Sam Kloese (NAIC) presented on GAMs; Michael Regier (Verisk) and Tim Hagan (Verisk) presented on regularization methods; Jonathan Fesenmeyer (Allstate) and Evan Petzdolt (Allstate) presented on geographic rating in personal lines insurance pricing; and Caolan Kovach-Orr (Verisk) and Vahid Meimand (Verisk) presented on tree-based models. In July, Larry Baeder (Milliman) presented on interpretable machine learning for insurance.

Ms. Darby made a motion, seconded by Mr. Grassel, to adopt the Task Force’s July 13 (Attachment One), June 8 (Attachment Two), May 11 (Attachment Three), and March 9 (see NAIC Proceedings – Spring 2021, Casualty Actuarial and Statistical (C) Task Force) minutes. The motion passed unanimously.

2. Adopted the Report of the Actuarial Opinion (C) Working Group

Ms. Krylova said the Actuarial Opinion (C) Working Group generally agreed that 2020 Statement of Actuarial Opinion submissions were fine but that some additional regulatory guidance would be helpful. Topics under discussion include reconciliation to Schedule P and a Board of Director’s review of qualification documentation. The actuarial opinion instructions will be revised to eliminate reference to the Casualty Actuarial Society’s (CAS) principles due to the CAS’ rescission of the reserving principles.
Ms. Krylova made a motion, seconded by Mr. Dyke, to adopt the report of the Actuarial Opinion (C) Working Group, including its July 22 (Attachment Four) and July 1 (Attachment Five) minutes. The motion passed unanimously.

3. **Adopted the Report of the Statistical Data (C) Working Group**

Mr. Vigliaturo said he appointed Ms. Darby as chair of the Statistical Data (C) Working Group. Ms. Darby said the Working Group has not met recently, but NAIC staff are reviewing auto and home data submissions.

4. **Discussed the U.S. Qualification Standard**

Mr. Vigliaturo said the Academy’s Committee on Qualifications released the second exposure draft of the U.S. Qualification Standards with a comment deadline of Aug. 20. Mr. Stolyarov said the changes made by the Academy were responsive to the comments the Task Force submitted on the first draft. He said he had preliminary discussions with NAIC staff about the second exposure draft, and some issues need discussion in regulator-to-regulator session. He said he is not sure another comment letter needs to be submitted, but state insurance regulators should discuss the issues and see if they can come to any agreement. Mr. Schwartz said he has some additional comments for discussion during the regulator-to-regulator session. He said one issue is that a new requirement was added in the second draft to require one hour of continuing education (CE) on bias topics.

Mr. Vigliaturo asked if anyone objected to a plan to meet in regulator-to-regulator session followed by an e-vote of any comment letter the following week. No objections were voiced. Mr. Vigliaturo said the deadline for comments is Aug. 20.

5. **Received a Report on Project #2019-49: Retroactive Reinsurance Exception**

Mr. Hay said he would present a proposal for discussion at the Fall National Meeting.

6. **Adopted a Charge for the Statistical Data (C) Working Group and Discussed Proposal 2021-11BWG**

Mr. Vigliaturo said the Task Force unanimously adopted a motion during its July 13 meeting to inform the Blanks (E) Working Group the Task Force is ready to provide guidance regarding the implementation of proposal 2021-11BWG if that proposal moves forward. The Blanks (E) Working Group met July 22 and took the following action: 1) deferred the revised proposal for comment until Oct. 22; 2) decided to send the revised proposal to the Task Force for review and comment; and 3) decided to send a referral to the Financial Analysis Solvency Tools (E) Working Group and the Financial Analysis (E) Working Group for review and comment about whether the information in the proposal would be useful for regulating for solvency purposes.

Mr. Birnbaum presented the changes made to the proposal (Attachment Six) since the Task Force’s July 13 meeting. He said the proposed additions would provide timely and useful information for financial and market analysis, the proposed additions are financial and not statistical data, and the proposed additions do not conflict with nor replace the Task Force’s statistical reporting. He asked the Task Force to support the proposal in its response to the Blanks (E) Working Group.

Mr. Chou asked whether an alternative option to speed up the statistical report of premium and exposure information would have a similar impact as the proposal. Mr. Birnbaum said then the blanks proposal would not be necessary. Currently, the statistical reporting machine does not provide that data until a year and a half after the end of the experience period. He said reinventing the statistical reporting system is not a short-term project. Ralph Blanchard (Travelers) said the premium and loss information at the policy form level is statistical information because it is not captured in financial reporting systems today. Ms. Starnes asked whether the quarterly reporting would include data by state or only nationwide. Mr. Birnbaum said it would be nationwide only on the quarterly statements. He said the information is still useful although it would be helpful to have by state information. Mr. Davis asked how the data would be used. Mr. Birnbaum replied that it might not be as useful to actuaries, but could be quite valuable to financial and market analysts.

Ms. Darby said NAIC staff gathered information in response to the request adopted by the Task Force on July 13 to provide the data and normal reporting times for the *Auto Insurance Database Report* and the *Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report* (Homeowners Report).

Ms. Darby said data for the *Auto Insurance Database Report* is obtained from four statistical agents—American Association of Insurance Services (AAIS), Insurance Services Office (ISO), Independent Statistical Services (ISS), and National Independent Statistical Service (NISS)—and four state entities—the California Department of Insurance (DOI), Massachusetts Commonwealth Automobile Reinsurers, Maryland Automobile Insurance Fund (MAIF), and the Texas DOI. Data received in
2021 would be for 2018/2019. The two years refer to written and earned premiums. For instance, in 2021, written exposures would be reported for 2019, and earned exposures would be reported for 2018. There are additional caveats, like earned exposures, and incurred claims for Texas are not available at all. Therefore, the Texas pure premium, frequency, and severity cannot be calculated. The NAIC currently receives two separate files from each entity—one for premiums and exposures and a second file for claims and losses. Currently, the timing for which each file is received is substantially the same.

Ms. Darby said data for the Homeowners Report is received from four statistical agents: the AAIS, the ISO, the NISS, and the American Property Casualty Insurance Association (APCIA); the California DOI; the Texas DOI; and multiple residual market programs. The reported data is two years behind the current calendar year. For example, 2019 data is reported in 2021. This report only includes premium and exposure data, all of which is included in one file.

For both publications, Ms. Darby said requests for data are sent to statistical agents, states, and residual market organizations in late January, with final data due from all entities in July. If all goes well, the data is clean and states are responsive regarding the state law section of the publication. Then the report can be completed in early fall. In recent years, there have been data concerns that needed to be addressed prior to release of the publications. There are fluctuations in the data due to different companies reporting to statistical agents from one year to the next, which can result in significant year-over-year (YOY) changes to premium and exposure data provided.

Ms. Darby said the information contained in both the Auto Insurance Database Report and Homeowners Report is voluntarily reported to the NAIC and not required through a data-sharing agreement. If the timeline were to be revised, all reporting entities would need to voluntarily agree to the change. Otherwise, there may need to be a formal agreement in place to get everyone on the same timeline going forward. Additionally, the Statistical Data (C) Working Group members would need to sign off on the changes, as they oversee the publications and any amendments would need to be considered for adoption. In terms of next steps, the Working Group can draft a letter, requesting that all of the organizations providing content for each report provide input and participate in a meeting to discuss the feasibility of an expedited timeline for reporting. Ms. Darby said the Task Force could additionally consider producing the reports in different formats or at different timelines, such as the earlier suggestion to consider reporting premium and loss data separately, along separate timelines. Again, the Task Force would need to confirm that each entity can abide by the expedited timeline and that they continue to be willing to do so under the voluntary nature of the reporting agreement.

Mr. Dyke said he is concerned about the quality checks that might be lost by receiving this data directly from companies. He said there is a robust data quality process that statistical reporting agents use. He is also concerned about potential misuse of the data. He said use of the data at a company level to identify trends could be misleading. For example, he said if there is more premium written in downtown Detroit, MI, then the average statewide premium would be higher but would not be a premium trend.

Mr. Chou made a motion, seconded by Mr. Dahl, to ask the Statistical Data (C) Working Group to gather information about the statistical reporting study can be completed prior to the deadline to respond to the Blanks (E) Working Group.

Mr. Birnbaum expressed concern whether the timeline can be sped up on receipt of premium and exposure information from outside parties. The Working Group should report back to the Task Force before Oct. 12. The motion passed unanimously. Mr. Birnbaum expressed concern whether the statistical reporting study can be completed prior to the deadline to respond to the Blanks (E) Working Group.

7. Received a Report on the NAIC Rate Model Reviews

Mr. Vigliaturo asked for a shortened report on rate model reviews due to time constraints during the meeting. Kris DeFrain (NAIC) said there are 30 states contracted with the NAIC using a Rate Review Support Services Agreement. She said the NAIC rate review team has produced 60 technical reports, with 47 standard GLMs, six regularized GLMs, 11 tree-based models (which includes random forests and GBMs), and five GAMs. She said there are sometimes more than one model in a filing. NAIC staff asked the Task Force if it would review the issues being evaluated for non-GLM models and provide guidance.

8. Heard Reports from Professional Actuarial Associations

Lauren Cavanaugh (Academy) said the Academy’s Casualty Practice Council formed a racial equity task force to address racial equity in the context of property/casualty (P/C) insurance. Comment letters were submitted to the NAIC and Colorado. Two issue briefs were published by the auto committee: 1) COVID-19; and 2) consumer cost of auto insurance. The Federal Insurance Office (FIO) asked for information on the availability and affordability of auto insurance. Derek Freihaut (Academy) said the Committee on Property and Liability Financial Reporting (COPLFR) is conducting its opinion seminar in December and is working on the law manual and practice note. He said COPLFR is seeking a regulatory member(s).
Brian Fannin (CAS) provided the CAS’ research report (Attachment Seven). Dale Hall (Society of Actuaries—SOA) provided the SOA’s research report (Attachment Eight).

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
Casualty Actuarial and Statistical (C) Task Force

Virtual Meeting
July 13, 2021

The Casualty Actuarial and Statistical (C) Task Force met July 13, 2021. The following Task Force members participated: Grace Arnold, Chair, represented by Phil Vigliaturo (MN); James J. Donelon, Vice Chair, represented by Nichole Torblaa (LA); Lori K. Wing-Heier represented by Sian Ng-Ashcraft (AK); Evan G. Daniels represented by Tom Zuppan (AZ); Ricardo Lara represented by Lynne Wehmueller (CA); Michael Conway represented by David Christhilf (DC); David Altmaier represented by Sandra Starnes (FL); Colin M. Hayashida represented by Randy Jacobson (HI); Doug Ommen represented by Travis Grassel (IA); Dana Popish Severinghaus represented by Judy Mottar (IL); Vicki Schmidt represented by Nicole Boyd (KS); Kathleen A. Birrane represented by Ron Coleman and Walter Dabrowski (MD); Eric A. Cioppa represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Chlora Lindley-Myers represented by Cynthia Amann (MO); Troy Downing represented by Mari Kindberg (MT); Mike Causey represented by Kevin Conley and Arthur Schwartz (NC); Chris Nicolopoulos represented by Christian Citarella (NH); Marlene Caride represented by Carl Sornson (NJ); Russell Toal represented by Anna Krylova (NM); Barbara D. Richardson represented by Gennady Stolyarov (NV); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by Ying Liu (OR); Jessica K. Altman represented by Kevin Clark (PA); Raymond G. Farmer represented by Will Davis and Michael Wise (SC); Doug Slape represented by J’ne Byckovski (TX); Michael S. Pieciak represented by Rosemary Raszka (VT); Mike Kreidler represented by Manabu Mizushima (WA); James A. Dodrill represented by Juanita Wimmer (WV); and Jeff Rude represented by Donna Stewart (WY).

1. Adopted Responses to Referrals from the Blanks (E) Working Group

Mr. Vigliaturo said the Task Force exposed the two referrals from the Blanks (E) Working Group and received comments (Attachment One-A). State insurance regulators and interested parties presented highlights from their written comments. Birny Birnbaum (Center for Economic Justice—CEJ) referred to a July 12 letter responding to specific comments submitted (Attachment One-B) and proposed some changes to proposal 2021-11BWG. The revised proposal is attached (Attachment One-C).

State regulatory discussion about proposal 2021-11BWG included: limitations on the use of average premiums (mostly to evaluate changes over time); a desire to get premium and exposure data earlier than the NAIC statistical reports; a question whether statistical reports could be published with more recent data; a question whether market data should be in the statutory financial statements; a question whether data compilation would be costly for insurers; a comment that states have the ability to issue data calls to get this type of information; a comment that data is not vital from a solvency standpoint so should not be in the statutory financial statements; and a desire to improve methods for reporting statistical data to the NAIC.

Mr. Birnbaum explained that the statistical reports cannot be sped up because the statistical agents collect claims data in addition to premium and exposure data. He added there are four statistical agents and two states that submit data, and then there is a significant amount of NAIC staff time taken to evaluate the data and fix reporting errors. He said use of data calls would result in a greater expense to insurers, and the reporting would not be uniform from one state to another.

Ms. Torblaa made a motion, seconded by Mr. Davis, to inform the Blanks (E) Working Group that the Task Force does not support proposal 2021-11BWG, but if the proposal does move forward for adoption, then the Task Force would offer additional guidance on the content. Discussion included it being premature to decide whether to support the proposal. Mr. Stolyarov requested a roll call vote. The motion failed 9-17 with four abstentions.

Mr. Schwartz made a motion, seconded by Mr. Jacobson, to request NAIC staff provide documentation to see sources of data for the auto and home reports and the time frames it takes to collect each of those pieces of data. The motion passed unanimously.

Mr. Stolyarov made a motion, seconded by Ms. Darby, to inform the Blanks (E) Working Group that the Task Force is ready to provide guidance regarding the implementation of proposal 2021-11BWG if that proposal moves forward. Furthermore, the
Task Force requests that Mr. Birnbaum submit the most current up-to-date version of the proposal for further consideration and suggestions from the Task Force. The motion passed unanimously.

Discussion about proposal 2021-13BWG included: a desire to have the proposed additional other liability data; a potential to add foster care other liability; a comment that the number of pieces seems too detailed; and a comment that incurred but not reported (IBNR) reserves are likely not available at this level of detail for most companies.

Ms. Torblaa made a motion, seconded by Mr. Davis, to inform the Blanks (E) Working Group that the Task Force supports proposal 2021-13BWG (with or without modification to the proposed lines of business), but it recommends that the reporting of IBNR be modified to be reporting of case reserves because the IBNR is likely not available at this level of detail. The motion passed unanimously.

2. **Discussed Exposure of the Academy’s U.S. Qualification Standards**

Mr. Vigliaturo said the Task Force commented on the first exposure draft of the American Academy of Actuaries (Academy) U.S. Qualification Standards. A second exposure has been released. Mr. Stolyarov and Mr. Schwartz volunteered to draft a comment letter for the Task Force’s consideration.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
July 6, 2021

Phil Vigliaturo
Chair
Casualty Actuarial and Statistical (C) Task Force
National Association of Insurance Commissioners (NAIC)

c/o: Kris DeFrain
kdefrain@naic.org

Re: 2021 NAIC Blanks Proposals 2021-11BWG and 2021-13BWG

Dear Mr. Vigliaturo:

On behalf of the Committee on Property and Liability Financial Reporting (COPLFR) of the American Academy of Actuaries, I appreciate this opportunity to provide comments on the proposed changes to the financial requirements exposed by the Blanks (E) Working Group of the National Association of Insurance Commissioners (NAIC) which requested the Casualty Actuarial and Statistical (C) Task Force (CASTF) to review and evaluate the proposals and provide it with comments on issues that might affect the work of the CASTF or on interested parties concerns. The CASTF requested public comments on June 8, 2021, to be submitted with a deadline of July 7, 2021.

COPLFR appreciates your consideration of our comments.

The exposed two proposals that we would like to provide comment on.

I. 2021-11BWG- Add a new annual statement supplement to the Property and Casualty (P/C) statement to capture exposure data for Annual Statement Lines 2.5, 4, 19.1, 19.2 and 21.2 of the Exhibit of Premiums and Losses. Add a column to the Quarterly Parts 1 and 2 to capture exposure data for these annual statement lines for the quarter.

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1 The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
II. 2021-13BWG- Add a new supplement to capture premium and loss data for Annual Statement Lines 17.1, 17.2 and 17.3 of the Exhibit of Premiums and Losses (State Page) – Other Liability by more granular lines of business.

We believe that the potential benefit that may be derived by the public from having access to additional reported information needs to be considered relative to the effort to obtain the additional information. We also believe that the quality and consistency of the data that would be provided under the proposals are a concern, and that the proposals should ensure the additional data will serve the intended use.

The level of detail that would be requested by the two exposure drafts is not regularly captured in typical company financial data systems. It will require time for each company to clarify the detailed requirements and then additional lead time to implement within individual company systems to ensure quality data can be provided.

The value of the reported data will depend on what is available from each specific company. Additional granularity of some data may still only be achieved through judgment and allocations made at the individual company level. This often makes detailed information less valuable once obtained and aggregated to the industry level. In addition, requesting data with unclear requirements and with definitions not commonly used across the industry is not likely to produce consistent and useful quality data.

Specific issues that we would like to point out, given the currently provided details of these two proposals, are separately discussed below.

2021-11BWG

- **Definition of exposure**—A clearer definition of how exposure should be calculated for each requested line is needed. Some lines where this additional information is requested contain significant issues related to mix of exposure.
  - For example, “Homeowners line 4” contains exposures varying in type including owner occupied, apartment renters, condo owners, and mobile home owners, with significantly varying lines of amount of insurance per exposure.
  - For Auto lines, would exposure for a policy having Comprehensive & Collision coverage be measured similarly to a policy containing only one Physical Damage coverage?

Comparison year over year within each company will be distorted when there are material changes in mix across these various types of exposures. Comparisons between companies could also be distorted. We recognize that this aggregated information is regularly used to compare premium but comparing average premiums could be distorted.

- **Calendar date alignment**—We note that the timing for the source of exposure data requested (that is available currently in company ratemaking systems) may not match the financial reporting data for financial premium. Exposures are typically maintained in detailed policy-based systems along with policy premium and are provided on a policy year basis. They are often separate from financial reporting systems where premium is on
a calendar-year-earned basis. While premiums from ratemaking and financial systems could be reconciled, they might not provide a precise match. We note that data from ratemaking systems is already available and provided when requested by regulators or through specific data calls and filing inquiries.

- **Existing alternative data sources**—Some of the data requested is already available through statistical plan reporting which may meet the intended need. Statistical plan data is primarily available to regulators (the restricted availability is intended to protect the proprietary nature of each company’s data).

Changes that COPLFR would suggest that would improve the proposal (2021-11BWG):

- Include a complete and clear definition of exposure and calculation for each line proposed, particularly as respects the crossing (or overlap) of calendar time periods. Clear specifications ensure greater consistency across companies reporting.
- Definitions that account or minimize distortions from mix would be recommended.
- If these requests move forward to requirements, we respectfully suggest a 2023 implementation date as the earliest date for achievement of those requests.
- We recommend that flood coverage (Annual Statement Line 2.5) be removed from the proposal, as flood has a mix of both Personal and Commercial policies, written on both primary and excess bases.

**2021-13-BWG**

- **Granularity and definition**—The (29) proposed components of additional reporting for Other Liability will require clear definition (or instruction) on how to map class plan or package policies to these new required sublines of Other Liability. Significant judgment will be necessary at the individual company level depending on the policies written by that company. It is not clear that the proposed sublines are exclusively defined to eliminate overlap, nor that they will subsequently add up to the whole (e.g., internet liability vs cyber; employee benefit liability vs. fiduciary; one package policy covering three sublines of liability). A particular policy type could possibly be matched to one reporting line or another, generating inconsistency across companies, or year after year as policy changes evolve or new products are distributed. It is not clear why more granularity of data would not be put into the statistical data requirements, rather than being added into the Annual Statement. The proposal notes an additional Appendix defining the 29 granular pieces, but we do not find those proposed components included in the exposure draft for review.
- **Credibility/Quality (IBNR)**—We note that further subdividing the Liability data, already sparse in areas, will not necessarily provide valuable additional information across all the data elements requested. Inclusion of Incurred But Not Reported (IBNR) reserves at this new granular level of detail will most likely be arrived at through a company-determined allocation process. Liability is generally a low frequency / high severity line of business. Actuarial reserves for Liability are necessarily analyzed at higher levels of aggregated data to arrive at meaningful estimates and to reduce volatility in those reserve estimates.
over time. While some companies may segment Liability into credible pieces given their business profile, likely no company utilizes the (29) sublines proposed in their derivation of IBNR reserves.

- **Inconsistency with the underlying policies**—We find that this breakout of a broad type/cause of loss product such as Liability would be excessive and also is not consistent with the purpose of the General Liability policy, which is to provide broader aggregated coverage across a variety of situations which by themselves may not be as easily or affordably insurable.

- **Preparation**—The proposed breakouts of Other Liability as currently listed as the sublines requested would not be consistently defined across companies. If this list will continue to change, it should be noted that the value and quality of the information would be reduced with each change, and each change would require additional company preparation time as well as discretion to report. Given appropriate time to prepare systems for this change, the quality of the data would improve.

Changes that COPLFR would suggest that would improve the proposal (2021-13-BWG):

- Remove the requirement to include IBNR reserves from this new granular level of Liability reporting.
- Clearly define the sublines and eliminate any overlap or redundancies. Balance the additional information requested with the value added by collecting that additional granularity. For example, what is the difference between cyber and internet liability? Where would you categorize a package Liability policy that provides coverage across three of the above proposed sublines?
- Please provide and expose for comment the Appendix noted in the proposal that clearly defines the lines and coverages requested.
- Provide sufficient lead time for system preparation and implementation to improve the quality of data obtained. If these requests move forward to requirements, we respectfully suggest a 2023 implementation date as the earliest date for achievement of those requests.

COPLFR appreciates this opportunity to provide comments to the NAIC Blanks Working Group (and CASTF). We hope these observations are helpful, and we welcome further discussion. If you have any questions about our comments, please contact Rob Fischer, the Academy’s casualty policy analyst, at fischer@actuary.org.

Sincerely,

Derek Freihaut, MAAA, FCAS
Chairperson
Committee on Property and Liability Financial Reporting
American Academy of Actuaries
July 7, 2021

Phil Vigliaturo, Chair
Casualty Actuarial and Statistical (C) Task Force
NAIC Central Office
1100 Walnut, Suite 1500
Kansas City, MO 64106-2197

Attn: Kris DeFrain, Director, Research and Actuarial Department

VIA Electronic Mail: kdefrain@naic.org

RE: Blanks Proposals

Dear Casualty Actuarial and Statistical Task Force Committee Members:

The American Property Casualty Insurance Association (APCIA)¹ appreciates the opportunity to provide feedback to the National Association of Insurance Commissioners’ (NAIC) Casualty Actuarial and Statistical (C) Task Force (CASTF) on the two referrals from the Blanks (E) Working Group. APCIA has significant concerns with both proposals and respectfully requests that CASTF not support their adoption.

New Supplement to Capture Property/Casualty Direct Exposure Written and Direct Exposure Earned

During CASTF’s initial discussion of the exposure for a new annual supplement to the financial statement for property and casualty direct exposure written and direct exposure earned, there was support for the proposition that this proposal would provide more timely information. Unfortunately, using this proposal to gain more timely information will lead to misleading data for both regulators and the public. Additionally, the public nature of these filings will offer competitor insight into proprietary information. As noted by at least one regulator on the call, regulators already have tools available to them to obtain necessary timely data. For example, regulators have the authority to review company data if they have concerns, and the Schedule P and Actuarial Statement of Opinion in the Annual Statement and rate filing submissions can also elicit the data sought. Even if this data is insufficient, the regulators have access to detailed market conduct data. Finally, regulators and industry worked well together to develop a data call under difficult circumstances to provide necessary information during the pandemic. APCIA struggles to identify why regulators need this new publicly available supplement data when there are many additional avenues to obtain this information.

Significantly, this proposal will sacrifice timely data for misleading data. The defined Exposure counts may, in some instances, not be appropriately inclusive of the coverage reported under the respected Annual Statement Line of Business. The Interested Party comment letter filed with the Blanks Working Group

¹ Representing nearly 60 percent of the U.S. property casualty insurance market, the American Property Casualty Insurance Association (APCIA) promotes and protects the viability of private competition for the benefit of consumers and insurers. APCIA represents the broadest cross-section of home, auto, and business insurers of any national trade association. APCIA members represent all sizes, structures, and regions, protecting families, communities, and businesses in the U.S. and across the globe.
provides the following useful example: “If ASL 4 Homeowners Exposures is all inclusive, the proposal to count written and earned ‘residences’ would include an array of policies ranging from rental policies to mansions, resulting in an average premium that has no real value to users. If ASL 4 Exposure does not include condo and/or rental policies, then the average premium would be misleadingly inflated.”

The consequences of misleading data, availability of alternative sources for timely information, and impact of the availability of proprietary information to competitors all suggest that this proposal should not be advanced.

New Supplement to Capture Property/Casualty Premium and Loss Data
APCIA notes that this proposal has some ambiguities and ultimately will not provide the insights that may be sought. For instance, there will be inconsistencies in reporting as companies use their individual judgment to identify how a package policy would fit into the new sublines and there is some question as to whether the reporting method will eliminate overlap or just cause additional confusion.

Further, this proposal will require a significant amount of work to retool systems to be able to capture the information as requested. The resulting capital and human resource costs are not necessary when regulators can request this detail from individual companies on a case-by-case basis or through a data call.

Thank you for the opportunity to comment. APCIA encourages members of CASTF to review the comment letters that have already been submitted to the Blanks Working Group for additional observations.

Respectfully submitted,

Angela Gleason
June 25, 2021

Mr. Jake Garn, Chair
Blanks Working Group
National Association of Insurance Commissioners
1100 Walnut St.
Kansas City, MO  64106

SUBJECT:   Blanks Working Group ("BWG") proposals exposed during the conference call on May 26, 2021

Dear Mr. Garn:

Interested parties ("IPs") appreciate the opportunity to review and comment on the 5 proposals that were exposed during a conference call by BWG on Wednesday, May 26, 2021.

2021-10     [Exposed changes remove language in Line 4.1 of the quarterly General Interrogatories Part 1 that requires filing of a quarterly merger/history form, which does not function with the database system as currently designed. The annual form shall still be required. Anticipated effective date is 1st Quarter 2022]

   IPs have no comments.
Exposed changes to add a new annual statement supplement in the Property/Casualty Statement to capture direct exposures written and direct exposures earned which will be reported for Annual Statement Lines 2.5, 4, 19.1, 19.2 and 21.2; also, add a column to the Quarterly Parts 1 and 2 to capture exposure data for these annual statement lines for the quarter. Anticipated effective date is 1st Quarter 2022 / Annual 2022]

IPs do not support 2021-11BWG for several reasons. Primarily, we are concerned that a fatal flaw exists at the core of this proposal, which, if adopted, would result in the reporting of misleading information and potentially provide competitors with proprietary information. We believe that there is no benefit to providing information on a timely basis if that information is misleading. The fatal flaw and additional concerns are outlined in the following discussion.

Fatal flaw: IPs believe that this proposal, if adopted, would result in misleading information and provide competitor insight into proprietary information.

The proposal focuses on collecting defined Exposure counts of specific ASLs, while presenting and analyzing it with total Premiums reported in the respective ASL. These defined Exposure counts may in some instances not be appropriately inclusive of the coverage reported under the respective ASL. For example, if ASL 4 Homeowners Exposures is all inclusive, the proposal to count written and earned “residences” would include an array of policies ranging from rental policies to mansions, resulting in an average premium that has no real value to users. If ASL 4 Exposure does not include condo and/or rental polices, then the average premium would be misleadingly inflated. For ASL 19.2 auto policies, if Premiums include, but Exposures exclude, miscellaneous vehicles, such as golf carts, private passenger trailers, and all-terrain vehicles, the average premium would be inflated. Furthermore, how misleading this broadly applied average may be for any individual company depends on the size and mix of their business reported under each ASL impacted by the proposal. This information, taken out of context, could be negatively construed and lead to detrimental results for companies. At the same time, publicizing Exposure counts by company would provide competitors with proprietary information.

The existing reports cited in this proposal (i.e. "Auto Database Report" and "Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owners" reports) may be distributed with a time lag, but they also have important context and underlying details, such as business line detail, which helps analyze and understand the data. The "Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owners" report issued in 2020 was almost 200 pages of data and narrative and included the fact that some of the information came from residual market data providers. The "Auto Database Report" issued in February 2021 was 255 pages and also acknowledged "Written premium and written exposure data were obtained from AAIS, ISO, ISS, NISS, the California Department of Insurance, the Texas Department of Insurance, MAIF, and the M-CAR". Additionally, the existing reports provide aggregate information and do not reveal company specific details. If the primary reason for this proposal is faster information, perhaps a more prudent approach would be a discussion with CASTF regarding whether opportunities exist in the process to produce quicker publication of existing reports.
Additional concerns:
1. The proposal’s justification included a comment that “…the severe time lag between actual experience and reporting fails to inform the public or policymakers of recent trends or outcomes and can, consequently, mislead the public and policymakers.” However, other data exists in quarterly and annual financial filings, and in rate filings, that can be used to identify meaningful trends. We would contend that the proposal, if adopted, would result in misleading information for which detailed clarification would not exist at the same time. This could have detrimental results to companies and the states in which they do business.

2. It is unclear to IPs why the disclosures in this proposal are needed. Regulators already have the authority to review a company’s data and operation if they have specific concerns. There is also a significant amount of company-level and more granular data and information available to regulators in Schedule P and the Actuarial Statement of Opinion in the annual statement, as well as in rate filing submissions. In addition, statistical data may be provided via statistical agents (e.g. ISO) rather than from individual companies. And, if this vast amount of data is insufficient for a regulatory need, regulators also have access to companies’ detailed market conduct data. IPs strongly believe these data sources obviate any need for the highly sensitive public disclosures contemplated in this proposal.

3. The proposal’s justification included, “Consider how valuable timely average premium values would have been for personal lines as the pandemic unfolded.” How would this data have been used? Is this to suggest that misleading average premiums would have been used as actionable information toward insurers? To what end? At this point, we are still seeing longer-reaching pandemic impacts such as repair/replacement cost increases due to unexpected supply shortages. Taking today’s general average premium per exposure out of context and adding a prospective narrative would be misleading and the possibility of it is concerning.

4. Does the definition of Exposure match that used for Exposure in the cited existing reports? If not, this would result in a disconnect between the proposed annual reporting and the cited existing reports.

5. Providing statistical data via financial reporting. Statistical data may be provided via statistical agents, such as ISO, rather than directly from individual companies. Therefore, not all companies have this Exposure information available today, or may not be available as defined, and would require enough time to implement. However, IPs do not believe this is a cost that would benefit policyholders or regulators.

IPs recommend that this exposure be rejected and that the regulators consider the need for ‘Exposure’ data within the annual statement filing process.
**2021-12** [Exposed changes to modify the Analysis of Operations by Lines of Business – Accident and Health for Life/Fraternal entities by adding and deleting lines to capture health specific data captured on the Health Analysis of Operations by Lines of Business but not on the Life/Fraternal Analysis of Operations page; also, add new crosschecks for the new lines and new crosschecks to the Analysis of Operations by Lines of Business – Summary to map the lines on the accident and health page to the summary. The purpose of the proposal is to modify the Analysis of Operations by Lines of Business – Accident and Health for Life/Fraternal entities to capture health specific data points captured on the Health Analysis of Operations page. Anticipated effective date is Annual 2022]

IPs offer the following general comments and request an extended comment period for this item to allow additional time for further evaluation. Since the suggested effective date is Annual 2022, there is still time to review, analyze and revise this proposal.

- The NAIC recently implemented changes to the 2019 annual statement for Life/Fraternal entities modifying the Analysis of Operations by Lines of Business (ANAOPS) to provide a more detailed breakdown by product group with a corresponding Summary page; considerable time and cost was spent by the NAIC and industry to develop and capture the revised reporting requirements. To comply with this proposal, the NAIC and industry would be required to develop and implement additional system updates again. This proposal requires more granular details, specifically for lines 1 and 9, which may not be readily available.
- The proposed changes would result in inconsistencies between the ANAOPS – Summary page and the ANAOPS – Lines of Business pages by creating different lines. The changes would negate current validations the NAIC has in place between the Summary and the detail pages, making the flow of information difficult to follow.
- The format changes suggested in this proposal would be in direct conflict with the tying in of data that the Schedule H proposal (2021-14BWG) is trying to achieve.
- Instead of the proposed changes to modify the existing ANAOPS – Accident and Health page, IPs recommend that consideration be given to retaining the current ANAOPS structure by developing an alternative method to capture the additional data separately. In addition, clarity would be needed on how certain products would be reflected in certain lines (e.g. LTC and DI benefits in lines 9.1 and 9.6). Perhaps the sponsors of this proposal and 2021-14BWG could collaborate on alternative reporting methods.
- IPs recommend making the following editorial revisions if this item moves forward as exposed:
  - On page 2 of the PDF, the instructions for ‘Line 1.6’ should be changed from “in the Exhibit, Part 1” to “in Exhibit 1, Part 1”.
  - On page 3 of the PDF, the instructions for ‘Line 7.2’ should be changed from “Aggregated at Line 8.3” to “Aggregated at Line 7.2”.
  - On page 5 of the PDF, the instructions for ‘Line 9.5’ should be changed from “Hospital/Medical Benefits on Line 9.2” to “Hospital/Medical Benefits on Line 9.1”.

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Exposed changes add a new supplement (Exhibit of Other Liabilities By Lines Of Business) to the Property annual statement to capture premium and loss data for Annual Statement Lines 17.1, 17.2 & 17.3 of the Exhibit of Premiums and Losses (State Page) – Other Liability to provide regulators more granular detail of the premium and losses of the diverse lines of business reported on such lines. Anticipated effective date is Annual 2022]

IPs offer the following comments, but also request an extended comment period for this item to allow additional time to further evaluate the significant proposed changes to the Property statement. Since the suggested effective date is Annual 2022, there is still time to review, analyze and revise this proposal.

- Business reported in ASL 17 is not usually internally managed to this proposed level of granularity; therefore, data infrastructure does not exist to capture or calculate all the requested data at this level (i.e. IBNR). A large expenditure of both NAIC and industry resources would be required to achieve this level of reporting. Regulators could request this detailed information from individual companies on a case-by-case basis where there is concern or the data seems relevant and meaningful. In addition, data calls could be used.
- If this item moves forward as exposed, IPs recommend that a new question be added to the 2022 Supplemental Exhibits and Schedules Interrogatories related to the filing of this new exhibit.
- IPs recommend making the following editorial revision if this item moves forward as exposed:
  - On page 2 of the PDF, the reference “Line 26 – All Other” should be “Line 29 – All Other”.

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Exposed changes expand the number of lines of business reported on Schedule H (Accident and Health Exhibit) to match the lines of business reported on the Health Statement and modify the instructions to be uniform between life/fraternal and property. The purpose of the proposal is to bring uniformity in the accident and health lines of business used on Schedule H with other schedules and exhibits in the annual statement. Anticipated effective date is Annual 2022.

IPs request an extended comment period for this item to allow interested parties additional time to evaluate the impacts to the Life/Fraternal and Property blanks. Since the suggested effective date is Annual 2022, there is still time to review, analyze, and revise this proposal as needed.

IPs recommend the following editorial revisions:

Use a consistent description for the 2 Comprehensive Hospital and Medical lines of business throughout 2020-33BWG_Modified (Health ASLs – Property Blank) and 2021-14BWG (Schedule H) as indicated below.

- Comprehensive (Hospital and Medical) Individual
- Comprehensive (Hospital and Medical) Group

2020-33BWG_Modified:
- Underwriting & Investment Exhibit I Parts 1, 1A, 1B, 2, and 2A
  - 13.1 Comprehensive (hospital and medical) individual
  - 13.2 Comprehensive (hospital and medical) group
- Insurance Expense Exhibit Parts II and III
  - 13.1 Comprehensive Individual
  - 13.2 Comprehensive Group
- Exhibit of Premiums and Losses (Statutory Page 14)
  - 13.1 Comprehensive (hospital and medical) Individual
  - 13.2 Comprehensive (hospital and medical) Group
- Quarterly PART 1 – LOSS EXPERIENCE and PART 2 – DIRECT PREMIUMS WRITTEN
  - 13.1 Comprehensive (hospital and medical) individual
  - 13.2 Comprehensive (hospital and medical) group
- Appendix P&C LOB
  - 13 Comprehensive (Hospital and Medical)

2021-14BWG:
- Underwriting & Investment Exhibit I Parts 1, 1A, 1B, 2, and 2A
  - 13.1 Comprehensive Individual Accident and Health
  - 13.2 Comprehensive Group Accident and Health
- Schedule H column headings:
  - Comprehensive (Hospital and Medical) Individual
  - Comprehensive (Hospital and Medical) Group
Tip Tipton, CPA  
Accounting Policy Manager  
Thrivent

Randy Hefel  
NAIC Liaison  
SOVOS

CC:  
Kim Hudson, Vice-Chair, California  
Mary Caswell, NAIC  
Calvin Ferguson, NAIC  
Keith Bell, Travelers  
Rose Albrizio, Equitable Financial
July 7, 2021

Mr. Phil Vigliaturo, Chair,
Casualty Actuarial and Statistical (C) Task Force

Re: 2021-11BWG

Dear Chair,

We appreciate the opportunity to submit the following comments on the 2021-11BWG proposal.

As the NAIC puts it, “The public wants two things from insurance regulators:
They want solvent insurers who are financially able to make good on the promises they have made, and
they want insurers to treat policyholders and claimants fairly. All regulatory functions will fall under
either solvency regulation or market regulation to meet these two objectives.”

We support the idea to have more timely report of current NAIC Homeowners Report and Auto Report.
We also appreciate the spirit of this proposal to address regulatory concerns regarding the needed
average written and average earned premium for residential property and personal auto coverages in a
far more timely fashion for market regulation. That said, we do not believe the proposal appropriately
addresses the root causes of problems, nor do we believe that the proposal as currently drafted would
meet the market regulation needs to provide accurate statistical reports in a timely manner.

Current NAIC Homeowners Report has 5 tables with statistics for house-years by state and countrywide
by policy type, policy form, amount of insurance, and average premiums by policy form/amount of
insurance by homeowners owner-occupied and tenants. NAIC Auto Report has 5 tables with statistics
for average premiums and expenditures for Liability, Collision and Comprehensive. The Auto Report also
has many tables for voluntary/residual, limits, and others by coverage. Although current NAIC statistics
reports have significant time lag, it does provide the accuracy and consistency for the needed statistics.
To create a supplement to those specific annual statement lines (ASL) without clearly defined statistics
and accuracy, the benefits are very limited if not also very confusing.

It is better to be late than incomplete or inaccurate. Different companies in different states may have
different market segment mix in term of coverage forms, house value, etc. 2021-11BWG proposal with
aggregate level exposures by state may create misleading results and conclusions. Similar situations will
also exist in the personal auto coverages. More exposures information with more granulated details is
available in the current NAIC Homeowners Report and Auto Report as described above, with some time
lag.

As an alternative, we would suggest looking at the current NAIC statistics reports and identify the root
causes of problems in time delay. If companies are using timely data to grow their business
strategically, NAIC and regulators should be able to work with the industry to improve the time lag. Are
the problems coming from delay reporting in specific few companies? Are the problems coming from
too many required statistics in the process? Are the problems coming from inconsistent reporting
databases?
We appreciate the consideration of our comments and look forward to discussing on a future call.

Best Regards,

Wanchin W. Chou, FCAS, MAAA, CPCU, CSPA  
Chief Insurance Actuary  
State of Connecticut Insurance Department  
Mail: PO Box 816, Hartford, CT 06142-0816  
Del: 153 Market St., Hartford, CT 06103  
Office Phone: 860-297-3943

cc: Kris DeFrain, NAIC, Qing He, Amy Waldhauer
From: Nichole Torblaa <Nichole.Torblaa@ldi.la.gov>
Sent: Tuesday, July 6, 2021 4:02 PM
To: DeFrain, Kris <kdefrain@naic.org>
Subject: Louisiana Comments regarding 2021-11BWG and 2021-13BWG Exposure Drafts

Louisiana does not support moving either Blanks proposal 2021-11BWG or 2021-13BWG forward at this time.

Proposal 2021-11BWG

2021-11BWG proposes a new annual statement supplement to the Property and Casualty (P/C) statement to capture exposure data for Annual Statement Lines 2.5, 4, 19.1, 19.2 and 21.2 of the Exhibit of Premiums and Losses. It adds a column to the Quarterly Parts 1 and 2 to capture exposure data for these annual statement lines for the quarter. According to the author, “This AS and QS Blanks proposal would allow the calculation of average written and average earned premium for residential property and personal auto coverages in a far more timely fashion.”

Louisiana believes it is premature to consider the proposed changes to financial statement exhibits and that this proposal should be studied by CASTF before changes to financial exhibits are made. If more current average premiums are needed, CASTF should create a supplemental report, to existing CASTF reports, that includes average premium on a timelier reporting schedule.

- Louisiana characterizes the data requested to be general/actuarial/rate information and not information that improves solvency regulation. The purpose and context of the AS and QS statements is the monitoring and regulation of company solvency. The proposed data does not fit within the context of solvency’s financial statements for collection, even if convenient. When discussing with Louisiana financial analysts, their comment is they have never felt this type of data was needed and, if made available by this proposal, would probably not be analyzed. If needed, our financial analyst would request such data on a case-by-case basis (which has never been done in Louisiana).
- The expense to companies to build a system to report the requested information outweighs its value to state regulators.
  - The collection of this data will require companies to build a new system to capture and report exposure details.
  - The collection of this new data, unless validated/audited, will be of limited value.
  - The proposal, though resulting in more current calculation of average premiums, will have its own set of issues, e.g., reliability when comparing state data because it only reports on the aggregation across coverages and forms; it is not a separate reporting by coverage or form as with the existing CASTF reports.
- Even though the average premiums from CASTF’s “Auto Database Report” and “ Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owners’ Insurance Report: Data for XXXX” may be “stale,” the average premium rankings do not change significantly over the course of two years and the reported average premiums remain useful for comparison purposes. The proposed data
collection and frequency (quarterly) would not add great value above the existing reports’ primary use.

- An increase in expenses to companies will be passed along to consumers in the form of higher premiums.
- Lastly and importantly, the collection of more timely average premium data, to supplement the existing CASTF “Auto Database Report” and “Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owners’ Insurance Report: Data for XXXX”, can easily, efficiently, and effectively be requested by CASTF as a supplemental report (either annual or quarterly). Such supplemental report can be integrated into the existing CASTF report workstream and can be reported upon either annually or quarterly. This new report would be for just average premiums (no loss data) and would not be expensive to create or disruptive to financial reporting requirements and systems.

Proposal 2021-13BWG

2021-13BWG proposes adding a new supplement to capture premium and loss data for Annual Statement Lines 17.1, 17.2 and 17.3 of the Exhibit of Premiums and Losses (State Page) – Other Liability by more granular lines of business. The purpose of this proposal is to provide regulators more granular detail of the premium and losses of the diverse lines of business reported on Annual Statement Lines 17.1, 17.2 & 17.3 of the Exhibit of Premiums and Losses (State Page).

Louisiana believes it is premature to consider the proposed changes to financial statement exhibits and that this proposal should be studied by CASTF before changes to financial exhibits are made. If more detailed liability data is needed, CASTF could create a supplemental report that includes average premium on a timelier reporting schedule.

- Louisiana characterizes the data requested to be general/actuarial/rate information and not information that improves solvency regulation. The purpose and context of the AS and QS statements is the monitoring and regulation of company solvency. The proposed data does not fit within the context of solvency’s financial statements for collection, even if convenient. When discussing with Louisiana financial analysts, their comment is they have never felt this type of refined data was needed and, if made available by this proposal, would probably not be analyzed. If needed, our financial analyst would request such data on a case-by-case basis (which has never been done in Louisiana).

- The expense to companies to build a system to report the requested information outweighs its value to state regulators.
  - The collection of this data will require companies to build a new system to capture and report the refined premium, exposure, loss, and expense details.
  - The collection of this new data, unless validated/audited, will be of limited value.
  - Louisiana would not be interested in having this data available. The collection of more detailed other liability data can easily be requested by individual states on a case-by-
case basis. Such a state request would not be as expensive to create or disruptive to financial reporting requirements impacting the entire commercial industry.

- An increase in expenses to companies will be passed along to consumers in the form of higher premiums.

Regards,
Nichole Torblaa

Nichole Torblaa, ACAS
Actuary
Louisiana Department of Insurance
1702 N. Third Street
Baton Rouge, LA 70802
225-342-4657
Nichole.Torblaa@ldi.la.gov
July 2, 2021

NAIC Casualty Actuarial and Statistical (C) Task Force
c/o Kris DeFrain - kdefrain@naic.org
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: 2021-11BWG and 2021-13BWG

Dear Chair, Vice Chair, and Task Force Members:

On behalf of the member companies of the National Association of Mutual Insurance Companies\(^1\) we respectfully submit these comments which are responsive to the proposed changes to the annual and quarterly statement blanks that, if adopted, would add a new annual statement supplement to capture direct exposures written and direct exposures earned for certain lines of business (2021-11BWG). It would also add a new exhibit in the statement of Premium and Losses (State Page) to capture more details regarding certain line of business premium and loss data (2021-13BWG). We submit these comments in hopes that regulators will join us in the effort to protect and educate consumers with relevant, timely information so that they may find the right product, at the right price, at the right time.

Although there is a strong desire to partner with regulators to resolve several outstanding issues, the NAMIC membership opposes both proposals as exposed. Further, we have specifically requested the Blanks (E) Working Group reject Agenda Item 2021-11BWG and provide an extended comment period for Agenda Item 2021-13BWG. NAMIC members support the Interested Parties comment letter (dated June 25, 2021) to the Financial Condition Blanks Working Group, stating their opposition to agenda item 2021-11BWG and their request for an extended comment period for Agenda Item 2021-13BWG. However, it is impossible to support an effective date for Annual 2022 for either proposal. We respectfully request that an effective date not be established until a policy decision is made as to whether the information requested serves a specific regulatory need. This shall include

\(^1\) The National Association of Mutual Insurance Companies is the largest property/casualty insurance trade group with a diverse membership of more than 1,400 local, regional, and national member companies, including seven of the top 10 property/casualty insurers in the United States. NAMIC members lead the personal lines sector representing 66 percent of the homeowner’s insurance market and 53 percent of the auto market. Through our advocacy programs we promote public policy solutions that benefit NAMIC member companies and the policyholders they serve and foster greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.
a full cost/benefit analysis for each proposal to ensure that the information being requested is meaningful and relevant to the consumer and the costs associated with implementation and compliance for both regulator and industry don’t outweigh the benefits.

The following comments are offered on each individual agenda item.

2021-11BWG
Agenda item 2021-11BWG proposes to add a new annual statement supplement to the Property and Casualty annual statement to capture direct exposures written and direct exposures earned. In addition, the proposal would also require new quarterly reporting on Part 1 – Loss Experience to capture the number of direct earned exposures and Part 2 – Direct Premium Written to capture the number of direct written exposures. Both the annual statement proposed change and the proposed changes to the quarterly statement are focused on the private flood (Line 2.5), homeowners (Line 4), private passenger auto no-fault (Line 19.1), other private passenger liability (Line 19.2), and private passenger auto physical damage (Line 21.1) lines of business.

The stated justification for agenda item 2021-11BWG is to obtain average personal auto and homeowners’ premiums (as well as private flood) per exposure in a more-timely manner. The quarterly and annual statement should not be used to collect meaningless or incomplete data elements, as it runs the risk of misleading consumers and takes away from regulators core mission to educate consumers and efficiently regulate a competitive insurance marketplace. Because the annual reports produced by the NAIC that include average personal auto and homeowners’ premiums are typically published 24 months after the end of the experience period, some believe there is validity in obtaining this information sooner. However, there are significant flaws with how the proposal is constructed, including using exposure counts to calculate average premium. If the proposal is adopted as exposed, it will produce misleading results that instead of educating consumers on average premium values will have the opposite effect. The mission of insurance regulators is often to educate and protect consumers, rather than support proposals that provide inaccurate and misleading information and consumer confusion.

To the best of our knowledge, exposure counts are not required anywhere else in the annual or quarterly statement; however, exposure counts are required for certain direct state reporting filings, but those filings are at the policy level. The purpose of those filings is to provide policy level information to the Statistical Agency in order to illustrate the direct relationship between the premium being written and the exposures. Nevertheless, it is difficult to see what value the regulator would get with exposure counts, absent other significant data elements at the policy level, and the risk of misinterpretation by consumers far outweighs the benefits.
Therefore, in addition to capturing information that appears useless in the calculation of average premium values, there is a valid concern that the data will create false impressions and unintended consequences for all parties involved. Regulators should be aware that exposure counts are typically included as part of the rating filing. This information may already be in the possession of the regulator. Consequently, there is concern with exposing this proprietary data on annual statements especially if unnecessary. One must consider the regulatory purpose of requiring reporting entities to produce this information more than once, if at all. Further, it is imperative to consider why the request is only for a limited set of information. Absent other pertinent data elements, this information is meaningless in achieving the objective of obtaining average personal auto and homeowners’ premium per exposure.

NAMIC implores the working group to take a measured approach in arriving at conclusions on these action items in order to ascertain the benefit of requiring this information be provided with the costs in terms of regulatory compliance for both regulator and industry given the potential futility of outcome. NAMIC specifically requests that statistical data not be included on the annual/quarterly statement blanks and encourages the working group to instead look for opportunities to assist the NAIC in speeding up the process of publishing its’ annual report of average personal auto and homeowners’ premiums. Further, NAMIC encourages the working group to have ongoing conversations with industry to find a solution that is amenable, amendable, timely, and achieves the objective of protecting and educating the consumers we all serve.

2021-13BWG

Agenda Item 2021-13BWG proposes to add a new “Exhibit of Other Liabilities by Line of Business” that if adopted would require all reporting entities that report “other liability” on Line 17 of the Exhibit of Premiums and Losses to prepare this new exhibit annually. The stated purpose of the exhibit is to provide more information on the “diverse lines of business filed on Annual Statement Line 17” and includes 28 different liability lines of business requiring the reporting of the following direct business categories: written premium, earned premium, unearned premium reserve, losses paid, losses incurred, losses unpaid, defense and cost containment paid, DCC incurred, and DCC unpaid.

To implement this new exhibit would require significant changes to how insurers manage the business reported on Line 17, including systems updates to track the additional granularity required in the proposed reporting. While Other Liability encompasses a sizable portion of premiums written by property/casualty insurers, it remains unclear what regulatory purpose would be served by dividing this LOB into 28 sub-LOBs. NAMIC members request

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2 Direct premiums written in 2020 for property/casualty insurers reporting on Line 17.1, 17.2 – Other Liability totaled $91 billion or 12.5% of total premiums written – NAIC 2020 Market Share Report.
additional time to comment on this proposal, as many of the new categories in the exhibit have not been defined, nor included in the Annual Statement Instructions.

Further, NAMIC members request the working group defer making any policy decision on whether to collect these data elements from all reporting entities until a cost/benefit study has been conducted. This study should factor in the cost of doing individual data calls as opposed to creating a new reporting supplement requirement for all reporting entities to comply with. As regulators consider their role in promoting a stable and competitive environment for consumers and insurers, top of mind should be how to balance what information from insurers is meaningful and relevant to the consumer but also would not put insurance companies at a competitive disadvantage. This issue strikes at the heart of that balance and requires a more deliberative process and additional time to consider. At very minimum, the regulators should take the necessary steps to protect consumers from misinformation and confusion.

* * * *

NAMIC appreciates the opportunity to take part in the process. Thank you for your consideration of these comments on this matter of importance to NAMIC, its member companies, and their policyholders. If there are any questions, please do not hesitate to contact me.

Sincerely,

Jonathan Rodgers
Director of Financial and Tax Policy
National Association of Mutual Insurance Companies

W:\National Meetings\2021\Summer\TF\CasAct\Comments Combined blanks proposal (reduced).pdf
Comments of the Center for Economic Justice to the
NAIC Blanks Working Group and Casualty Actuarial and Statistical Task Force

Response to Comments on Blanks Proposal 2021-11BWG

July 12, 2021

CEJ offers the following responses to comments submitted on Blanks Proposal 2021-11BWG. The proposal would add earned exposure and written exposure data elements for the personal auto and homeowners lines of business to the annual and quarterly financial statements. For the annual statement, the reporting would be by-state in new exhibits that pull written premium and earned premium for the relevant lines of business from the Exhibit of Premiums and Losses (State Page). For the quarterly statements, earned exposures and written exposures would be added to Part 1 and Part 2, respectively.

We have already amended our proposal to remove the private flood line of business.

The benefits of the additions are significant, as set out in the proposal. Most important, with the additions, regulators and the public would be able to identify trends in exposures and average premium for the largest personal lines of property casualty insurance in a time frame to make this information useful.

CEJ has offered to work with interested parties to strengthen the proposal and address any shortcomings. No interested party has reached out to CEJ. Further, only one interested party has offered “suggestions” for improvements, but those “suggestions” were non-specific and were criticisms of the proposal incorrectly framed as “suggestions.”

CEJ organizes our response to the commenters by category of comment.

1. “Misleading data for regulators and the public.”

The most common objection among thecommenters is that the average written and earned premiums calculated from the proposed financial statement additions would be “misleading data for regulators and the public.” A representative comment comes from the interested parties:
“If ASL 4 Homeowners Exposures is all inclusive, the proposal to count written and earned ‘residences’ would include an array of policies ranging from rental policies to mansions, resulting in an average premium that has no real value to users. If ASL 4 Exposure does not include condo and/or rental policies, then the average premium would be misleadingly inflated.”

“For ASL 19.2 auto policies, if Premiums include, but Exposures exclude, miscellaneous vehicles, such as golf carts, private passenger trailers, and all-terrain vehicles, the average premium would be inflated. Furthermore, how misleading this broadly applied average may be for any individual company depends on the size and mix of their business reported under each ASL impacted by the proposal. This information, taken out of context, could be negatively construed and lead to detrimental results for companies.”

**The claim of “misleading” is without merit for several reasons.**

First, commenters point to the two statistical reports as providing information that is not misleading. Yet, the average premium that could be calculated from the proposed additions are the same average premium calculations found in the two statistical reports. It is unclear how the same average premium calculation can be simultaneously misleading and relevant information.

The proposed additions will permit the calculation of average homeowners premium by dividing premium by exposure. This is the same calculation found in the total column of Table 4 of that report, including a report by state and countrywide aggregate.1 While the report also provides average premium by homeowners policy form, the fact that an aggregate average premium is calculated and presented demonstrates that regulators who publish the report and industry who have never objected to this metric do not find aggregate average premium “misleading.”

The same response applies to the “misleading” claim for personal auto. The auto database report provides several average premium calculations. One is “average expenditure” which is the sum of liability, collision and comprehensive premium divided by liability written exposures. A second is combined average premium which is the sum of liability premium divided by liability written exposures, collision premium divided by collision written exposures and comprehensive premium divided by comprehensive written exposures.2

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1 [https://content.naic.org/sites/default/files/publication-hmr-zu-homeowners-report.pdf](https://content.naic.org/sites/default/files/publication-hmr-zu-homeowners-report.pdf)
The proposed addition permits the exact same calculation of average expenditure as found in the auto database and a very similar calculation to the combined average premium calculation.

**Second, commenters seem to be complaining about the basic concept of an average.** Interested parties complain that any average premium calculation will be misleading because it combines different types of policies and different vehicles – “policies ranging from rental policies to mansions, resulting in an average premium that has no real value to users.”

By this logic, every average premium calculation found in the two statistical reports are “misleading.” For example, even within the average premium calculation by policy form in the homeowners statistical report, that average premium averages the premiums from small homes to mansions. The average premium calculations in the auto database average premiums for old and new vehicles for inexpensive vehicles and expensive vehicles and for different liability limits.

The nature of the average statistic is that it is a description of different outcomes. Consider some of the most highly-used statistics – average home prices, average family income or the unemployment rate. Each is a summary statistic of widely varying situations – the average of home prices for small, medium, large and massive homes in different locations, the average of income for different professions and family composition and the average of unemployment across different industries and markets. *Yet, these statistics are recognized as useful, despite these limitations, predominantly because they permit a timely analysis of changes over time. That is precisely what the proposed additions to the annual and quarterly statement will permit.*

**Third, while interested parties argue that the proposed additions will produce “misleading” average premium calculations, they ignore the fact that the current statistical reports produce misleading information.** The current statistical reports are misleading because they present average premium values that are two to three years old. In March 2021, the NAIC issued a press release and released the auto database report with average premium calculations for 2018. Some states – with low average premiums – issued press releases citing the report. We suggest it is far more misleading to release average premium data for 2018 in March 2021 than any of the concerns raised by interested parties with the blanks proposal. When someone reads that press release or references the average premium calculation in the two statistical reports, they will be misled into thinking that the data are somehow relevant and timely.
2. “Provide Competitors with Proprietary Information”

Interested parties offer the claim of “proprietary information” without evidence or explanation. Presumably, the claim of “proprietary information” is offered to suggest that if written and earned exposures were reported, reporting companies would suffer competitive harm – that, somehow, competitors could use the written and earned exposure data – by state on an annual basis and countrywide on a quarterly basis – to learn the competitor’s strategy.

Interested parties provide no evidence or even an explanation for this claim because it is an absurd claim. First, we know that the insurer achieving the fastest growth over the last decade – Progressive – provides the number of policies in force along with written and earned premium on a monthly basis – broken out not just for personal auto but by personal auto sold through agency versus direct channels. The fact that the fastest growing personal auto insurer – the one with the most to lose by providing “proprietary” information – voluntarily provides exposure counts on a monthly basis explodes the interested parties’ “proprietary” argument,

Second, it is unclear why or how any competitor would or could use this exposure information to gain some competitive advantage. Putting aside the fact that the quarterly exposure counts are countrywide and the annual counts are by state – aggregates too large to gain any meaningful insight for competitive purposes – insurers have access to many other data sources to gain far more timely and granular competitive insight. Insurers have real-time access to competitors’ rate filings as well as competitor quoting information, among other sources.

Third, the financial statements contain public information far more relevant and useful for competitors to ascertain another insurers’ business strategy. Consider the detailed reporting of loss reserves and changes in loss reserves by line of business. Using this information, a competitor could assess the loss reserving strategy of other insurers. Or consider the detailed reporting of investments – literally every stock and bond bought, held and sold. A competitor could use this information to assess the investment strategy of other insurers. Or consider the detailed reporting of every reinsurance agreements. A competitor could assess other insurers’ use of affiliated and unaffiliated reinsurance strategies. In contrast, the highly-aggregated exposure data cannot possibly provide the same types of insights.

3 https://ml.globenewswire.com/Resource/Download/5cef1e8f-b788-4e83-9daa-2f1cf5cd9d33
3. "Costs outweigh benefits"

Interested parties argue that benefits are lacking for 2021-11BWG and costs are significant. Again, interested parties’ claims are without evidence or support. Louisiana, for example, claims that “Expense to companies outweighs benefits,” “Require[s] companies to build a new system to capture and report exposure details,” and “Unless validated/audited will be of limited value.”

It is unclear why the costs of providing this information will be material to insurers and consumers. The new data elements – written exposures and earned exposures – are routinely captured in the course of insurers’ business, routinely used in insurers’ personal auto and residential property insurance rate filings and reported by many insurers in pay-for-public reports – Fast Track reports:

The Fast Track Monitoring System was developed to provide insurance professionals with a sampling of significant data by line of insurance at the earliest possible date. Participation in the Fast Track Monitoring System for Private Passenger Automobile involves the reporting of quarterly loss ratio data and claim cost and frequency data on an accelerated basis, so that it is received by the statistical agent within 45 days of the end of each quarter. The statistical agents collecting Fast Track data are Independent Statistical Service, Inc. (ISS), National Independent Statistical Service (NISS), and ISO Data, Inc.

For personal auto insurance, fast track data included earned exposures – “earned car years” and “earned house years” – for personal auto and homeowners, respectively.

Given the widespread use by insurers of these exposure metrics, it is unclear why “new systems to capture” the data would be required. While the data elements may need to be pulled from different data pools within an insurers’ overall information system, that is no different from other information reported in the annual and quarterly financial statements.

Further, the relevant cost metric for evaluation is the marginal cost of reporting additional data in the financial statements. We suggest that marginal cost is low in absolute terms and lower in relative terms to the many other changes and additions to the annual and quarterly statements that occur each year.

Let’s put the cost in perspective relative to premiums. According to data published by the NAIC, in 2020, there was $110 billion in homeowners (line 4) written premium and $249 billion in personal auto (lines 19.1, 19.2 and 21.1) written premium. Now let’s assume a preposterously large marginal cost for insurers of, say, $10 million to report the new data elements. That would represent less than 3/1000ths of a percent of premium – or less than 3

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4 https://content.naic.org/sites/default/files/web_market_share_property_casualty.pdf

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cents for a policy with a $1,000 premium. Of course, the marginal cost of second and later years’ reporting would be far less than the initial reporting. So the cost per premium dollar would be much lower when considered over a multiple year period.

The benefits are significant and clearly outweigh any costs to insurers. First, the benefits to the proposal additions include more timely data that is clearly of interest to regulators and the public. While the two statistical reports have much useful information beyond average premium calculations, it is unclear what purpose is served by publishing average premium in these reports since the data are so old and not relevant for current analysis.

Imagine if insurers were to make rate filings in March 2021 with data only through year-end 2018. No regulator would accept such stale data. Or imagine that any of the other data in the annual statement were that stale – 2018 investments instead of 2020 investments reported in March 2021. The relevance of timely data is no less true for exposure counts and average premium.

Second, the most significant benefit for both financial and market analysis is the ability to track trends in exposures and average premium on a timely, quarterly basis. As with most indices or major averages, it is the analysis of changes over time that provide the most useful information. The proposed additions will create the opportunity for this type of timely analysis of changes over time.

Third, the proposal is, by far, the most efficient method of capturing this important information. Some commenters suggested that regulators have other means of collecting these data – from rate filings or special data calls. There is no existing, timely data collection of these data elements. Rate filings are not a comprehensive or uniform or timely source of the data since insurers do not routinely make complete rate filings on a quarterly basis or include the relevant information in every rate filing. Special data calls are far more expensive for insurers than routine ongoing reporting and are far less reliable for data quality. By adding the data elements to existing, routine reporting, the data will reported using the most efficient and common data reporting tools and provide comprehensive and uniform reporting.

Fourth, regulators, insurers and the public benefit with reporting of and publishing of current experience. As noted above, we believe it is far misleading to issue average premium data in March 2021 – which will likely be misinterpreted as current information – than any alleged problems with “averages.”

Fifth, the proposal provides new data elements that will make other information in the annual and quarterly statements more useful. For example, the availability of exposure counts offers new and improved opportunities to analyze changes in written and earned premiums.
Sixth, the proposal provides relevant information to interested stakeholders, including academics, policy-makers and other third parties who routinely publish “average premium” information. A major benefit of the proposal is the availability of relevant and timely public information from a respected source. Right now, there are a variety of websites that publish “average premium” values based on a variety of methodologies – none of which are as reliable as those available with the proposed financial statement additions.

In summary, the benefits of the proposed addition far outweigh the costs to insurers.

4. “Improve the timeliness of the current statistical reports instead.”

Some commenters suggested, as alternatives to the proposed financial statement additions, speeding up the production of the current statistical reports or issuing special data calls or culling information from existing sources. None of these suggested alternatives are a viable substitute for the proposed financial statement additions.

First, the proposal is not intended to replace the existing statistical reports because those reports have far more information than simply average premium. Most importantly, the statistical reports include claims information – and that is the source of the lengthy delay between the experience period and the publication of the reports. Simply stated, claims take time to develop, so matching claims to exposures requires time for the claims to be reported and settled.

In addition, the nature of the data collection for the statistical reports requires a far lengthier and complicated process than the proposed financial statement additions. To produce the statistical reports, the NAIC must gather data from several statistical agents and several individual states and then combine and audit those data. In contrast, the proposed financial statement additions involve direct reporting from insurers to the NAIC through an existing reporting document and, consequently, will always be much faster than the reporting and compilation associated with the statistical reports.

Second, as discussed above, there are no other timely sources of the data in a comprehensive and uniform manner. Rate filings cannot generate comprehensive and uniform data. Fast Track data is reported by only a portion of the industry and is not readily available to the public.

Third, as discussed above, special data calls are far more inefficient, costly and less reliable than routine financial statement reporting and don’t permit the critical use of timely analyzing trends in average premium over time. Insurers have long complained about the cost of special data calls, so when insurers argue against routine reporting of data through existing reporting instruments, we can be certain that the complaint is not about cost.
5. “Clearer definitions of exposure are needed.”

The Academy comments include the following as suggestions that would “improve the proposal.”

Include a complete and clear definition of exposure and calculation for each line proposed, particularly as respects the crossing (or overlap) of calendar time periods. Clear specifications ensure greater consistency across companies reporting; and Definitions that account or minimize distortions from mix would be recommended.

While we welcome the opportunity to improve the proposal, we cannot identify the problems alleged by the Academy. Of note is the fact that the Academy has not offered the proposed guidance it alleges that insurers seek. Comments for blanks proposals routinely offer the specific wording in the comments to implement the concepts they propose. But, not for this proposal.

The Academy argues that additional, clearer definitions are needed to address the fact that the homeowners lines contains different policy forms. Yet, it is unclear how any reporting company could misinterpret the proposed instruction which refer to either an insured vehicle or an insured property.

The proposed definitions are:

A Written Exposure for Annual Statement Line 4 is defined as a single residential property for which coverage was written at any time during the calendar reporting period and remained in force through the end of the calendar reporting year. If the coverage was written and cancelled within the calendar reporting year, the written exposure is the fraction of the year the coverage was in force.

A Written exposure for Annual Statement Lines 19.1, 19.2 and 21.1 is defined as single motor vehicle for which coverage was written at any time during the calendar reporting year and remained in force through the end of the calendar reporting year. If the coverage was written and cancelled within the calendar reporting year, the written exposure is the fraction of the year the coverage was in force.

An Earned Exposure for Annual Statement Line 4 is defined as the fraction of the calendar reporting year for which a single residential property had coverage in force.

An Earned Exposure for Annual Statement Lines 19.1, 19.2 and 21.2 is defined as the fraction of the calendar reporting year for which a single motor vehicle had coverage in force.
Given these definitions, the Academy “suggestions” make no sense. First, it is crystal clear how exposures should be calculated for each line of business – the definitions are industry standard for two of the most common metrics in insurance. The Academy’s complaint that homeowners include a variety of homeowners policy forms has no relevance for defining an exposure. Given the proposed instructions, it is unclear how an insurer could misinterpret an exposure for a renter’s policy form or a condo policy form. Similarly, it is unclear how an insurer could misinterpret an exposure for a motorcycle or a mobile home written on a personal auto policy form.

Similarly, the complaint / “suggestion” regarding “crossing (or overlap) of calendar time periods” is clearly addressed in the definitions. There are few concepts in property casualty insurance more widely used than written exposure and earned exposure. The difference between the two measures of exposure relates specifically to what portion of the exposure is counted within a calendar year. The proposed definitions directly address – with industry standards – how to measure exposures that may overlap reporting periods.

6. “The requested information is not solvency related and shouldn’t be in the AS and QS.”

This comment from Louisiana is deeply flawed in two major respects – the data do have relevance for financial oversight and the financial statements include much information that is not “solvency-related.”

We strongly believe that the addition of exposure elements to the annual and quarterly financial statements will assist financial analysts, as well as market analysts. The addition of exposure data permits financial analysts to better understand and assess changes in premium from one reporting period to the next. Change in quarterly premium written and earned can be better understood with related exposure counts – is the insurer’s premium change a result of changes in average premium per exposure or simply changes in exposure?

Further, the financial statements include a variety of information not related to insurer solvency, including, for example, the new private flood supplement, the credit insurance experience exhibit, the bail bond supplement and Schedule T Exhibit of Premiums Written. While not solvency related, these parts of annual statement reporting provide necessary information for regulators to carry out statutory responsibilities. These non-solvency exhibits and supplements in the financial statements because it is the most efficient and effective method of collecting comprehensive and uniform data from insurers to meet a specific regulatory purpose. That same rationale applies to the proposed 2021-11BWG.

Thank you for your consideration. We urge both CASTF and Blanks to support proposal 2021-11BWG.
**NAIC BLANKS (E) WORKING GROUP**

Blanks Agenda Item Submission Form

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**BLANK(S) TO WHICH PROPOSAL APPLIES**

| [ X ] ANNUAL STATEMENT | [ X ] INSTRUCTIONS | [ X ] CROSSCHECKS |
| [ X ] QUARTERLY STATEMENT | [ X ] BLANK | |
| [ ] Life, Accident & Health/Fraternal | [ ] Separate Accounts | [ ] Title |
| [ X ] Property/Casualty | [ ] Protected Cell | [ ] Other ___________________ |
| [ ] Health | [ ] Health (Life Supplement) |

Anticipated Effective Date: 1st Quarter Annual 2022

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Add a new annual statement supplement to capture exposure data for Annual Statement Lines 2.5.4, 19.1, 19.2 and 21.2. Add a column to the Quarterly Parts 1 and 2 to capture exposure data for these annual statement lines for the quarter.

***See Next Page For More Details***

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

***See Next Page For Details***

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: ____________________________________________

Other Comments:

** This section must be completed on all forms.
IDENTIFICATION OF ITEM(S) TO CHANGE

Add a new annual statement supplement to the Property and Casualty annual statement to capture “Direct Exposures Written” and “Direct Exposures Earned” which will be reported, initially only for Annual Statement Lines 2.5 (Private Flood), 4 (Homeowners), 19.1 (PPA No Fault), 19.2 (PPA Liability) and 21.1 (PPA Physical Damage).

Add one column to property casualty quarterly statement Part 1 Loss experience between current columns 1 and 2 for “Direct Exposures Earned” only for only for Lines 2.5 (Private Flood), 4 (Homeowners), 19.1 (PPA No Fault), 19.2 (PPA Liability) and 21.1 (PPA Physical Damage).

Add one column to property casualty quarterly statement Part 2 Direct Premium Written between current columns 1 and 2 for “Direct Exposures Written” only for only for Lines 2.5 (Private Flood), 4 (Homeowners), 19.1 (PPA No Fault), 19.2 (PPA Liability) and 21.1 (PPA Physical Damage).

Add instructions for reporting the additional data elements, consisting of definitions and examples for the new data elements.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The average written and average earned premium per exposure is an important metric for a variety of regulatory and public policy purposes. The NAIC annually produces reports of average personal auto and homeowners premiums, but the data in these reports are old and stale for timely assessment of absolute average premium and changes in average premium over time. Both reports are typically produced 24 months after the end of the experience period and 36 months after the beginning of the experience period. Homeowners average premiums for 2018 was published in January 2021 in the “Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owners’ Insurance Report: Data for 2018.” Personal auto average premiums for 2018 was published in March 2021 in the “Auto Database Report.” While there are valid reasons for the length of time needed to produce these reports – primarily because these reports contain information beyond average premium – the average premium numbers lose significant relevance because of their age.

This AS and QS Blanks proposals would allow the calculation of average written and average earned premium for residential property and personal auto coverages in a far more timely fashion – within three to four months following the reporting year instead of 24 months and would provide timely and useful quarterly information. The benefits of timelier average premium data are considerable. Timely average premium data would permit financial analysts to utilize changes in average premium as part of financial analysis. Similarly, the more-timely average premium data would become a valuable tool for market regulation analysts, including, but not limited to, an added data point for use with the Market Conduct Annual Statement. Last, but not least, this proposal would allow the NAIC to calculate and publish average annual premium data for residential property and personal auto insurance by state in a time frame to both make the data meaningful for describing market conditions and to inform individual state regulators and policymakers of actual changes in personal lines average premiums – as opposed to expected changes gleaned from rate filings.

Consider how valuable timely average premium values would have been for personal lines as the pandemic unfolded. Consider also the value of quarterly data for average premium for personal lines versus only an annual average. The lack of timeliness of the average premium values means that these data have very limited or no use for either financial or market analysis. The lack of timeliness also means that the data are no use in informing public policy debates about personal lines insurance costs. In addition, the severe time lag between actual experience and reporting fails to inform the public or policymakers of recent trends or outcomes and can, consequently, mislead the public and policymakers.
ANNUAL STATEMENT INSTRUCTIONS – PROPERTY

DIRECT PREMIUM AND EXPOSURES
Annual Statement Lines 2.5, 4, 19.1, 19.2 and 21.1
Allocated by States and Territories

This supplement must be filed with the NAIC by March 1 each year.

This supplement should be completed by those reporting entities that write direct business reported on the Exhibit of Premiums and Losses for each Annual Statement Lines (ASL) listed below. A separate page will be completed for each ASL.

<table>
<thead>
<tr>
<th>ASL 2.5 (Private Flood)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASL 4 (Homeowners)</td>
</tr>
<tr>
<td>- Excluding Renters, Condominiums and Co-ops</td>
</tr>
<tr>
<td>- Renters, Condominiums and Co-ops</td>
</tr>
<tr>
<td>ASL 19.1 (Private Passenger Auto No-Fault – Personal Injury Protection)</td>
</tr>
<tr>
<td>ASL 19.2 (Other Private Passenger Auto Liability)</td>
</tr>
<tr>
<td>ASL 21.1 (Private Passenger Auto Physical Damage)</td>
</tr>
</tbody>
</table>

Column 1 – Direct Premiums Written

The amounts reported for each line should agree with the amounts reported for the corresponding Annual Statement Line in Column 1, Line 35 of the Exhibit of Premiums and Losses for that state.

| Line 59 (Part 1 plus Part 2) should equal Line 4, Column 1, Line 35 of the Exhibit of Premiums and Losses (GT Page) |
| Line 59 (Part 3) should equal Line 19.1, Column 1, Line 35 of the Exhibit of Premiums and Losses (GT Page) |
| Line 59 (Part 4) should equal Line 19.2, Column 1, Line 35 of the Exhibit of Premiums and Losses (GT Page) |
| Line 59 (Part 5) should equal Line 21.1, Column 1, Line 35 of the Exhibit of Premiums and Losses (GT Page) |

Column 2 – Direct Written Exposures

A Written Exposure for Annual Statement Lines 2.5 and 4 is defined as a single residential property for which coverage was written at any time during the calendar reporting period and remained in force through the end of the calendar reporting year. If the coverage was written and cancelled within the calendar reporting year, the written exposure is the fraction of the year the coverage was in force.

A Written exposure for Annual Statement Lines 19.1, 19.2 and 21.1 is defined as single motor vehicle for which coverage was written at any time during the calendar reporting year and remained in force through the end of the calendar reporting year. If the coverage was written and cancelled within the calendar reporting year, the written exposure is the fraction of the year the coverage was in force.
Examples. Assume a homeowners policy is written on July 1 during the reporting year and remains in force through the end of the reporting year. This activity would be reported as one (1.0) written exposure.

Assume a private passenger policy with No-Fault, Liability and Physical Damage coverages was written on April 1 and cancelled by the insured on July 1. This activity would be reported as 0.25 written exposure.

Column 3 – Direct Premiums Earned

The amounts reported for each line should agree with the amounts reported for the corresponding Annual Statement Line in Column 2, Line 35 of the Exhibit of Premiums and Losses for each state.

| Line 59 (Part 1 plus Part 2) should equal Line 4, Column 2, Line 35 of the Exhibit of Premiums and Losses (GT Page) |
| Line 59 (Part 3) should equal Line 19.1, Column 2, Line 35 of the Exhibit of Premiums and Losses (GT Page) |
| Line 59 (Part 4) should equal Line 19.2, Column 2, Line 35 of the Exhibit of Premiums and Losses (GT Page) |
| Line 59 (Part 5) should equal Line 21.1, Column 2, Line 35 of the Exhibit of Premiums and Losses (GT Page) |

Column 4 – Direct Earned Exposures

An Earned Exposure for Annual Statement Lines 2.5 and 4 is defined as the fraction of the calendar reporting year for which a single residential property had coverage in force.

An Earned Exposure for Annual Statement Lines 19.1, 19.2 and 21.2 is defined as the fraction of the calendar reporting year for which a single motor vehicle had coverage in force.

Examples. Assume a homeowners policy is written on July 1 during the reporting year and remains in force through the end of the reporting year. This activity would be reported as 0.5 earned exposure.

Assume a private passenger policy with No-Fault, Liability and Physical Damage coverages was written on April 1 and cancelled by the insured on July 1. This activity would be reported as 0.25 earned exposure.
QUARTERLY STATEMENT INSTRUCTIONS – PROPERTY

PART 1 – LOSS EXPERIENCE

Column 1 – Direct Premiums Earned

Display direct premiums earned by line of business. The total must agree with the Statement of Income Page 4, Direct Premiums Earned Line 1.1, Column 1.

Column 2 – Direct Earned Exposures

An Earned Exposure for Annual Statement Lines 2.5 and 4 is defined as the fraction of the calendar reporting year for which a single residential property had coverage in force.

An Earned Exposure for Annual Statement Lines 19.1, 19.2 and 21.2 is defined as the fraction of the calendar reporting year for which a single motor vehicle had coverage in force.

Examples. Assume a homeowners policy is written on July 1 during the reporting year and remains in force through the end of the reporting year. This activity would be reported as 0.5 earned exposure.

Assume a private passenger policy with No-Fault, Liability and Physical Damage coverages was written on April 1 and cancelled by the insured on July 1. This activity would be reported as 0.25 earned exposure.

Column 23 – Direct Losses Incurred

Display direct losses incurred by line of business. The total must agree with the Statement of Income Page 4, Direct Losses Incurred Line 2.1, Column 1.

Column 24 – Direct Loss Percentage

Column 23 (Direct Losses Incurred)/Column 1 (Direct Premiums Earned) multiplied by 100.

Column 45 – Prior Year to Date Direct Loss Percentage

Display year-to-date direct loss percentages by line of business for the same quarter of the prior year.

Line 30 – Warranty

Data for this line should be reported prospectively (i.e., Prior year amounts need not be restated) starting with the 2008 reporting year.
PART 2 – DIRECT PREMIUMS WRITTEN

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Current Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Display current quarter direct premiums written by line of business.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 2</th>
<th>Direct Written Exposures</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Written Exposure for Annual Statement Lines 2.5 and 4 is defined as a single residential property for which coverage was written at any time during the calendar reporting period and remained in force through the end of the calendar reporting year. If the coverage was written and cancelled within the calendar reporting year, the written exposure is the fraction of the year the coverage was in force.</td>
<td></td>
</tr>
<tr>
<td>A Written exposure for Annual Statement Lines 19.1, 19.2 and 21.1 is defined as single motor vehicle for which coverage was written at any time during the calendar reporting year and remained in force through the end of the calendar reporting year. If the coverage was written and cancelled within the calendar reporting year, the written exposure is the fraction of the year the coverage was in force.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Examples.</th>
<th>Assume a homeowners policy is written on July 1 during the reporting year and remains in force through the end of the reporting year. This activity would be reported as one (1.0) written exposure.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assume a private passenger policy with No-Fault, Liability and Physical Damage coverages was written on April 1 and cancelled by the insured on July 1. This activity would be reported as 0.25 written exposure.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 23</th>
<th>Current Year to Date</th>
</tr>
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<tbody>
<tr>
<td>Display year-to-date direct premiums written.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 24</th>
<th>Prior Year, Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Display year-to-date direct premiums written from the same quarter of the prior year.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Line 30</th>
<th>Warranty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data for this line should be reported prospectively (i.e., Prior year amounts need not be restated) starting with the 2008 reporting year.</td>
<td></td>
</tr>
</tbody>
</table>
### DIRECT PREMIUM AND EXPOSURES

**Allocated by States and Territories**

For the Year Ended December 31, 20___
To be filed by March 1

#### Private Flood
Annual Statement Line 2.5

| State                | AL | AK | AZ | AR | CA | CO | CT | DC | FL | GA | HI | ID | IL | IN | IA | KS | KY | LA | MA | MI | MN | MO | MS | MT | NE | NV | NH | NJ | NM | NY | NC | ND | OH | OK | OR | PA | RI | SC | SD | TN | TX | UT | VA | WV | WI | WY | AS | GU | PR | VI | MP | CA | QA |
|----------------------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Premium             | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  |
| Exposure            | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  |

#### Note:
- Premium and Exposure values are represented as 0 for simplicity in this example.
- Actual values may differ based on the specific data collected.

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### Table: DIRECT PREMIUM AND EXPOSURES

#### Allocated by States and Territories

For The Year Ended December 31, 20 (To Be Filed by March 1)

#### Part 1 – Homeowners (Excluding Renters, Condominiums and Co-ops)

<table>
<thead>
<tr>
<th>State</th>
<th>1 Direct Premiums Written</th>
<th>2 Direct Exposures Written</th>
<th>3 Direct Premiums Earned</th>
<th>4 Direct Exposures Earned</th>
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</tbody>
</table>
### Part 2 – Homeowners (Renters, Condominiums and Co-ops)

#### Annual Statement Line 4

<table>
<thead>
<tr>
<th>State</th>
<th>Direct Premiums Written</th>
<th>2 Direct Exposures Written</th>
<th>3 Direct Premiums Earned</th>
<th>4 Direct Exposures Earned</th>
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### SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason, enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

#### MARCH FILING

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<thead>
<tr>
<th>Interrogatory</th>
<th>RESPONSES</th>
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<tbody>
<tr>
<td>1. Will an actuarial opinion be filed by March 1?</td>
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<tr>
<td>2. Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?</td>
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<tr>
<td>3. Will the confidential Risk-based Capital Report be filed with the NAIC by March 1?</td>
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<tr>
<td>4. Will the confidential Risk-based Capital Report be filed with the state of domicile, if required, by March 1?</td>
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#### APRIL FILING

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<tr>
<td>5. Will the Insurance Expense Exhibit be filed with the state of domicile and the NAIC by April 1?</td>
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<tr>
<td>6. Will the Management’s Discussion and Analysis be filed by April 1?</td>
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<tr>
<td>7. Will the Supplemental Investment Risks Interrogatories be filed by April 1?</td>
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#### MAY FILING

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<td>8. Will this company be included in a combined annual statement that is filed with the NAIC by May 1?</td>
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#### JUNE FILING

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<td>9. Will an audited financial report be filed by June 1?</td>
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<tr>
<td>10. Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?</td>
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The following supplemental reports are required to be filed as part of your statement filing if your company is engaged in the type of business covered by the supplement. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason, enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

#### MARCH FILING

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<td>11. Will Schedule 54 (Stockholder Information Supplement) be filed with the state of domicile by March 1?</td>
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<tr>
<td>12. Will the Financial Guaranty Insurance Exhibit be filed by March 1?</td>
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<tr>
<td>13. Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1?</td>
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<tr>
<td>14. Will Supplement A to Schedule 5 (Medical Professional Liability Supplement) be filed by March 1?</td>
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<td>15. Will the Reinsurance Summary Supplemental Filing for General Interrogatory 9 be filed with the state of domicile and the NAIC by March 1?</td>
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<td>16. Will the Premiums Attributed to Protected Cells Exhibit be filed by March 1?</td>
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<td>17. Will the Reinsurance Attestation Supplement be filed with the state of domicile and the NAIC by March 1?</td>
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<td>18. Will the Reinsurance Attestation Supplement be filed with the state of domicile and the NAIC by March 1?</td>
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<td>19. Will the Reinsurance Attestation Supplement be filed with the state of domicile and the NAIC by March 1?</td>
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<td>20. Will the Reinsurance Attestation Supplement be filed with the state of domicile and the NAIC by March 1?</td>
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<tr>
<td>21. Will the Director and Officer Insurance Coverage Supplement be filed with the state of domicile and the NAIC by March 1?</td>
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<tr>
<td>22. Will an approval from the Reporting entity’s state of domicile for relief related to the one-year cooling off period for an independent CPA be filed electronically with the NAIC by March 1?</td>
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<tr>
<td>23. Will an approval from the Reporting entity’s state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1?</td>
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<tr>
<td>24. Will the Supplemental Schedule for Reinsurance Counterparty Reporting Exception – Asbestos and Pollution contracts be filed with the state of domicile and the NAIC by March 1?</td>
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#### APRIL FILING

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<tr>
<td>25. Will the Credit Insurance Experience Exhibit be filed with the state of domicile and the NAIC by April 1?</td>
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<td>26. Will the Long-term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?</td>
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<td>27. Will the Accident and Health Policy Experience Exhibit be filed by April 1?</td>
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<td>28. Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?</td>
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<td>29. Will the regulator-only (non-public) Supplemental Health Care Exhibit’s Allocation Report be filed with the state of domicile and the NAIC by April 1?</td>
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<td>30. Will the Cybersecurity and Identity Theft Insurance Coverage Supplement be filed with the state of domicile and the NAIC by April 1?</td>
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<td>31. Will the Life, Health &amp; Annuity Guaranty Association Assessable Premium Exhibit – Parts 1 and 2 be filed with the state of domicile and the NAIC by April 1?</td>
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<tr>
<td>32. Will the Private Flood Insurance Supplement be filed with the state of domicile and the NAIC by April 1?</td>
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#### AUGUST FILING

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<td>33. Will Management’s Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?</td>
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**Explanation:**

**Bar Code:**

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## QUARTERLY STATEMENT BLANK – PROPERTY

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© 2021 National Association of Insurance Commissioners 14
### PART 2 – DIRECT PREMIUMS WRITTEN

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Casualty Actuarial and Statistical (C) Task Force
Virtual Meeting
June 8, 2021

The Casualty Actuarial and Statistical (C) Task Force met June 8, 2021. The following Task Force members participated: Grace Arnold, Chair, represented by Phil Vigliaturo (MN); James J. Donelon, Vice Chair, represented by Rich Piazza (LA); Lori K. Wing-Heier represented by Katie Hegland (AK); Jim L. Ridling represented by Daniel Davis (AL); Evan G. Daniels represented by Tom Zuppan (AZ); Ricardo Lara represented by Mitra Sanandajifar and Lynne Wehmueller (CA); Michael Conway represented by Mitchell Bronson (CO); Andrew N. Mais represented by Wanchin Chou (CT); Colin M. Hayashida represented by Randy Jacobson (HI); Doug Ommen represented by Travis Grassel (IA); Dana Popish Severinghaus represented by Judy Mottar (IL); Vicki Schmidt represented by Nicole Boyd (KS); Kathleen A. Birrane represented by Robert Baron and Walter Dabrowski (MD); Eric A. Cioppa represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Chlora Lindley-Myers represented by Cynthia Amann and Jo LeDuc (MO); Troy Downing represented by Mari Kindberg (MT); Mike Causey represented by Kevin Conley and Arthur Schwartz (NC); Marlene Caride represented by Carl Sornson (NJ); Russell Toal represented by Anna Krylova (NM); Barbara D. Richardson represented by Gennady Stolyarov (NV); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolli represented by TK Keen (OR); Jessica K. Altman represented by Kevin Clark, Jim DiSanto, and Michael McKenney (PA); Raymond G. Farmer represented by Will Davis (SC); Doug Slape represented by Miriam Fisk (TX); Michael S. Pieciak represented by Rosemary Rasza (VT); Mike Kreidler represented by Eric Slavich (WA); James A. Dodrill represented by Juanita Wimmer (WV); and Jeff Rude represented by Donna Stewart (WY).

1. Exposed the Referrals from Blanks (E) Working Group

Mr. Vigliaturo said the Blanks (E) Working Group sent the Task Force two referrals (Attachment Two-A).

Birny Birnbaurm (Center for Economic Justice—CEJ) described his proposal, 2021-11BWG; its purpose; and its benefits. He said his proposal would add a new annual statement supplement to capture exposure data for specific lines of business and add a column to the Quarterly Part 1 and Part 2 to capture exposure data for the same lines of business. He stated the Task Force’s Auto Insurance Database Report and Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report (Homeowners Report) include similar information but are published so late that its data is old. He asked the Task Force to provide suggestions for improvement to the proposal, support the proposal, and support implementation for annual statement 2021 reporting. Mr. Birnbaurm said the reporting should not be difficult for companies or cost much.

Mr. Stolyarov said he supports the proposal to gain insights earlier. Mr. Jacobson said the definition of “exposure” may vary across different parties. Mr. Chou said homeowner averages are affected by the distribution of companies’ issued owners or others forms. Typical contract types and average premiums would not be comparable from one company to another. He also asked whether the Best’s Aggregate & Averages could be used instead of this proposal. Mr. Conley asked about the exposure definition for auto physical damage. Mr. Birnbaurm verified that if an auto had comprehensive and collision coverage, one exposure would be reported; if it only had comprehensive coverage, the number of exposures would still be one. Mr. Schwartz said there are issues with the requested data not being homogeneous to produce useable information. Mr. McKenney said reporting on the new flood insurance supplement was fraught with errors and that he feared similar reporting issues with this proposal because it would need to be verified by someone. Mr. Birnbaurm said this proposal should be easier for companies to complete accurately because it flows with information already reported. Mr. Will Davis said from a solvency perspective, he does not believe having this data in the annual statement would be useful. He said he can obtain information from the actuarial report and other sources already. He said the state can issue a data call if there is need for market information. Ralph Blanchard (Travelers) expressed concerns about the timing and accuracy and said that if the proposal passes, the reporting should be delayed until 2023. He said statistical information should not be in the annual statement. Mr. Birnbaurm said the averages resulting from this reporting would be similar to what is produced by the Statistical Data (C) Working Group when it reports average home insurance or auto insurance premium by state.

Mr. Chou made a motion, seconded by Mr. Piazza, to exposed proposal 2021-11BWG for a 30-day public comment period ending July 7, 2021.
Mr. Vigliaturo said the second proposal referred to the Task Force, 2021-13BWG, would add an exhibit to provide more granular detail for the diverse lines of business reported as “other liability.” He said this proposal from a New Hampshire state insurance regulator would not affect any of the Task Force’s statistical reports. Mr. Schwartz asked how the data would be used. He said he is interested in adding another line to report liability for foster parents. Mr. Slavich said the proposal would capture most data required to be reported in an annual data call for Washington. He said he would like to see the report expanded in a couple of places. Mr. Blanchard said the biggest issue is that asking for incurred but not reported (IBNR) reserves at the proposed level of detail is problematic. He suggested a focus on case reserves instead.

Mr. Piazza made a motion, seconded by Mr. Slavich, to expose proposal 2021-13BWG for a 30-day public comment period ending July 7, 2021.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
TO: Phil Vigliaturo, Chair; Rich Piazza, Vice Chair
Casualty Actuarial and Statistical (C) Task Force

FROM: Jake Garn, Utah Chief Financial Examiner, Chair
Blanks (E) Working Group

DATE: May 28, 2021

RE: 2021-11BWG – New Supplement to Detail Direct Exposures Written and Earned
2021-13BWG – Exhibit of Other Liabilities by Lines of Business

The Blanks (E) Working Group exposed two proposals at its May 26 meeting. Interested parties asked that the proposals be concurrently referred to the Casualty Actuarial and Statistical (C) Task Force for comment. Some concerns expressed by interested parties were in the reporting breakout level of exposures in proposal 2021-11BWG, indicating that there are mid-term cancellations and additions as well as multi-auto policies, which may be difficult to record. Interested parties also indicated that the additional breakout in proposal 2021-13BWG could affect the accuracy of the incurred but not reported amounts. The Working Group would like the Task Force to review the proposals and evaluate any issues that may affect the work of the Task Force, as well as comment on the interested parties’ concerns.

In proposal 2021-11BWG, the sponsor requests the addition of a new Property and Casualty annual statement supplement to capture “Direct Exposures Written” and “Direct Exposures Earned,” which will be reported initially only for annual statement line 2.5 (Private Flood), line 4 (Homeowners), line 19.1 (PPA No Fault), line 19.2 (PPA Liability) and line 21.1 (PPA Physical Damage). The sponsor requests a first quarter 2022 effective date.

In proposal 2021-13BWG, the sponsor requests the addition of a new supplement to capture premium and loss data on a more granular level for annual statement line 17.1, line 17.2 and line 17.3 of the Exhibit of Premiums and Losses (State Page) – Other Liability. The purpose of this proposal is to provide state insurance regulators greater detail of the premium and losses of these diverse lines of business. The sponsor requests an annual 2022 effective date.

To facilitate the sponsors’ effective dates and the Blanks (E) Working Group time frame, NAIC staff request that comments be provided by June 25 to Mary Caswell (NAIC) at mcaswell@naic.org.

cc: Kris DeFrain, NAIC, Director, Research and Actuarial Department
### NAIC BLANKS (E) WORKING GROUP

#### Blanks Agenda Item Submission Form

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<tr>
<th>CONTACT PERSON:</th>
<th>Birny Birnbaum</th>
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<tr>
<td>TELEPHONE:</td>
<td>512 784 7663</td>
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<tr>
<td>EMAIL ADDRESS:</td>
<td><a href="mailto:birny@cej-online.org">birny@cej-online.org</a></td>
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<tr>
<td>ON BEHALF OF:</td>
<td>Center for Economic Justice</td>
</tr>
<tr>
<td>NAME:</td>
<td>Birny Birnbaum</td>
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<tr>
<td>TITLE:</td>
<td>Director</td>
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<tr>
<td>AFFILIATION:</td>
<td>NAIC Designated Consumer Representative</td>
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<td>ADDRESS:</td>
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**FOR NAIC USE ONLY**

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**BLANK(S) TO WHICH PROPOSAL APPLIES**

| [ X ] ANNUAL STATEMENT |
| [ X ] QUARTERLY STATEMENT |
| [ X ] INSTRUCTIONS |
| [ X ] CROSSCHECKS |
| [ ] Life, Accident & Health/Fraternal |
| [ ] Property/Casualty |
| [ ] Health |
| [ ] Separate Accounts |
| [ ] Protected Cell |
| [ ] Health (Life Supplement) |
| [ ] Title |
| [ ] Other |

Anticipated Effective Date: 1st Quarter 2022

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Add a new annual statement supplement to capture exposure data for Annual Statement Lines 2.5, 4, 19.1, 19.2 and 21.2. Add a column to the Quarterly Parts 1 and 2 to capture exposure data for these annual statement lines for the quarter.

***See Next Page For More Details***

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

***See Next Page For Details***

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: _____________________________________________

Other Comments: ________________________________________________________________

** This section must be completed on all forms.  Revised 7/18/2018
IDENTIFICATION OF ITEM(S) TO CHANGE

Add a new annual statement supplement to the Property and Casualty annual statement to capture “Direct Exposures Written” and “Direct Exposures Earned” which will be reported, initially only for Annual Statement Lines 2.5 (Private Flood), 4 (Homeowners), 19.1 (PPA No Fault), 19.2 (PPA Liability) and 21.1 (PPA Physical Damage).

Add one column to property casualty quarterly statement Part 1 Loss experience between current columns 1 and 2 for “Direct Exposures Earned” only for only for lines 2.5 (Private Flood) 4 (Homeowners), 19.1 (PPA No Fault), 19.2 (PPA Liability) and 21.1 (PPA Physical Damage).

Add one column to property casualty quarterly statement Part 2 Direct Premium Written between current columns 1 and 2 for “Direct Exposures Written” only for only for lines 2.5 (Private Flood) 4 (Homeowners), 19.1 (PPA No Fault), 19.2 (PPA Liability) and 21.1 (PPA Physical Damage).

Add instructions for reporting the additional data elements, consisting of definitions and examples for the new data elements.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The average written and average earned premium per exposure is an important metric for a variety of regulatory and public policy purposes. The NAIC annually produces reports of average personal auto and homeowners premiums, but the data in these reports are old and stale for timely assessment of absolute average premium and changes in average premium over time. Both reports are typically produced 24 months after the end of the experience period and 36 months after the beginning of the experience period. Homeowners average premiums for 2018 was published in January 2021 in the “Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owners’ Insurance Report: Data for 2018.” Personal auto average premiums for 2018 was published in March 2021 in the “Auto Database Report.” While there are valid reasons for the length of time needed to produce these reports – primarily because these reports contain information beyond average premium – the average premium numbers lose significant relevance because of their age.

This AS and QS Blanks proposals would allow the calculation of average written and average earned premium for residential property and personal auto coverages in a far more timely fashion – within three to four months following the reporting year instead of 24 months and would provide timely and useful quarterly information. The benefits of timelier average premium data are considerable. Timely average premium data would permit financial analysts to utilize changes in average premium as part of financial analysis. Similarly, the more-timely average premium data would become a valuable tool for market regulation analysts, including, but not limited to, an added data point for use with the Market Conduct Annual Statement. Last, but not least, this proposal would allow the NAIC to calculate and publish average annual premium data for residential property and personal auto insurance by state in a time frame to both make the data meaningful for describing market conditions and to inform individual state regulators and policymakers of actual changes in personal lines average premiums – as opposed to expected changes gleaned from rate filings.

Consider how valuable timely average premium values would have been for personal lines as the pandemic unfolded. Consider also the value of quarterly data for average premium for personal lines versus only an annual average. The lack of timeliness of the average premium values means that these data have very limited or no use for either financial or market analysis. The lack of timeliness also means that the data are no use in informing public policy debates about personal lines insurance costs. In addition, the severe time lag between actual experience and reporting fails to inform the public or policymakers of recent trends or outcomes and can, consequently, mislead the public and policymakers.

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2021-11BWG.doc
ANNUAL STATEMENT INSTRUCTIONS – PROPERTY

DIRECT PREMIUM AND EXPOSURES
Annual Statement Lines 2.5, 4, 19.1, 19.2 and 21.1
Allocated by States and Territories

This supplement must be filed with the NAIC by March 1 each year.

This supplement should be completed by those reporting entities that write direct business reported on the Exhibit of Premiums and Losses for each Annual Statement Lines (ASL) listed below. A separate page will be completed for each ASL.

ASL 2.5 (Private Flood)
ASL 4 (Homeowners)
ASL 19.1 (Private Passenger Auto No-Fault – Personal Injury Protection)
ASL 19.2 (Other Private Passenger Auto Liability)
ASL 21.1 (Private Passenger Auto Physical Damage)

Column 1 – Direct Premiums Written

The amounts reported for each line should agree with the amounts reported for the corresponding Annual Statement Line in Column 1, Line 35 of the Exhibit of Premiums and Losses for that state.

Column 2 – Direct Written Exposures

A Written Exposure for Annual Statement Lines 2.5 and 4 is defined as a single residential property for which coverage was written at any time during the calendar reporting period and remained in force through the end of the calendar reporting year. If the coverage was written and cancelled within the calendar reporting year, the written exposure is the fraction of the year the coverage was in force.

A Written exposure for Annual Statement Lines 19.1, 19.2 and 21.1 is defined as single motor vehicle for which coverage was written at any time during the calendar reporting year and remained in force through the end of the calendar reporting year. If the coverage was written and cancelled within the calendar reporting year, the written exposure is the fraction of the year the coverage was in force.

Examples. Assume a homeowners policy is written on July 1 during the reporting year and remains in force through the end of the reporting year. This activity would be reported as one (1.0) written exposure.

Assume a private passenger policy with No-Fault, Liability and Physical Damage coverages was written on April 1 and cancelled by the insured on July 1. This activity would be reported as 0.25 written exposure.
Column 3 – Direct Premiums Earned

The amounts reported for each line should agree with the amounts reported for the corresponding Annual Statement Line in Column 2, Line 35 of the Exhibit of Premiums and Losses for each state.

Column 4 – Direct Earned Exposures

An Earned Exposure for Annual Statement Lines 2.5 and 4 is defined as the fraction of the calendar reporting year for which a single residential property had coverage in force.

An Earned Exposure for Annual Statement Lines 19.1, 19.2 and 21.2 is defined as the fraction of the calendar reporting year for which a single motor vehicle had coverage in force.

Examples. Assume a homeowners policy is written on July 1 during the reporting year and remains in force through the end of the reporting year. This activity would be reported as 0.5 earned exposure.

Assume a private passenger policy with No-Fault, Liability and Physical Damage coverages was written on April 1 and cancelled by the insured on July 1. This activity would be reported as 0.25 earned exposure.
QUARTERLY STATEMENT INSTRUCTIONS – PROPERTY

PART 1 – LOSS EXPERIENCE

Column 1 – Direct Premiums Earned
Display direct premiums earned by line of business. The total must agree with the Statement of Income Page 4, Direct Premiums Earned Line 1.1, Column 1.

Column 2 – Direct Earned Exposures
An Earned Exposure for Annual Statement Lines 2.5 and 4 is defined as the fraction of the calendar reporting year for which a single residential property had coverage in force.

An Earned Exposure for Annual Statement Lines 19.1, 19.2 and 21.2 is defined as the fraction of the calendar reporting year for which a single motor vehicle had coverage in force.

Examples. Assume a homeowners policy is written on July 1 during the reporting year and remains in force through the end of the reporting year. This activity would be reported as 0.5 earned exposure.

Assume a private passenger policy with No-Fault, Liability and Physical Damage coverages was written on April 1 and cancelled by the insured on July 1. This activity would be reported as 0.25 earned exposure.

Column 23 – Direct Losses Incurred
Display direct losses incurred by line of business. The total must agree with the Statement of Income Page 4, Direct Losses Incurred Line 2.1, Column 1.

Column 34 – Direct Loss Percentage
Column 23 (Direct Losses Incurred)/Column 1 (Direct Premiums Earned) multiplied by 100.

Column 45 – Prior Year to Date Direct Loss Percentage
Display year-to-date direct loss percentages by line of business for the same quarter of the prior year.

Line 30 – Warranty
Data for this line should be reported prospectively (i.e., Prior year amounts need not be restated) starting with the 2008 reporting year.
PART 2 – DIRECT PREMIUMS WRITTEN

Column 1  –  Current Quarter

Display current quarter direct premiums written by line of business.

Column 2  –  Direct Written Exposures

A Written Exposure for Annual Statement Lines 2.5 and 4 is defined as a single residential property for which coverage was written at any time during the calendar reporting period and remained in force through the end of the calendar reporting year. If the coverage was written and cancelled within the calendar reporting year, the written exposure is the fraction of the year the coverage was in force.

A Written exposure for Annual Statement Lines 19.1, 19.2 and 21.1 is defined as single motor vehicle for which coverage was written at any time during the calendar reporting year and remained in force through the end of the calendar reporting year. If the coverage was written and cancelled within the calendar reporting year, the written exposure is the fraction of the year the coverage was in force.

Examples. Assume a homeowners policy is written on July 1 during the reporting year and remains in force through the end of the reporting year. This activity would be reported as one (1.0) written exposure.

Assume a private passenger policy with No-Fault, Liability and Physical Damage coverages was written on April 1 and cancelled by the insured on July 1. This activity would be reported as 0.25 written exposure.

Column 23  –  Current Year to Date

Display year-to-date direct premiums written.

Column 34  –  Prior Year, Year to Date

Display year-to-date direct premiums written from the same quarter of the prior year.

Line 30  –  Warranty

Data for this line should be reported prospectively (i.e., Prior year amounts need not be restated) starting with the 2008 reporting year.
## ANNUAL STATEMENT BLANK – PROPERTY

### DIRECT PREMIUM AND EXPOSURES

*Allocated by States and Territories*

**For The Year Ended December 31, 2020**

**(To Be Filed by March 1)**

#### Private Flood

**Annual Statement Line 2.5**

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**Direct Premiums Written**

**Direct Exposures Written**

**Direct Premiums Earned**

**Direct Exposures Earned**

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## SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason, enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

### MARCH FILING

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<th>No.</th>
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<tbody>
<tr>
<td>1.</td>
<td>Will an actuarial opinion be filed by March 1?</td>
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<td>2.</td>
<td>Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?</td>
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<td>3.</td>
<td>Will the confidential Risk-based Capital Report be filed with the MAIC by March 1?</td>
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<tr>
<td>4.</td>
<td>Will the confidential Risk-based Capital Report be filed with the state of domicile, if required, by March 1?</td>
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### APRIL FILING

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<td>5.</td>
<td>Will the Insurance Expense Exhibit be filed with the state of domicile and the NAIC by April 1?</td>
<td>……………………</td>
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<tr>
<td>6.</td>
<td>Will Management’s Discussion and Analysis be filed by April 1?</td>
<td>……………………</td>
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<td>7.</td>
<td>Will the Supplemental Investment Risks Interrogatories be filed by April 1?</td>
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### MAY FILING

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<td>8.</td>
<td>Will this company be included in a combined annual statement that is filed with the NAIC by May 1?</td>
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### JUNE FILING

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<td>9.</td>
<td>Will an audited financial report be filed by June 1?</td>
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<td>10.</td>
<td>Will Accountants Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1?</td>
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### JUNE FILING

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<tr>
<td>11.</td>
<td>Will Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1?</td>
<td>……………………</td>
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<td>12.</td>
<td>Will the Financial Guaranty Insurance Exhibit be filed by March 1?</td>
<td>……………………</td>
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<tr>
<td>13.</td>
<td>Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1?</td>
<td>……………………</td>
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<tr>
<td>14.</td>
<td>Will Supplement A to Schedule T (Medical Professional Liability Supplement) be filed by March 1?</td>
<td>……………………</td>
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<tr>
<td>15.</td>
<td>Will the Traded Surplus Statement be filed with the state of domicile and the NAIC by March 1?</td>
<td>……………………</td>
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<tr>
<td>16.</td>
<td>Will the Premiums Attributed to Protected Cells Exhibit be filed by March 1?</td>
<td>……………………</td>
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<tr>
<td>17.</td>
<td>Will the Reinsurance Summary Supplemental Filing for General Interrogatory 9 be filed with the state of domicile and the NAIC by March 1?</td>
<td>……………………</td>
</tr>
<tr>
<td>18.</td>
<td>Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC by March 1?</td>
<td>……………………</td>
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<tr>
<td>19.</td>
<td>Will the confidential Actuarial Opinion Summary be filed with the state of domicile, if required, by March 15 (or the date otherwise specified)?</td>
<td>……………………</td>
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<tr>
<td>20.</td>
<td>Will the Reinsurance Attestation Supplement be filed with the state of domicile and the NAIC by March 1?</td>
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<tr>
<td>21.</td>
<td>Will the Exceptions to the Reinsurance Attestation Supplement be filed with the state of domicile by March 1?</td>
<td>……………………</td>
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<tr>
<td>22.</td>
<td>Will the Bail Bond Supplement be filed with the state of domicile and the NAIC by March 1?</td>
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<td>23.</td>
<td>Will the Director and Officer Insurance Coverage Supplement be filed with the state of domicile and the NAIC by March 1?</td>
<td>……………………</td>
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<tr>
<td>24.</td>
<td>Will an approval from the reporting entity’s state of domicile for relief related to the one-year cooling off period for independent CPA be filed electronically with the NAIC by March 1?</td>
<td>……………………</td>
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<td>25.</td>
<td>Will an approval from the reporting entity’s state of domicile for relief related to the one-year rotation requirement for lead audit partner be filed electronically with the NAIC by March 1?</td>
<td>……………………</td>
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<td>26.</td>
<td>Will an approval from the reporting entity’s state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1?</td>
<td>……………………</td>
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<tr>
<td>27.</td>
<td>Will the Supplemental Schedule for Reinsurance Counterparty Reporting Exception – Asbestos and Pollution contracts be filed with the state of domicile and the NAIC by March 1?</td>
<td>……………………</td>
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<td>28.</td>
<td>Will the Direct Premium and Exposures Supplement be filed with NAIC by March 1?</td>
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### APRIL FILING

<table>
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<th>No.</th>
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<td>29.</td>
<td>Will the Credit Insurance Experience Exhibit be filed with the state of domicile and the NAIC by April 1?</td>
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<td>30.</td>
<td>Will the Long-term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?</td>
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<td>31.</td>
<td>Will the Accident and Health Policy Experience Exhibit be filed by April 1?</td>
<td>……………………</td>
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<td>32.</td>
<td>Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?</td>
<td>……………………</td>
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<tr>
<td>33.</td>
<td>Will the regulator-only (non-public) Supplemental Health Care Exhibit’s Allocation Report be filed with the state of domicile and the NAIC by April 1?</td>
<td>……………………</td>
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<tr>
<td>34.</td>
<td>Will the Cybersecurity and Identity Theft Insurance Coverage Supplement be filed with the state of domicile and the NAIC by April 1?</td>
<td>……………………</td>
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<tr>
<td>35.</td>
<td>Will the Life, Health &amp; Annuity Guaranty Association Assessable Premium Exhibit – Parts 1 and 2 be filed with the state of domicile and the NAIC by April 1?</td>
<td>……………………</td>
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<td>36.</td>
<td>Will the Private Flood Insurance Supplement be filed with the state of domicile and the NAIC by April 1?</td>
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### AUGUST FILING

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<td>37.</td>
<td>Will Management’s Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?</td>
<td>……………………</td>
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### Explanation:

**Bar Code:**

© 2021 National Association of Insurance Commissioners 13
# QUARTERLY STATEMENT BLANK – PROPERTY

## PART 1 – LOSS EXPERIENCE

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### DETAILS OF WRITE-INS

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<td>Totals (Lines 3401 through 3403 plus 3496) (Line 34 above)</td>
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## PART 2 – DIRECT PREMIUMS WRITTEN

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<td>3. Farmowners Multiple Peril</td>
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<td>19.3 Commercial Auto No-Fault (Personal Injury Protection)</td>
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<td>33. Reinsurance-Nonproportional Assumed Financial Lines</td>
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<td>34. Aggregate Write-Ins for Other Lines of Business</td>
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### DETAILS OF WRITE-INS

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NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

<table>
<thead>
<tr>
<th>CONTACT PERSON:</th>
<th>Patricia Gosselin</th>
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<tr>
<td>ADDRESS:</td>
<td>215 S. Fruit St., Ste. 14 Concord, NH 03301</td>
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DATE: 04/15/2021

FOR NAIC USE ONLY

Agenda Item # 2021-13BWG

Changes to Existing Reporting [ X ]
New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

No Impact [ ]
Modifies Required Disclosure [ ]

DISPOSITION

[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group CASTF
[ X ] Received For Public Comment
[ ] Adopted Date
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify)

BLANK(S) TO WHICH PROPOSAL APPLIES

[ X ] ANNUAL STATEMENT
[ ] QUARTERLY STATEMENT
[ X ] INSTRUCTIONS
[ X ] CROSSCHECKS
[ ] Life, Accident & Health/Fraternal
[ X ] Property/Casualty
[ X ] Health
[ ] Separate Accounts
[ ] Protected Cell
[ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2022

IDENTIFICATION OF ITEM(S) TO CHANGE

Add a new supplement to capture premium and loss data for Annual Statement Lines 17.1, 17.2 & 17.3 of the Exhibit of Premiums and Losses (State Page) – Other Liability by more granular lines of business.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to provide regulators more granular detail of the premium and losses of the diverse lines of business reported on Annual Statement Lines 17.1, 17.2 & 17.3 of the Exhibit of Premiums and Losses (State Page).

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: 

Other Comments:

** This section must be completed on all forms.
ANNUAL STATEMENT INSTRUCTIONS – PROPERTY

Exhibit of Other Liabilities by Lines of Business
As Reported on Line 17 of The Exhibit of Premiums and Losses

All reporting entities reporting “Other Liability” on Line 17 of the Exhibit of Premiums and Losses must prepare this exhibit. The exhibit is to be prepared and filed by all reporting entities no later than March 1 of each year.

The purpose of the Exhibit of Other Liabilities by Lines of Business is to provide more information on the diverse lines of business filed on Annual Statement Line 17. The exhibit should be reported on a direct basis (before assumed and ceded reinsurance).

For definitions of the products reported on Lines 1 through 28, see the appendix of these instructions. Line 26 – All Other will include all products not reported on Lines 1 through 28.

Column 1 – Written Premium

Line 30 should equal Exhibit of Premiums and Losses Grand Total Page Column 1, Line 17.1 + Line 17.2 + Line 17.3.

Column 2 – Earned Premium

Line 30 should equal Exhibit of Premiums and Losses Grand Total Page Column 2, Line 17.1 + Line 17.2 + Line 17.3.

Column 3 – Unearned Premium Reserve

Line 30 should equal Exhibit of Premiums and Losses Grand Total Page Column 4, Line 17.1 + Line 17.2 + Line 17.3.

Column 4 – Losses Paid (Deducting Salvage)

Line 30 should equal Exhibit of Premiums and Losses Grand Total Page Column 5, Line 17.1 + Line 17.2 + Line 17.3.

Column 5 – Losses Incurred

Line 30 should equal Exhibit of Premiums and Losses Grand Total Page Column 6, Line 17.1 + Line 17.2 + Line 17.3.

Column 6 – Losses Unpaid

Line 30 should equal Exhibit of Premiums and Losses Grand Total Page Column 7, Line 17.1 + Line 17.2 + Line 17.3.

Column 7 – Defense and Cost Containment Paid

Line 30 should equal Exhibit of Premiums and Losses Grand Total Page Column 8, Line 17.1 + Line 17.2 + Line 17.3.

Column 8 – Defense and Cost Containment Incurred

Line 30 should equal Exhibit of Premiums and Losses Grand Total Page Column 9, Line 17.1 + Line 17.2 + Line 17.3.

Column 9 – Defense and Cost Containment Unpaid

Line 30 should equal Exhibit of Premiums and Losses Grand Total Page Column 10, Line 17.1 + Line 17.2 + Line 17.3.
## Exhibit of Other Liabilities by Lines of Business

**As Reported on Line 17 of the Exhibit of Premiums and Losses**

*(To Be Filed by March 1)*

### Direct Business Only

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**NAIC Proceedings – Summer 2021**

Attachment Two-A

Casualty Actuarial and Statistical (C) Task Force
The Casualty Actuarial and Statistical (C) Task Force met May 11, 2021. The following Task Force members participated: Grace Arnold, Chair, represented by Phil Vigliaturo (MN); James J. Donelon, Vice Chair, represented by Rich Piazza (LA); Lori K. Wing-Heier represented by Katie Hegland (AK); Jim L. Ridling represented by Daniel Davis (AL); Evan G. Daniels represented by Vanessa Darrah and Tom Zuppan (AZ); Michael Conway represented by Mitchell Bronson and Sydney Sloan (CO); Andrew N. Mais represented by George Bradner, Wanchin Chou and Qing He (CT); Karima A. Woods represented by David Christhilf (DC); Colin M. Hayashida represented by Randy Jacobson (HI); Doug Ommen, Travis Grassel and Andria Seip (IA); Dana Popish Severinghaus represented by Anthony Brodel and Reid McClintock (IL); Vicki Schmidt represented by Nicole Boyd (KS); Kathleen A. Birnane represented by Ron Coleman (MD); Eric A. Cioppa represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Chlora Lindley-Myers represented by Cynthia Amann and LeAnn Cox (MO); Troy Downing represented by Mari Kindberg (MT); Mike Causey represented by Kevin Conley and Arthur Schwartz (NC); Chris Nicolopoulos represented by Christian Citarella (NH); Russell Toal represented by Anna Krylova (NM); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica K. Altman represented by Michael McKenney (PA); Raymond G. Farmer represented by Karl Bitzky (SC); Doug Slape represented by J’ne Byckovski, Miriam Fisk, Eric Hintikka and Bethany Sims (TX); Michael S. Pecjak represented by Rosemary Raszka (VT); Mike Kreidler represented by Eric Slavich (WA); and Jeff Rude represented by Donna Stewart (WY). Also participating was: Halina Smosna (NY).

1. **Discussed the CAS’S Recission of the SOP**

Mr. Vigliaturo said there has been a development at the Casualty Actuarial Society (CAS) regarding its recission of the Statement of Principles (SOP). Jessica Leong (CAS) said the CAS Board decided to reinstate the “Statement of Principles Regarding Property and Casualty Insurance Ratemaking” as it relates to U.S. regulated ratemaking.

Many Task Force members and interested parties expressed contentment with this action and do not desire to move forward with any further action. Mr. Schwartz said there was consideration by members of the Society of Actuaries (SOA) in the 1980s of copying the document for life and health insurance; he encouraged that action to be taken. Gennady Stolyarov (NV) issued a written statement, saying the immediate need for action is resolved. In the longer term, Mr. Schwartz said he is supportive of the NAIC adopting a similar statement of principles that would not be subject to the unilateral decisions of a private organization. Mr. Bradner said he would not support the NAIC having a competing document with the CAS principles. J. Robert Hunter (Consumer Federation of America—CFA) said he plans to present issues to address in the future.

Mr. Davis questioned whether the initial rescindment was made because of a desire to use price optimization. Ms. Leong said the actions were in no way due to a desire to do price optimization. She said the topic was never discussed by the Board in making its decisions. She said the rescindment action was taken to “clean up shop” because of the duplication with actuarial standards of practice (ASOPs). Mr. Hunter said the decision to rescind the SOP occurred at the same time as much debate on price optimization, and they seemed linked.

Birny Birnbaum (Center for Economic Justice—CEJ) suggested that the CAS reflect on the need for transparency and inclusion. He said CAS processes should be improved in relation to public policy and social issues. Ms. Smosna said Article 9 of the CAS’S constitution states that no opinion with respect to public interest shall be publicly expressed except in matters in the professional competence for actuaries, and only then with a two-thirds vote of the Board. Mr. Hunter said the CAS has begun to address some public issues. He said a paper was issued on rating factors, coauthored with the Insurance Information Institute (III), which was discussed for two years without anyone knowing. He said it was a biased and inaccurate statement, and it misconstrued his position on the impact of some rating variables on the poor.

The Task Force decided to take no immediate action to develop ratemaking principles. Mr. Vigliaturo said if members want to have the NAIC develop something in the future, suggestions should be submitted to NAIC staff.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
Actuarial Opinion (C) Working Group
Virtual Meeting
July 22, 2021

The Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met July 22, 2021. The following Working Group members participated: Anna Krylova, Chair (NM); Susan Andrews and Amy Waldbauer (CT); David Christhilf (DC); Judy Mottar (IL); Brock Bubar (ME); Gordon Hay (NE); Tom Botsko (OH); Andrew Schallhorn (OK); and James DiSanto (PA). Also participating were: Kevin Dyke (MI); and Arthur Schwartz (NC).

1. **Discussed SAO Instructions**

Ms. Krylova said two proposals were introduced during the Working Group’s July 1 meeting. One is to set a deadline for providing qualification documentation to the Board. The second is to require additional language that asserts the actuary’s compliance with respect to the qualification documentation provided to the Board. She said both changes would require changes to the Statement of Actuarial Opinion (SAO) instructions. She said the deadline to propose instruction changes for 2021 has passed, but the Working Group could propose these changes for 2022 instructions. Ms. Krylova said she will draft proposed instructions for the Working Group’s consideration.

Ms. Krylova said the Working Group previously discussed the Casualty Actuarial Society (CAS) Board’s rescission of its Statements of Principles and subsequent reinstatement of the Statement of Principles on Ratemaking with the caveat that it is for reference for U.S. regulated ratemaking. The SAO instructions mention the group of Statements of Principles, but the Statement of Principles on Reserving was not reinstated. Mr. Dyke said the SAO instructions also mention “principles” generally in another section, but he said he interprets that as referring to the CAS principles. The Working Group decided both should be removed. The Blanks (E) Working Group is expected to make these editorial changes for the 2021 instructions.

2. **Discussed Schedule P Reconciliation**

Ms. Krylova said the Working Group agreed during its July 1 meeting to add guidance about Schedule P reconciliation. Michelle Iarkowski (American Academy of Actuaries—Academy) said based on her reviews of reconciliations during regulatory financial examinations, she compiled the following issues: 1) a reconciliation showed data from the company’s systems reconciled to Schedule P, but there was no reconciliation of the data used for the actuarial analysis to Schedule P; 2) guidance is needed regarding whether the Schedule P reconciliation should be for direct and assumed or net of reinsurance amounts. Mr. Botsko said the choice of the reconciliation data (direct and assumed vs. net) could be left to the actuary, but state insurance regulators should require the actuary explain why he or she chose one over the other; 3) guidance is needed regarding the manner that loss adjustment expenses (LAEs) need to be reconciled. Adjusting and other (A&O) expenses are usually reconciled separately. Sometimes defense and cost containment (DCC) expenses are reconciled separately; 4) reconciliation for claim counts and earned premiums is optional, but there is no requirement to document why the reconciliation was not done. She said she has never seen a reconciliation for claim counts and suggests state insurance regulators consider removing reference to claims counts in the Regulatory Guidance on Property and Casualty Statutory Statements of Actuarial Opinion (Regulatory Guidance). Mr. Hay said he has never seen an actuary’s letter to the auditor saying claim counts were a material part of the actuarial review. Ralph Blanchard (Travelers) said flexibility is needed, so dictating a specific approach does not make sense. He said the claim counts were initially put into Schedule P so when a company needed to be taken over, the receiver would have an idea of the amount of claims handling needed. Mr. Schwartz agreed that claim count definitions vary by company and line of business, and he does not believe reconciliation would be useful; and 5) the actuary needs to explain “material” differences in the reconciliation, but there is no requirement to state that differences are deemed immaterial when the amount is more than rounding differences. Mr. Botsko said the word “material” is vague, and state insurance regulators might need to add clarity.

Ms. Iarkowski said the Regulatory Guidance could include these topics with an aim for the actuary to communicate that the data used is reconciled to Schedule P. She said a reconciliation of all data in total, all coverages and loss elements combined, does not give her confidence in the financial examination that the actuary used the correct data. Ms. Krylova said she would draft some language for the Regulatory Guidance to add clarity on the issues mentioned and remove the claim count reference in the Schedule P reconciliation section.
3. **Discussed Board Review of Qualification Documentation**

Ms. Krylova said Connecticut submitted some proposed language regarding review of actuarial qualification documentation. The proposed wording is: “If the Board of the holding company reviews the qualification documents of the appointed actuary who signs the opinion of all companies in a specific pool, the Board minutes of the statutory entity have to say that they reviewed that holding company’s assessment regarding the qualification documents and find it appropriate for their statutory entity.”

Mr. Blanchard said for Travelers, that means there would be 40 responses to say “yes.” He said he does not see a value with such a statement, and the holding company’s assessment should be sufficient. Ms. Andrews said the wording would address the need of a specific entity being reviewed in a financial analysis and would address corporate governance for an individual entity. Mr. Blanchard asked whether the holding company’s assessment could be reviewed instead because this just creates paperwork without additional value. Mr. Hay wondered if the holding company’s Board would provide such information to the pool or affiliates and said he does not believe he needs any prescribed language from the individual entity. He said he would review the pool as a statutory entity. Mr. Blanchard suggested the review should be conducted by who will receive the actuarial opinion and hear the report. Ms. Iarkowski said there are differences in practice and that she could not find guidance. Ms. Krylova said it would seem helpful to add some clarity to ensure fairness in financial exams.

Having no further business, the Actuarial Opinion (C) Working Group adjourned.

W:\National Meetings\2021\Summer\TF\CasAct\AOWG\7-22 AOWG min.docx
The Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met July 1, 2021. The following Working Group members participated: Anna Krylova, Chair (NM); Miriam Fisk, Vice Chair (TX); Susan Andrews and Qing He (CT); David Christhilf (DC); Judy Mottar, Chantel Long, and Anthony Bredel (IL); Sandra Darby (ME); Gordon Hay (NE); Tom Botsko (OH); and Kevin Clark and James DiSanto (PA). Also participating was: Kevin Dyke (MI).

1. Discussed Reviews of 2020 SAO

The Working Group discussed financial reviews of insurance companies’ Statements of Actuarial Opinion (SAO). Mr. Botsko said he had more than the average number of newly appointed actuaries. He said the new actuaries complied with the requirements and wrote good opinions with one exception. Ms. Fisk said this is the first year for more specific attestation and that a handful of actuaries in Texas did not provide the correct attestation. Ms. Andrews said some did not correctly attest on the Casualty Actuarial Society (CAS) website to meet both general and specific qualification standards. Mr. Hay said he had two actuaries who used language to address submission of documents to the Board of Directors. He suggested improving the SAO instructions, but the Working Group noted that the opportunity to change 2022 instructions has passed. Ms. Krylova said more guidance could be added to the 2021 Regulatory Guidance on Property and Casualty Statutory Statements of Actuarial Opinion (Regulatory Guidance).

Michelle Iarkowski (American Academy of Actuaries—Academy) said there is no deadline for providing the qualification documentation, so one could issue the opinion without having completed the documentation and/or submitted the documentation to the Board. Some actuaries provide it to the Audit Committee in March or April after the opinion is issued. Ms. Andrews questioned whether the document should be delivered to the Board before an opinion is issued. Mr. Hay said the qualification documents do not have to be with the Board when the Board makes its decision about continued appointment of the appointed actuary. Ms. Andrews said new actuaries must submit the document before initially appointed, so the issue occurs only with renewals. Ms. Andrews said the Board’s governance responsibilities are to annually evaluate the qualifications of the appointed actuary. Mr. DiSanto said it gets complicated because in Pennsylvania, a Board is not required to reappoint an actuary each year; once appointed, the actuary remains until specifically unappointed. Mr. Dyke said it seems there are two separate issues: 1) whether the documentation is not being included in work papers; and 2) whether the Board is reviewing the documentation. Ms. Krylova said it seems there is consensus to consider setting a deadline for submission of qualification documentation to the Board. She said the Working Group would need to consider qualification standards allowing an actuary to document how continuing education (CE) will be completed by the end of March when writing the SAO.

2. Discussed Issues with Schedule P Reconciliation

Mr. Botsko said some opining actuaries did not follow the annual statement instructions about Schedule P reconciliation. For example, when pool percentages change, the actuary reconciled on a total basis versus by company by line. The actuary applied materiality for the reason to conduct the reconciliation on a total basis. Ms. Iarkowski said another reconciliation issue is some consulting actuaries have been reconciling to Schedule P based on the data provided to the actuary rather than the final actuarial exhibits. Mr. Hay said the actuary sometimes does not provide information such as who did the reconciliation and additional information. He has asked the actuary to be more specific, but the actuary has not done that. Mr. Dyke said some actuaries might be conflating the reliance on data requirement and the separate issue of Schedule P reconciliation. He said the Schedule P reconciliation is a higher bar. Ms. Andrews suggested the Working Group consider requiring documentation of who performed the Schedule P reconciliation. The Working Group agreed the problem is mostly a compliance issue, and they can consider additional guidance this year.

3. Discussed 2021 Regulatory Guidance

Ms. Krylova said the CAS Board rescinded its multiple Statements of Principles. The CAS Board subsequently decided to reinstate the Statement of Principles on Ratemaking with the caveat that it is for reference for U.S. regulated ratemaking. The SAO instructions mention the group of Statements of Principles. The Statement of Principles on Reserving was not reinstated. Ms. Krylova wondered if the caveat should be mentioned in the instructions even though it is a header and not part of the title. Mr. Dyke said the reason for reference to the Statements of Principles seems to be about the development of reserves using...
“accepted” principles. The Statement of Principles on Reserving was not reinstated. The Working Group might need to make revisions.

Ms. Iarkowski asked whether state insurance regulators want the qualification documentation submitted to all companies in a group that use one appointed actuary. Ms. Andrews said the state insurance regulators have to review the companies in their state. The companies in a group can be domiciled in different states. Mr. Blanchard said it would seem the Board of the holding company should be involved rather than the individual entities where the Boards can be made up of senior management. Ms. Andrews said the financial review process does not have the appointed actuary analysis at a group level. Ms. Iarkowski said guidance would be helpful.

Having no further business, the Actuarial Opinion (C) Working Group adjourned.
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

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<td>EMAIL ADDRESS: <a href="mailto:birny@cej-online.org">birny@cej-online.org</a></td>
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<td>ON BEHALF OF: Center for Economic Justice</td>
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<tr>
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<td>TITLE: Director</td>
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FOR NAIC USE ONLY

Agenda Item #: 2021-11BWG
Year 2022
Changes to Existing Reporting [ X ]
New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT
No Impact [ X ]
Modifies Required Disclosure [ ]

DISPOSITION
[ ] Rejected For Public Comment
[ X ] Referred To Another NAIC Group
CASTF, FAWG and FAST
[ ] Received For Public Comment
[ ] Adopted Date
[ ] Rejected Date
[ X ] Deferred Date 07/22/2021
[ ] Other (Specify)

BLANK(S) TO WHICH PROPOSAL APPLIES

[X ] ANNUAL STATEMENT  [X ] INSTRUCTIONS  [X ] CROSSCHECKS
[X ] QUARTERLY STATEMENT  [X ] BLANK

[ ] Life, Accident & Health/Fraternal
[ ] Separate Accounts
[ ] Title

[X ] Property/Casualty
[ ] Protected Cell
[ ] Other ___________________

[ ] Health
[ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2022

IDENTIFICATION OF ITEM(S) TO CHANGE

Add a new annual statement supplement to capture exposure data for Annual Statement Lines 4, 19.1, 19.2 and 21.2. Add a column to the Quarterly Parts 1 and 2 to capture exposure data for these annual statement lines for the quarter.

***See Next Page For More Details***

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE

***See Next Page For Details***

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

** This section must be completed on all forms. Revised 7/18/2018

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2021-11BWG (revised).doc
IDENTIFICATION OF ITEM(S) TO CHANGE

Add a new annual statement supplement to the Property and Casualty annual statement to capture “Direct Exposures Written” and “Direct Exposures Earned” which will be reported, initially only for Annual Statement Lines 4 (Homeowners), 19.1 (PPA No Fault), 19.2 (PPA Liability) and 21.1 (PPA Physical Damage).

Add one column to property casualty quarterly statement Part 1 Loss experience between current columns 1 and 2 for “Direct Exposures Earned” only for only for Lines 4 (Homeowners), 19.1 (PPA No Fault), 19.2 (PPA Liability) and 21.1 (PPA Physical Damage).

Add one column to property casualty quarterly statement Part 2 Direct Premium Written between current columns 1 and 2 for “Direct Exposures Written” only for only for Lines 4 (Homeowners), 19.1 (PPA No Fault), 19.2 (PPA Liability) and 21.1 (PPA Physical Damage).

Add instructions for reporting the additional data elements, consisting of definitions and examples for the new data elements.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The average written and average earned premium per exposure is an important metric for a variety of regulatory and public policy purposes. The NAIC annually produces reports of average personal auto and homeowners premiums, but the data in these reports are old and stale for timely assessment of absolute average premium and changes in average premium over time. Both reports are typically produced 24 months after the end of the experience period and 36 months after the beginning of the experience period. Homeowners average premiums for 2018 was published in January 2021 in the “Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owners’ Insurance Report: Data for 2018.” Personal auto average premiums for 2018 was published in March 2021 in the “Auto Database Report.” While there are valid reasons for the length of time needed to produce these reports – primarily because these reports contain information beyond average premium – the average premium numbers lose significant relevance because of their age.

This AS and QS Blanks proposals would allow the calculation of average written and average earned premium for residential property and personal auto coverages in a far more timely fashion – within three to four months following the reporting year instead of 24 months and would provide timely and useful quarterly information. The benefits of timelier average premium data are considerable. Timely average premium data would permit financial analysts to utilize changes in average premium as part of financial analysis. Similarly, the more-timely average premium data would become a valuable tool for market regulation analysts, including, but not limited to, an added data point for use with the Market Conduct Annual Statement. Last, but not least, this proposal would allow the NAIC to calculate and publish average annual premium data for residential property and personal auto insurance by state in a time frame to both make the data meaningful for describing market conditions and to inform individual state regulators and policymakers of actual changes in personal lines average premiums – as opposed to expected changes gleaned from rate filings.

Consider how valuable timely average premium values would have been for personal lines as the pandemic unfolded. Consider also the value of quarterly data for average premium for personal lines versus only an annual average. The lack of timeliness of the average premium values means that these data have very limited or no use for either financial or market analysis. The lack of timeliness also means that the data are no use in informing public policy debates about personal lines insurance costs. In addition, the severe time lag between actual experience and reporting fails to inform the public or policymakers of recent trends or outcomes and can, consequently, mislead the public and policymakers.
ANNUAL STATEMENT INSTRUCTIONS – PROPERTY

DIRECT PREMIUM AND EXPOSURES
Annual Statement Lines 2.5, 4, 19.1, 19.2 and 21.1
Allocated by States and Territories

This supplement must be filed with the NAIC by March 1 each year.

This supplement should be completed by those reporting entities that write direct business reported on the Exhibit of Premiums and Losses for each Annual Statement Lines (ASL) listed below. A separate page will be completed for each ASL.

ASL 4 (Homeowners)
- Excluding Renters, Condominiums and Co-ops
- Renters, Condominiums and Co-ops

ASL 19.1 (Private Passenger Auto No-Fault – Personal Injury Protection)

ASL 19.2 (Other Private Passenger Auto Liability)

ASL 21.1 (Private Passenger Auto Physical Damage)

Column 1 – Direct Premiums Written

The amounts reported for each line should agree with the amounts reported for the corresponding Annual Statement Line in Column 1, Line 35 of the Exhibit of Premiums and Losses for that state.

- Line 59 (Part 1 plus Part 2) should equal Line 4, Column 1, Line 35 of the Exhibit of Premiums and Losses (GT Page)
- Line 59 (Part 3) should equal Line 19.1, Column 1, Line 35 of the Exhibit of Premiums and Losses (GT Page)
- Line 59 (Part 4) should equal Line 19.2, Column 1, Line 35 of the Exhibit of Premiums and Losses (GT Page)
- Line 59 (Part 5) should equal Line 21.1, Column 1, Line 35 of the Exhibit of Premiums and Losses (GT Page)

Column 2 – Direct Written Exposures

A Written Exposure for Annual Statement Lines 4 is defined as a single residential property for which coverage was written at any time during the calendar reporting period and remained in force through the end of the calendar reporting year. If the coverage was written and cancelled within the calendar reporting year, the written exposure is the fraction of the year the coverage was in force.

A Written exposure for Annual Statement Lines 19.1, 19.2 and 21.1 is defined as single motor vehicle for which coverage was written at any time during the calendar reporting year and remained in force through the end of the calendar reporting year. If the coverage was written and cancelled within the calendar reporting year, the written exposure is the fraction of the year the coverage was in force.
Examples. Assume a homeowners policy is written on July 1 during the reporting year and remains in force through the end of the reporting year. This activity would be reported as one (1.0) written exposure.

Assume a private passenger policy with No-Fault, Liability and Physical Damage coverages was written on April 1 and cancelled by the insured on July 1. This activity would be reported as 0.25 written exposure.

Column 3 – Direct Premiums Earned

The amounts reported for each line should agree with the amounts reported for the corresponding Annual Statement Line in Column 2, Line 35 of the Exhibit of Premiums and Losses for each state.

Line 59 (Part 1 plus Part 2) should equal Line 4, Column 2, Line 35 of the Exhibit of Premiums and Losses (GT Page)

Line 59 (Part 3) should equal Line 19.1, Column 2, Line 35 of the Exhibit of Premiums and Losses (GT Page)

Line 59 (Part 4) should equal Line 19.2, Column 2, Line 35 of the Exhibit of Premiums and Losses (GT Page)

Line 59 (Part 5) should equal Line 21.1, Column 2, Line 35 of the Exhibit of Premiums and Losses (GT Page)

Column 4 – Direct Earned Exposures

An Earned Exposure for Annual Statement Lines 4 is defined as the fraction of the calendar reporting year for which a single residential property had coverage in force.

An Earned Exposure for Annual Statement Lines 19.1, 19.2 and 21.2 is defined as the fraction of the calendar reporting year for which a single motor vehicle had coverage in force.

Examples. Assume a homeowners policy is written on July 1 during the reporting year and remains in force through the end of the reporting year. This activity would be reported as 0.5 earned exposure.

Assume a private passenger policy with No-Fault, Liability and Physical Damage coverages was written on April 1 and cancelled by the insured on July 1. This activity would be reported as 0.25 earned exposure.
**QUARTERLY STATEMENT INSTRUCTIONS – PROPERTY**

**PART 1 – LOSS EXPERIENCE**

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Direct Premiums Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Display direct premiums earned by line of business. The total must agree with the Statement of Income Page 4, Direct Premiums Earned Line 1.1, Column 1.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 2</th>
<th>Direct Earned Exposures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>An Earned Exposure for Annual Statement Lines 4 is defined as the fraction of the calendar reporting year for which a single residential property had coverage in force.</td>
</tr>
<tr>
<td></td>
<td>An Earned Exposure for Annual Statement Lines 19.1, 19.2 and 21.2 is defined as the fraction of the calendar reporting year for which a single motor vehicle had coverage in force.</td>
</tr>
<tr>
<td></td>
<td>Examples. Assume a homeowners policy is written on July 1 during the reporting year and remains in force through the end of the reporting year. This activity would be reported as 0.5 earned exposure.</td>
</tr>
<tr>
<td></td>
<td>Assume a private passenger policy with No-Fault, Liability and Physical Damage coverages was written on April 1 and cancelled by the insured on July 1. This activity would be reported as 0.25 earned exposure.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 23</th>
<th>Direct Losses Incurred</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Display direct losses incurred by line of business. The total must agree with the Statement of Income Page 4, Direct Losses Incurred Line 2.1, Column 1.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 34</th>
<th>Direct Loss Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Column 23 (Direct Losses Incurred)/Column 1 (Direct Premiums Earned) multiplied by 100.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 45</th>
<th>Prior Year to Date Direct Loss Percentage</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Display year-to-date direct loss percentages by line of business for the same quarter of the prior year.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Line 30</th>
<th>Warranty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data for this line should be reported prospectively (i.e., Prior year amounts need not be restated) starting with the 2008 reporting year.</td>
</tr>
</tbody>
</table>
### PART 2 – DIRECT PREMIUMS WRITTEN

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Current Quarter</th>
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<tbody>
<tr>
<td></td>
<td>Display current quarter direct premiums written by line of business.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 2</th>
<th>Direct Written Exposures</th>
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<td></td>
<td>A Written Exposure for Annual Statement Lines 4 is defined as a single residential property for which coverage was written at any time during the calendar reporting period and remained in force through the end of the calendar reporting year. If the coverage was written and cancelled within the calendar reporting year, the written exposure is the fraction of the year the coverage was in force.</td>
</tr>
<tr>
<td></td>
<td>A Written exposure for Annual Statement Lines 19.1, 19.2 and 21.1 is defined as single motor vehicle for which coverage was written at any time during the calendar reporting year and remained in force through the end of the calendar reporting year. If the coverage was written and cancelled within the calendar reporting year, the written exposure is the fraction of the year the coverage was in force.</td>
</tr>
</tbody>
</table>

**Examples.** Assume a homeowners policy is written on July 1 during the reporting year and remains in force through the end of the reporting year. This activity would be reported as one (1.0) written exposure.

Assume a private passenger policy with No-Fault, Liability and Physical Damage coverages was written on April 1 and cancelled by the insured on July 1. This activity would be reported as 0.25 written exposure.

<table>
<thead>
<tr>
<th>Column 33</th>
<th>Current Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Display year-to-date direct premiums written.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 34</th>
<th>Prior Year, Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Display year-to-date direct premiums written from the same quarter of the prior year.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Line 30</th>
<th>Warranty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data for this line should be reported prospectively (i.e., Prior year amounts need not be restated) starting with the 2008 reporting year.</td>
</tr>
</tbody>
</table>
## ANNUAL STATEMENT BLANK – PROPERTY

### DIRECT PREMIUM AND EXPOSURES

**Allocated by States and Territories**

For The Year Ended December 31, 2020

(To Be Filed by March 1)

### Part 1 – Homeowners (Excluding Renters, Condominiums and Co-ops)

#### Annual Statement Line 4

<table>
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<tr>
<th></th>
<th>Direct Premiums Written</th>
<th>Direct Exposures Written</th>
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2021-11BWG (revised).doc
### Part 2 – Homeowners (Renters, Condominiums and Co-ops)  
**Annual Statement Line 4**

<table>
<thead>
<tr>
<th>State or District</th>
<th>1 Direct Premiums Written</th>
<th>2 Direct Exposures Written</th>
<th>3 Direct Premiums Earned</th>
<th>4 Direct Exposures Earned</th>
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<tbody>
<tr>
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### SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a “NONE” report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason, enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

#### MARCH FILING

1. Will an actuarial opinion be filed by March 1?

2. Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?

3. Will the confidential Risk-based Capital Report be filed with the NAIC by March 1?

4. Will the confidential Risk-based Capital Report be filed with the state of domicile, if required, by March 1?

#### APRIL FILING

5. Will the Insurance Expense Exhibit be filed with the state of domicile and the NAIC by April 1?

6. Will Management’s Discussion and Analysis be filed by April 1?

7. Will the Supplemental Investment Risks Interrogatories be filed by April 1?

#### MAY FILING

8. Will this company be included in a combined annual statement that is filed with the NAIC by May 1?

#### JUNE FILING

9. Will an audited financial report be filed by June 1?

10. Will Accountants Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1?

#### MAY FILING

11. Will the Reinsurance Summary Supplemental Filing for General Interrogatory 9 be filed with the state of domicile and the NAIC by March 1?

12. Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1?

13. Will the Trusteed Surplus Statement be filed with the state of domicile and the NAIC by March 1?

14. Will the Reinsurance Attestation Supplement be filed with the state of domicile and the NAIC by March 1?

15. Will an approval from the reporting entity’s state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1?

16. Will the Direct Premium and Exposures Supplement be filed with the NAIC by March 1?

#### JUNE FILING

17. Will the Trusteed Surplus Statement be filed with the state of domicile and the NAIC by March 1?

18. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC by March 1?

19. Will the confidential Actuarial Opinion Summary be filed with the state of domicile, if required, by March 15 (or the date otherwise specified)?

20. Will the Reinsurance Attestation Supplement be filed with the state of domicile and the NAIC by March 1?

21. Will the Reinsurance Attestation Supplement be filed with the state of domicile and the NAIC by March 1?

22. Will the Bond Supplement be filed with the state of domicile and the NAIC by March 1?

23. Will the Director and Officer Insurance Coverage Supplement be filed with the state of domicile and the NAIC by March 1?

24. Will an approval from the reporting entity’s state of domicile for relief related to the five-year rotation requirement for lead audit partner be filed electronically with the NAIC by March 1?

25. Will an approval from the reporting entity’s state of domicile for relief related to the one-year cooling off period for independent CPA be filed electronically with the NAIC by March 1?

26. Will an approval from the reporting entity’s state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1?

27. Will the Direct Premium and Exposures Supplement be filed with the NAIC by March 1?

#### AUGUST FILING

28. Will the Credit Insurance Experience Exhibit be filed with the state of domicile and the NAIC by April 1?

29. Will the Long-term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?

30. Will the Accident and Health Policy Experience Exhibit be filed by April 1?

31. Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?

32. Will the regulator-only (non-public) Supplemental Health Care Exhibit’s Allocation Report be filed with the state of domicile and the NAIC by April 1?

33. Will the Cybersecurity and Identity Theft Insurance Coverage Supplement be filed with the state of domicile and the NAIC by April 1?

34. Will the Life, Health & Annuity Guaranty Association Assessable Premium Exhibit – Parts 1 and 2 be filed with the state of domicile and the NAIC by April 1?

35. Will the Private Flood Insurance Supplement be filed with the state of domicile and the NAIC by April 1?

#### EXPLANATION:

If the supplement is required of your company but is not being filed for whatever reason, enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

---

**Bar Code:**

---
## QUARTERLY STATEMENT BLANK – PROPERTY

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2021-11BWG (revised).doc
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2021 Individual Grants Competition

- Modeling claims reserving on Individual data
  by Gian Paolo Clemente, Gabriele Pittarello and Diego Zappa
- Assessing cyber risk via network theory
  by Alessandra Cornaro and G.P. Clemente
- Applications of Gaussian Process Regression Models in Claims Reserving
  by Marco De Virgilis and Giulio Ercole Carnevale
- Compositional Data Regression in Insurance with Exponential Family PCA
  by Guojun Gan and Emiliano A. Valdez
- NLP and other AI Techniques for Applications in Actuarial Science
  by Dr. Don Hong, Vajira A Manathunga, Qiang Wu, and Lu Xiong
- Matrix Variate Distributions as a Tool for Insurers and their Application to Natural Hazard Loss Modeling
  by Petar Jevtic and Luca Regis
- Pandemic, Infection Disease Models and Insurance Applications
  by Runhuan Feng and Sooie-Hoe Loke;
- Statistical Modeling of Data Breach Risks: Time to Identification and Notification
  by Maochao Xu, PhD.;
- A conformal prediction credibility interval
  by Liang Hong with the SOA.
Recent and Future PE Events

- R Bootcamp
- Python workshop
- Casualty Loss Reserve Seminar
- CAS International Seminar: New Thinking for Pricing
  Climate Risk
- CAS International Seminar: On Insurability and Transfer of
  Pandemic Business Interruption Risk
- 2021 CAS Online Seminar: Bridging the Gap: Technical
  Analysis vs Business Strategy for Tomorrow’s Culturally
  Empowered Actuary

Professional Education

- Hachemeister Prize (2021): AGLM: A Hybrid Modeling Method of GLM and Data Science Techniques
- E-Forum COVID-19 essays
- Disparate Impact
- Social inflation
- New Python package for reserving
- Cannabis research w/CIA
- CASCOR IFRS 17

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Highlights of Recent Research Reports

- **Business Interruption Insurance Compendium**
  - Released May 2021
  - [https://www.soa.org/resources/research-reports/2021/business-interruption-insurance/](https://www.soa.org/resources/research-reports/2021/business-interruption-insurance/)
  - Includes articles, papers, program proposals and legislative notes that provide insight into Business Interruption Insurance and the effects of the coronavirus (COVID-19) pandemic on its current and future state of coverage.

- **Actuarial Weather Extremes**
  - Monthly reports that identifies and examines unusual or extreme single-day or multi-day weather events across North America
  - [https://www.soa.org/resources/research-reports/2019/weather-extremes/](https://www.soa.org/resources/research-reports/2019/weather-extremes/)
  - Special Report on Hurricane Elsa, July 5 - 11

- New Education Offering

- Launch of “Ethical and Responsible Use of Data and Predictive Models” Certificate Program
- Website launching later this week: [www.soa.org/ERUcert](http://www.soa.org/ERUcert)
Figure 2
Total Rainfall Produced by Hurricane Elsa, Ranked Against Historical Data (source: GHCN data)
As the insurance industry works more with big data, artificial intelligence (AI) and predictive analytics, there is a new set of ethical questions to consider. The potential for more decision-making to be in the control of algorithms raises significant new risks to the insurance profession and adds complexity for regulators.

It is important for actuaries, data scientists, regulators and others who work in the insurance industry, to understand ethical and responsible data use and model construction guidelines. These guidelines will provide greater assurance that appropriate procedures are used for data acquisition and manipulation, and also for the building, use and maintenance of predictive models.

The Society of Actuaries (SOA) is deeply committed to the importance of responsible data usage and has created a first-of-its-kind Ethical and Responsible Use of Data and Predictive Models Certificate Program.

Participants should expect an extremely comprehensive and rigorous curriculum where they will learn about ethical and responsible data usage through seven self-guided modules, three instructor-led webinars, and a graded, take-home final assessment. Upon passing the final assessment, participants will receive a certificate recognizing their expertise in the Ethical and Responsible Use of Data and Predictive Models from the SOA.

This course does not assume a knowledge of predictive analytics in particular but does assume a familiarity with financial modeling and working with actuarial data.

**PARTICIPANT PROFILES**

- Actuaries working with big data, AI, and machine learning, and those who are responsible for signing off on model results and for communicating to the C-suite and to regulators
- Data scientists and other professionals working with big data, AI and machine learning models in insurance

**BENEFITS OF THE CERTIFICATE**

- Allows the bearer of the certificate to show that as a data-ethics trained individual, their filing work carries a certain level of assurance that they are following an ethical framework
- Helps ensure actuarial teams and data teams are speaking the same language and operating under the same umbrella of best practices
- Provides assurance for regulators that the individual has a deep understanding of ethical issues and how market and regulatory context affects models
- Helps to mitigate risks associated with the many ethical questions the industry is facing with big data on the frontier of actuarial science
- Offers a framework with ethical criteria to consider when working with predictive models and algorithms
- Provides practical instruction, soft skills integration, and a level of rigor consistent with current SOA credentials

To learn more about this program, visit [soa.org/ERUcert](http://soa.org/ERUcert)
SURPLUS LINES (C) TASK FORCE

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John Meetz (Wholesale & Specialty Insurance Association—WSIA) Comment Letter (Attachment Four) .......... 8-191

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The Surplus Lines (C) Task Force met Aug. 5, 2021. The following Task Force members participated: James J. Donelon, Chair, Stewart Guerin and Tom Travis (LA); Larry D. Deiter, Vice Chair (SD); Ricardo Lara represented by Kim Hudson (CA); Michael Conway represented by Rolf Kaumann (CO); David Altmaier represented by Virginia Christy (FL); Colin M. Hayashida represented by Martha Im (HI); Dean L. Cameron represented by Randy Pipal (ID); Dana Popish Severinghaus represented by Marcy Savage (IL); Troy Downing (MT); Russell Toal (NM); Mike Causey represented by Fred Fuller (NC); Glen Mulready represented by Eli Snowbarger (OK); Jessica K. Altman represented by David Buono (PA); Doug Slape represented by Jamie Walker (TX); Mike Kreidler represented by Jeff Rude (WY).

1. **Adopted its 2020 Fall National Meeting Minutes**

   Mr. Baughman made a motion, seconded by Superintendent Toal, to adopt the Task Force’s Nov. 18, 2020, minutes. The motion passed unanimously.

2. **Adopted its 2022 Proposed Charges**

   Commissioner Donelon stated that the 2022 proposed charges (Attachment One) for the Task Force and Surplus Lines (C) Working Group did not contain any changes compared to the 2021 charges.

   Mr. Kaumann made a motion, seconded by Superintendent Toal, to adopt the Task Force’s 2022 proposed charges. The motion passed unanimously.

3. **Adopted the Report of the Surplus Lines (C) Working Group**

   Mr. Guerin reported that since 2020 the Fall National Meeting, the Surplus Lines (C) Working Group met June 21 and March 2 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings. He indicated that during these meetings, the Working Group discussed four applications seeking approval for listing on the NAIC Quarterly Listing of Alien Insurers, and all four of the applications were approved. Mr. Guerin stated that the Working Group also met July 7 (Attachment Two) to address two administrative tasks. He stated that the Working Group discussed amendments to the NAIC Standard Form - Trust Agreement for Alien Excess or Surplus Lines Insurers and proposed modifications to the NAIC Quarterly Listing of Alien Insurers. Mr. Guerin stated that the Working Group exposed these draft documents for a 30-day public comment period ending Aug. 6.

   Mr. Kaumann made a motion, seconded by Mr. Baughman, to adopt the report of the Surplus Lines (C) Working Group. The motion passed unanimously.

4. **Discussed the Formation of a Drafting Group to Amend Model #870**

   Commissioner Donelon summarized that last summer, he introduced the potential reopening of the Nonadmitted Insurance Model Act (#870) to bring it up to date regarding the implementation of the federal Dodd-Frank Nonadmitted and Reinsurance Reform Act of 2010. As a result, he directed NAIC staff to form a drafting group to study Model #870 and determine if it required modernization. He stated that as a result of that study, a Request for NAIC Model Law Development was drafted and presented to the Task Force and subsequently approved by the Task Force during the Nov. 18 meeting. He indicated that on April 14, 2021, the Request for NAIC Model Law Development was approved by the Executive (EX) Committee. Commissioner Donelon stated that work should begin on the draft amendments to the model. He indicated that Illinois, Louisiana, Texas, and Washington have volunteered to be drafting group members, and he asked for any additional volunteer states. Hearing none, he asked Andy Daleo (NAIC) to begin organizing meetings of the drafting group.

   John Meetz (Wholesale & Specialty Insurance Association—WSIA) stated that he is pleased with the comments within the redlined draft of Model #870 (Attachment Three) and indicated that he submitted a comment letter for consideration (Attachment Four). Bob Woody (American Property Casualty Insurance Association—APCIA) asked if the drafting group...
meetings would be open to interested parties. Commissioner Donelon stated that the drafting group meetings would be held in open session.

Having no further business, the Surplus Lines (C) Task Force adjourned.

W:\National Meetings\2021\Summer\TF\SURL\Draft Minute.docx
SURPLUS LINES (C) TASK FORCE

The mission of the Surplus Lines (C) Task Force is to monitor the surplus lines market and regulation, including the activity and financial condition of U.S. and alien surplus lines insurers by providing a forum for discussion of issues and to develop or amend relevant NAIC model laws, regulations and/or guidelines.

Ongoing Support of NAIC Programs, Products or Services

1. The Surplus Lines (C) Task Force will:
   A. Provide a forum for discussion of current and emerging surplus lines-related issues and topics of public policy and determine appropriate regulatory response and action.
   B. Review and analyze quantitative and qualitative data on U.S. domestic and alien surplus lines industry results and trends.
   C. Monitor federal legislation related to the surplus lines market and ensure all interested parties remain apprised.
   D. Develop or amend relevant NAIC model laws, regulations and/or guidelines.
   E. Oversee the activities of the Surplus Lines (C) Working Group.

2. The Surplus Lines (C) Working Group will:
   A. Operate in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings and operate in open session when discussing surplus lines topics and policy issues, such as amendments to the International Insurers Department (IID) Plan of Operation.
   B. Maintain and draft new guidance within the IID Plan of Operation regarding standards for admittance and continued inclusion on the NAIC Quarterly Listing of Alien Insurers.
   C. Review and consider appropriate decisions regarding applications for admittance to the NAIC Quarterly Listing of Alien Insurers.
   D. Analyze renewal applications of alien surplus lines insurers on the NAIC Quarterly Listing of Alien Insurers and ensure solvency and compliance per the IID Plan of Operation guidelines for continued listing.
   E. Provide a forum for surplus lines-related discussion among jurisdictions.

NAIC Support Staff: Andy Daleo
The Surplus Lines (C) Working Group of the Surplus Lines (C) Task Force met July 7, 2021. The following Working Group members participated: Stewart Guerin, Chair (LA); Eli Snowbarger, Vice Chair (OK); David Phifer (AK); Michelle Lo (CA); Rolf Kaumann (CO); Virginia Christy (FL); Scott Sanders (GA); Marcy Savage (IL); William Leach (NJ); Jose Joseph (NY); Amy Garcia (TX); and Melanie Anderson (WA).

1. Discussed Draft Amendments to the NAIC Standard Form - Trust Agreement for Alien Excess or Surplus Lines Insurers

Andy Daleo (NAIC) summarized the proposed changes to the NAIC Standard Form – Trust Agreement for Alien Excess or Surplus Lines Insurers (Trust). He stated that the proposed changes are meant to be prospective beginning in 2022; therefore, should the amendments be adopted, companies currently on the NAIC Quarterly Listing of Alien Insurers (Listing) are not required to execute an amended Trust. He outlined the following draft amendments to the Trust:

**Article 2.1 – Duration of the Trust**
- The current termination language within Article 2 of the Trust was modified to remove the five-year waiting period as a requirement for termination. The proposed language of the notification of termination remains; however, the five-year period has been amended to a 90-day period if one of the following three criteria is met. First, is an option for an insurer to provide evidence that no outstanding claims or liabilities related to the U.S. business written remains on the books. This option is only available to companies that have not written occurrence policies. The second criterion indicates that the quarterly listed insurer becomes a licensed U.S. domiciled insurer. This criterion has a 60-day notification period. The last criterion states that the insurer can enter into an assumption reinsurance agreement with a U.S. licensed insurer, an accredited reinsurer, or an insurer that is currently on the Listing. Mr. Daleo explained that the proposed amendments to Article 2 are a result of several issues that NAIC staff have addressed regarding insurers that did not or forgot to provide notification to the trustee, which meant the five-year waiting period clock also did not begin. Further, he stated that if quarterly listed companies opt to not amend and replace the Trust, the original Trust language with the five-year waiting period would be required.

**Article 1 - Definitions**
- Qualified U.S. Financial Institution – Amendments were drafted to bring the definition in alignment with the NAIC International Insurers Department (IID) Plan of Operation.
- Readily Marketable Security – Modifications were drafted to align the definition with the Credit for Reinsurance Model Regulation (#786).
- Receiver – The definition was drafted to align with the Insurer Receivership Model Act (#555).

**Article 2.7 – Trust Fund Minimum Amount and Quality**
- The drafted modifications to the California provision included in the materials should be rejected per the California Department of Insurance (DOI), and the original language in the Trust will be exposed.

Thomas M. Dawson (McDermott Will & Emery) questioned the inclusion of the California investment provision in the Trust, which conflicts with the intent that there be one list of alien insurers eligible to write business in the U.S. per the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act). He commented that California can require that insurers listed on the List of Approved Surplus Line Insurers (LASLI) to abide by the investment criteria. However, insurers not listed on the LASLI should not have to abide by California’s investment criteria. Mr. Dawson stated that this could lead to other states requesting that their investment criteria be included in the Trust. Ms. Lo indicated that the California DOI will review Mr. Dawson’s comment and provide a response. Mr. Guerin suggested that Dan Schelp (NAIC) coordinate with California to see if any future changes are warranted. Mr. Dawson also questioned the involvement of the domiciliary commissioner in the termination of the Trust as outlined in Article 2, Section 2.1. He indicated that Article 2, Section 2.14 requires the insurer to provide evidence of no outstanding liability through an actuarial and/or audit report with respect to termination. He stated that it is not the domiciliary commissioner that enters into the active oversight of the termination process. He indicated that the NAIC IID and the trustee address the reporting and analysis of the termination.
Mr. Dawson stated that the last occurrence policies were written in 1986, and he questioned whether it is necessary to include that language in the Trust. He indicated that the professionals could help inform whether there are any liabilities remaining under policies issued by a company.

Andrea T. Best (McDermott Will & Emery) indicated that the new language in Article 2, Section 2.1 removed the option for an assignment agreement, and she questioned if this would prevent the option for Part VII transfers that have been frequent in the United Kingdom (UK). Mr. Daleo and Mr. Guerin had no objections to adding the assignment agreement language back into the Trust.

Mr. Guerin requested the exposure of the draft Trust. Mr. Snowbarger made a motion, seconded by Mr. Joseph, to expose the draft Trust for a 30-day public comment period. The motion passed unanimously.

2. Discussed Proposed Modifications to the Quarterly Listing of Alien Insurers

Bree Wilson (NAIC) summarized proposed changes to the Listing. She stated that the trustee and financial data were added to the Listing in April 2001 and January 2012, respectively. She indicated that providing additional information outside the approved Listing could potentially influence a user to pick one company over another, which is not the intent of the Listing. She outlined the following modifications to the Listing:

- Hyperlinks were added that direct the user to the IID Plan of Operation, the Working Group web page, and the latest Listing.
- The criteria to be admitted to the Listing were removed, given that they are available within the Plan of Operation.
- The Trust and financial information were removed and replaced by contact information to eliminate the need for a separate contact listing.
- The Trustee appendix was removed from the publication, given the recommendation to remove the company specific trustee detail.

Mr. Guerin requested the exposure of the Listing modifications. Ms. Lo made a motion, seconded by Mr. Kaumann, to expose the Listing modification for a 30-day public comment period. The motion passed unanimously.

3. Discussed Other Matters

Mr. Dawson introduced Clark Fitz-Hugh (International Sureties) to speak to the potential of surety bonds as a funding device for surplus lines, and he indicated that this topic has previously been discussed with the Working Group as early as the 90s. Mr. Fitz-Hugh indicated that the reason he is bringing this issue before the Working Group is that many of the insurers that are on the Listing are clients of his, and many of the insurers have asked him to explore this avenue of funding the Trust. He stated that the use of surety bonds would be cheaper, provide less maintenance, and be easier to move assets and monitor. He also said a surety company is in essence a financial institution that is the same as a bank. The wording of a surety bond can be identical to a letter of credit with the same payment terms, conditions, and length of obligation. Mr. Fitz-Hugh also included that a surety bond is regulated by the federal government through the Circular 570 list. Mr. Guerin asked Mr. Fitz-Hugh to put together a packet for the Working Group to add to a future agenda. He also asked Mr. Daleo to refer to the Working Group archives to see what was previously discussed on this topic.

Having no further business, the Surplus Lines (C) Working Group adjourned.
NONADMITTED INSURANCE MODEL ACT

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Section 1. Short Title

This Act shall be known and may be cited as “The Nonadmitted Insurance Act.”

Section 2. Purpose—Necessity for Regulation

This Act shall be liberally construed and applied to promote its underlying purposes which include:

A. Protecting persons seeking insurance in this state;
B. Permitting surplus lines insurance to be placed with reputable and financially sound nonadmitted insurers and exported from this state pursuant to this Act;
C. Establishing a system of regulation which will permit orderly access to surplus lines insurance in this state and encourage admitted insurers to provide new and innovative types of insurance available to consumers in this state;
D. Providing a system through which persons may purchase insurance other than surplus lines insurance, from nonadmitted insurers pursuant to this Act;
E. Protecting revenues of this state; and
F. Providing a system pursuant to this Act which subjects nonadmitted insurance activities in this state to the jurisdiction of the insurance commissioner and state and federal courts in suits by or on behalf of the state.

Section 3. Definitions

As used in this Act:

A. “Admitted insurer” means an insurer licensed to do an insurance business in this state;
B. ________________________________
C. “Commissioner” means the insurance commissioner of [insert name of state], or the commissioner’s deputies or staff, or the Commissioner, Director or Superintendent of Insurance in any other state.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term “commissioner” appears.
D. “Eligible surplus lines insurer” means a nonadmitted insurer with which a surplus lines licensee may place surplus lines insurance pursuant to Section 5 of this Act.

E. “Export” means to place surplus lines insurance with a nonadmitted insurer.

F. “Foreign decree” means any decree or order in equity of a court located in any United States jurisdiction, including a federal court of the United States, against any person engaging in the transaction of insurance in this state.

G. “Insurer” means any person, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, insurance exchange syndicate, fraternal benefit society, and any other legal entity engaged in the business of insurance.

H. “Kind of insurance” means one of the types of insurance required to be reported in the annual statement which must be filed with the commissioner by admitted insurers.

I. “Nonadmitted insurer” means an insurer not licensed to do an insurance business in this state.

J. “Person” means any natural person or other entity, including, but not limited to, individuals, partnerships, associations, trusts or corporations.

K. “Policy” or “contract” means any contract of insurance, including but not limited to annuities, indemnity, medical or hospital service, workers’ compensation, fidelity or suretyship.

L. “Reciprocal state” means a state that has enacted provisions substantially similar to:

(1) Sections 5F, 5I(5), 5Q(10), 5R(4) and Section 6; and

(2) The allocation schedule and reporting form contained in [cite the regulation on surplus lines taxation].

M. “Surplus,” as used in the financial requirements of Section 5, means funds over and above liabilities and capital of the company for the protection of policyholders.

N. “Surplus lines insurance” means any property and casualty insurance in this state on properties, risks or exposures, located or to be performed in this state, permitted to be placed through a surplus lines licensee with a nonadmitted insurer eligible to accept such insurance, pursuant to Section 5 of this Act.

Drafting Note: If a state chooses to adopt the alternative Section 5B, this definition of “surplus lines insurance” should be consistent with the acceptable coverage listed in Section 5B. States may choose to extend the definition of “surplus lines insurance” beyond property/casualty insurance.

O. “Surplus lines licensee” means an individual, firm or corporation licensed under Section 5 of this Act to place insurance on properties, risks or exposures located or to be performed in this state with nonadmitted insurers eligible to accept such insurance.

P. “Transaction of insurance”

(1) For purposes of this Act, any of the following acts in this state effected by mail or otherwise by a nonadmitted insurer or by any person acting with the actual or apparent authority of the insurer, on behalf of the insurer, is deemed to constitute the transaction of an insurance business in or from this state:

(a) The making of or proposing to make, as an insurer, an insurance contract;

(b) The making of or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety.
The taking or receiving of an application for insurance;

The receiving or collection of any premium, commission, membership fees, assessments, dues or other consideration for insurance or any part thereof;

The issuance or delivery in this state of contracts of insurance to residents of this state or to persons authorized to do business in this state;

The solicitation, negotiation, procurement or effectuation of insurance or renewals thereof;

The dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, the fixing of rates or investigation or adjustment of claims or losses or the transaction of matters subsequent to effectuation of the contract and arising out of it, or any other manner of representing or assisting a person or insurer in the transaction of risks with respect to properties, risks or exposures located or to be performed in this state;

The transaction of any kind of insurance business specifically recognized as transacting an insurance business within the meaning of the statutes relating to insurance;

The offering of insurance or the transacting of insurance business;

Offering an agreement or contract which purports to alter, amend or void coverage of an insurance contract.

The provisions of this subsection shall not operate to prohibit employees, officers, directors or partners of a commercial insured from acting in the capacity of an insurance manager or buyer in placing insurance on behalf of the employer, provided that the person’s compensation is not based on buying insurance.

The venue of an act committed by mail is at the point where the matter transmitted by mail is delivered or issued for delivery or takes effect.

Drafting Note: States may need to alter this subsection to reflect their decision as to whether they intend to permit citizens to directly purchase coverage within the state from a nonadmitted insurer, or if self-purchasing of coverage will be permitted only when it occurs outside the state. States electing to allow direct procurement will need to insert an appropriate exemption in Section 4A of this Act. Additionally, states should consider whether the preceding definition of “transaction of insurance” is consistent with other statutory definitions of this phrase in the state. Finally, states may want to consider whether group insurance purchases or the maintenance of insurance books and records in this state should fall within the scope of the definition of “transaction of insurance.”

Q. “Type of insurance” means coverage afforded under the particular policy that is being placed.

R. “Wet marine and transportation insurance” means:

(1) Insurance upon vessels, crafts, hulls and other interests in them or with relation to them;

(2) Insurance of marine builder’s risks, marine war risks and contracts of marine protection and indemnity insurance;

(3) Insurance of freight and disbursements pertaining to a subject of insurance within the scope of this subsection; and

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(4) Insurance of personal property and interests therein, in the course of exportation from or importation into any country, or in the course of transportation coastwise or on inland waters, including transportation by land, water or air from point of origin to final destination, in connection with any and all risks or perils of navigation, transit or transportation, and while being prepared for and while awaiting shipment, and during any incidental delays, transshipment, or reshipment; provided, however, that insurance of personal property and interests therein shall not be considered wet marine and transportation insurance if the property has:

(a) Been transported solely by land; or

(b) Reached its final destination as specified in the bill of lading or other shipping document; or

(c) The insured no longer has an insurable interest in the property.

Comment: The language added in 1994 to the end of the definition of “wet marine and transportation insurance” (Subparagraphs 4(a), 4(b), and 4(c)) is intended to clarify the scope of the definition, which ultimately affects the exemption of certain risks from this Act. The 1994 amendments address current regulatory concerns and concerns raised by those who drafted the 1983 amendments to the Model Surplus Lines Law. The 1983 drafters wrote: “Several [drafters] felt the term ‘storage’ should not appear in... [the wet marine definition] to ensure that warehousemen and other types of insurance covering risks of storage are not interpreted to be within the purview of this definition. The term ‘delays’ is sufficiently broad to cover temporary storage while in the course of transit.”

Drafting Note: In addition to the definitions provided in this section, individual states may wish to consider adopting definitions for “agent,” “broker” or “producer” in a manner consistent with its other laws. Additionally, states may want to cross-reference the definition of “insurance” as it appears elsewhere in the state insurance code. The definition of insurance should reach illegal unauthorized activities.

Section 4. Placement of Insurance Business

A. An insurer shall not engage in the transaction of insurance unless authorized by a license in force pursuant to the laws of this state, or exempted by this Act or otherwise exempted by the insurance laws of this state.

B. A person shall not engage in a transaction of insurance or shall in this state directly or indirectly act as agent for, or otherwise represent or aid on behalf of another, a nonadmitted insurer in the solicitation, negotiation, procurement or effectuation of insurance, or renewals thereof, or forwarding of applications, or delivery of policies or contracts or inspection of risks, or fixing of rates, or investigation or adjustment of claims or losses, or collection or forwarding of premiums, or in any other manner represent or assist the insurer in the transaction of insurance.

C. A person who represents or aids a nonadmitted insurer in violation of this section shall be subject to the penalties set forth in Section 7 of this Act. No insurance contract entered into in violation of this section shall preclude the insured from enforcing his rights under the contract in accordance with the terms and provisions of the contract of insurance and the laws of this state, to the same degree those rights would have been enforceable had the contract been lawfully procured.

D. If the nonadmitted insurer fails to pay a claim or loss within the provisions of the insurance contract and the laws of this state, a person who assisted or in any manner aided directly or indirectly in the procurement of the insurance contract, shall be liable to the insured for the full amount under the provisions of the insurance contract.

E. Section 4B or 4D shall not apply to a person in regard to an insured who independently procures insurance as provided under Section 6. This section shall not apply to a person, properly licensed as an agent or broker in this state who, for a fee and pursuant to a written agreement, is engaged solely to offer to the insured advice, counsel or opinion, or service with respect to the benefits, advantages or disadvantages promised under any proposed or in-force policy of insurance if the person does not, directly or indirectly, participate in the solicitation, negotiation or procurement of insurance on behalf of the insured;

Drafting Note: If a state collects tax on unlicensed transactions which violate this Act, it may consider imposing liability for payment of those taxes on persons who violate this Act by assisting in the procurement of nonadmitted insurance.

Drafting Note: Some states permit other licensed professionals to engage in these activities as provided in their insurance statutes or other state statutes. Those states may want to amend Section 4E to include those professionals, to the extent they act within the scope of their licenses.
F. This section shall not apply to a person acting in material compliance with the insurance laws of this state in the placement of the types of insurance identified in Paragraphs (1), (2), (3) and (4) below:

(1) Surplus lines insurance as provided in Section 5. For the purposes of this subsection, a licensee shall be deemed to be in material compliance with the insurance laws of this state, unless the licensee committed a violation of Section 5 that proximately caused loss to the insured;

(2) Transactions for which a certificate of authority to do business is not required of an insurer under the insurance laws of this state;

Drafting Note: A number of states exempt from licensing and premium taxation nonprofit educational insurers insuring only nonprofit educational institutions and their employees. Some states require certificates of authority while others require licensing, and the appropriate language should be used in Paragraph (2) above. Additionally, some states may want to consider adding language to establish an option of allowing persons to file for an exemption with the Department of Insurance.

(3) Reinsurance provided that, unless the commissioner waives the requirements of this subsection:

(a) The assuming insurer is authorized to do an insurance or reinsurance business by its domiciliary jurisdiction and is authorized to write the type of reinsurance in its domiciliary jurisdiction; and

(b) The assuming insurer satisfies all legal requirements for such reinsurance in the state of domicile of the ceding insurer;

(4) The property and operation of railroads or aircraft engaged in interstate or foreign commerce, wet marine and transportation insurance;

(5) Transactions subsequent to issuance of a policy not covering properties, risks or exposures located, or to be performed in this state at the time of issuance, and lawfully solicited, written or delivered outside this state.

Drafting Note: States may also wish to consider exempting from Section 4A of this Act self-procured insurance or industrial insurance purchased by a sophisticated buyer who does not necessarily require the same regulatory protections as an average insurance buyer. Additionally, some states allow other insurance transactions with nonadmitted insurers. Examples include certain aviation and railroad risks. Other states may want to narrow the scope of the exemptions above or reserve the right to approve exemptions on a case-by-case basis.

Section 5. Surplus Lines Insurance

A. Surplus lines insurance may be placed by a surplus lines licensee if:

(1) Each insurer is an eligible surplus lines insurer; and

(2) Each insurer is authorized to write the type of insurance in its domiciliary jurisdiction; and

(3) The full amount or type of insurance cannot be obtained from insurers who are admitted to do business in this state. The full amount or type of insurance may be procured from eligible surplus lines insurers, provided that a diligent search is made among the insurers who are admitted to transact and are actually writing the particular type of insurance in this state if any are writing it; and

(4) All other requirements of this Act are met.

Drafting Note: States may prefer to reference “kind of insurance” rather than “type of insurance” in Section 5A(3). The term utilized should be defined within the Act.

The diligent search requirement of Section 5A(3) must be satisfied in accordance with the statutes and regulations of the governing state. Such statutes and regulations might vary from state to state in terms of the number of declinations required and the person designated to conduct the search.

Section 5A(3) does not prohibit a regulatory system in which a surplus lines licensee may place with an eligible nonadmitted insurer any coverage listed on a current “export list” maintained by the commissioner. The export list would identify types of insurance for which no admitted market exists. The commissioner may waive the diligent search requirement for any such type of insurance.
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Drafting Note: Utilizing the “full amount” standard in Section 5A(3) of this Act may have certain market implications. An alternative to this approach would be to require that whatever part of the coverage is attainable through the admitted market be placed in the admitted market and only the excess part of the coverage may be exported.

B. Subject to Section 5A(3) of this Act, a surplus lines licensee may place any coverage with a nonadmitted insurer eligible to accept the insurance, unless specifically prohibited by the laws of this state.

[Alternative Subsection B]

B. Subject to Section 5A(3) of this Act, a surplus lines licensee may place only the following types of coverage with a nonadmitted insurer eligible to accept insurance: [list acceptable coverage].

Drafting Note: The two statutory alternatives described in Section 5B represent different regulatory approaches to defining those coverages which may be placed in the nonadmitted market and they would impact the admitted market in different manners.

C. A surplus lines licensee shall not place coverage with a nonadmitted insurer, unless, at the time of placement, the surplus lines licensee has determined that the nonadmitted insurer:

(1) Has established satisfactory evidence of good repute and financial integrity, and

(2) Qualifies under one of the following subparagraphs:

(a) Has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction which equals the greater of:

   (I) The minimum capital and surplus requirements under the law of this state; or

   (II) $15,000,000;

Drafting Note: States that have not previously increased capital and surplus requirements may wish to consider implementation of the capital and surplus requirements in this subparagraph in a series of phases over a period of up to three (3) years. In some circumstances, implementation of a $15,000,000 capital and surplus requirement may represent a dramatic increase over existing requirements. States may wish to allow insurers which are eligible under existing law some period of time to increase their capital and surplus to meet the new standards.

(ii) The requirements of Subparagraph (a)(i) may be satisfied by an insurer’s possessing less than the minimum capital and surplus upon an affirmative finding of acceptability by the commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability and company record and reputation within the industry. In no event shall the commissioner make an affirmative finding of acceptability when the nonadmitted insurer’s capital and surplus is less than $4,500,000; or

D. Insurance procured under this section shall be valid and enforceable as to all parties.

E. Withdrawal of Eligibility as a Surplus Lines Insurer

If at any time the commissioner has reason to believe that a surplus lines insurer:

No longer meets standards set forth in Section 5C of this Act;

Drafting Note: Individual states should consider whether such declarations of uneligibility are appropriate in view of the state’s other due process and administrative procedure requirements.

F. Surplus Lines Tax

(1) In addition to the full amount of gross premiums charged by the insurer for the insurance, every person licensed pursuant to Section 5H of this Act shall collect and pay to the commissioner a sum...
equal to [insert number] percent of the gross premiums charged, less any return premiums, for surplus lines insurance provided by the licensee pursuant to the license. Where the insurance covers properties, risks or exposures located or to be performed both in and out of this state, the sum payable shall be computed on that portion of the gross premiums allocated to this state pursuant to Paragraph (4) of this subsection less the amount of gross premiums allocated to this state and returned to the insured. The tax on any portion of the premium unearned at termination of insurance having been credited by the state to the licensee shall be returned to the policyholder directly by the surplus lines licensee or through the producing broker, if any. The surplus lines licensee is prohibited from rebating, for any reason, any part of the tax.

(2) At the time of filing the [insert monthly, quarterly, annual] report as set forth in Subsection R of this section, each surplus lines licensee shall pay the premium tax due for the policies written during the period covered by the report.
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(4)

Deleted: If a surplus lines policy procured through a surplus lines licensee covers properties, risks or exposures only partially located or to be performed in this state, the tax due shall be computed on the portions of the premiums which are attributable to the properties, risks or exposures located or to be performed in this state. In determining the amount of premiums taxable in this state, all premiums written, procured or received in this state shall be considered written on properties, risks or exposures located or to be performed in this state, except premiums which are properly allocated or apportioned and reported as taxable premiums of a reciprocal state. In no event shall the tax payable to this state be less than the tax due pursuant to Paragraph (4) of this subsection; provided, however, in the event that the amount of tax due under this provision is less than $50 in any jurisdiction, it shall be payable in the jurisdiction in which the affidavit required in Subsection K of this section is filed. The commissioner shall, at least annually furnish to the commissioner of a reciprocal state, as defined in Section 3L, a copy of all filings reporting an allocation of taxes as required by this subsection.

Deleted: Risks or exposures located or to be performed in this state.

In determining the amount of premiums taxable in this state, all premiums written, procured or received in this state shall be considered written on properties, risks or exposures located or to be performed in this state, except premiums which are properly allocated or apportioned and reported as taxable premiums of a reciprocal state. In no event shall the tax payable to this state be less than the tax due pursuant to Paragraph (4) of this subsection; provided, however, in the event that the amount of tax due under this provision is less than $50 in any jurisdiction, it shall be payable in the jurisdiction in which the affidavit required in Subsection K of this section is filed. The commissioner shall, at least annually furnish to the commissioner of a reciprocal state, as defined in Section 3L, a copy of all filings reporting an allocation of taxes as required by this subsection.

Deleted: In determining the amount of gross premiums taxable in this state for a placement of surplus lines insurance covering properties, risks or exposures only partially located or to be performed in this state, the tax due shall be computed on the portions of the premiums which are attributable to properties, risks or exposures located or to be performed in this state and which relates to the kinds of insurance being placed as determined by reference to an allocation schedule duly promulgated in a regulation by the commissioner.

(a) If a policy covers more than one classification:

(i) For any portion of the coverage identified by a classification on the Allocation Schedule, the tax shall be computed by using the Allocation Schedule for the corresponding portion of the premium.

(ii) For any portion of the coverage not identified by (i) above.

Deleted: Drafting Note: Subparagraph (b) above may be included in the Act or in a separate regulation at the option of the state. It is highly recommended that the model Allocation Schedule and reporting form be adopted by regulation in conjunction with the adoption of the above language. In order for the model law to work effectively, the allocation schedules used by the states should be as uniform as possible.
G. Collection of Tax

If the tax owed by a surplus lines licensee under this section has been collected and is not paid within the time prescribed, the same shall be recoverable in a suit brought by the commissioner against the surplus lines licensee and the surety on the bond filed under Subsection H of this section. The commissioner may charge interest at the rate of [insert number] percent per year for the unpaid tax.

H. Surplus Lines Licenses

(1) A person shall not procure a contract of surplus lines insurance with a nonadmitted insurer unless the person possesses a current surplus lines insurance license issued by the commissioner.

(2) The commissioner may issue a surplus lines license to a qualified holder of a current property and casualty agent’s or broker’s or general agent’s license but only when the broker or agent has:

(a) Remitted the [insert amount] annual fee to the commissioner;
(b) Submitted a completed license application on a form supplied by the commissioner;
(c) Passed a qualifying examination approved by the commissioner, except that all holders of a license prior to the effective date of this Act shall be deemed to have passed such an examination;
(d) In the case of a resident agent, filed with the commissioner, and continues to maintain during the term of the license, in force and unimpaired, a bond in favor of this state in the penal sum of [insert amount] aggregate liability, with corporate sureties approved by the commissioner. The bond shall be conditioned that the surplus lines licensee will conduct business in accordance with the provisions of this Act and will promptly remit the taxes as provided by law. No bond shall be terminated unless at least thirty (30) days prior written notice is given to the licensee and commissioner;
(e) If a resident, established and continues to maintain an office in this state; and
(f) Designated the commissioner as agent for service of process, thereby designating the commissioner to be the licensee’s true and lawful attorney upon whom may be served all lawful process in a proceeding instituted by or on behalf of an insured or beneficiary arising out of any contract of insurance, and shall signify its agreement that such service of process is of the same legal force and validity as personal service of process in this state upon the licensee.

(3) A nonresident person shall receive a nonresident surplus lines license if:

(a) The person is currently licensed as a surplus lines licensee and in good standing in his or her home state;
(b) The person has submitted the proper request for licensure and has paid the fees required by [insert appropriate reference to state law or regulation];
(c) The person has submitted or transmitted to the insurance commissioner the application for licensure that the person submitted to his or her home state, or in lieu of the same, a completed Uniform Application; and

Drafting note: Under Public Law No. 106-102 (the “Gramm-Leach-Bliley Act”), it is believed that a requirement for a nonresident agent to file a bond may contravene the reciprocity provisions. The requirement for a resident agent to file a bond would not, seemingly, contravene these provisions, and there may be methodologies whereby such resident bonds could become reciprocal between states. Some states have expressed concern that their bonding requirements constitute important consumer protections, and that elimination of these simply to comply with Gramm-Leach-Bliley may result in unintended consequences, and a lack of control over possibly unscrupulous nonresident agents.
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(d) The person’s home state awards nonresident surplus lines licenses to residents of this state on the same basis.

Drafting Note: In accordance with Public Law No. 106-102 (the “Gramm-Leach-Bliley Act”) states should not require any additional attachments to the Uniform Application or impose any other conditions on applicants that exceed the information requested within the Uniform Application.

(4) The insurance commissioner may verify the person’s licensing status through the Producer Database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

(5) A nonresident surplus lines licensee who moves from one state to another state or a resident surplus lines licensee who moves from this state to another state shall file a change of address and provide certification from the new resident state within thirty (30) days of the change of legal residence. No fee or license application is required.

(6) The insurance commissioner shall waive any requirements for a nonresident surplus lines license applicant with a valid license from his or her home state, except the requirements imposed by this subsection, if the applicant’s home state awards nonresident surplus lines licenses to residents of this state on the same basis.

(7) Each surplus lines license shall expire on [insert date] of each year, and an application for renewal shall be filed before [insert date] of each year upon payment of the annual fee and compliance with other provisions of this section. A surplus lines licensee who fails to apply for renewal of the license before [insert date] shall pay a penalty of $[insert amount] and be subject to penalties provided by law before the license will be renewed.

Drafting Note: States may wish to reference their specific licensing statutes in this section.

Drafting Note: Some states allow surplus lines licensees to hold binding authorities on behalf of eligible surplus lines insurers. States which allow such binding authorities might want to establish minimum standards for the related agreements. In addition, states might want to consider requiring surplus lines licensees with such binding authorities to submit the related agreements to state regulators for review and approval.

I. Suspension, Revocation or Nonrenewal of Surplus Lines Licensee’s License

The commissioner may suspend, revoke or refuse to renew the license of a surplus lines licensee after notice and hearing as provided under the applicable provision of this state’s laws upon one or more of the following grounds:

(1) Removal of the resident surplus lines licensee’s office from this state;

(2) Removal of the resident surplus lines licensee’s office accounts and records from this state during the period during which the accounts and records are required to be maintained under Subsection Q of this section;

(3) Closing of the surplus lines licensee’s office for a period of more than thirty (30) business days, unless permission is granted by the commissioner;

(4) Failure to make and file required reports;

(5) Failure to transmit required tax on surplus lines premiums to this state or a reciprocal state to which a tax is owing;

(6) Failure to maintain required bond;

(7) Violation of any provision of this Act; or

(8) For any cause for which an insurance license could be denied, revoked, suspended or renewal refused under Sections [insert applicable citation].

Commented [Model 87022]: Consider redrafting given the NRRA provision (Section 523) regarding the requirements to participate in NAIC National Producer Database.
J. Actions Against Eligible Surplus Lines Insurers Transacting Surplus Lines Business

(1) An eligible surplus lines insurer may be sued upon a cause of action arising in this state under a surplus lines insurance contract made by it or evidence of insurance issued or delivered by the surplus lines licensee. A policy issued by the eligible surplus lines insurer shall contain a provision stating the substance of this section and designating the person to whom the commissioner shall mail process.

(2) The remedies provided in this section are in addition to any other methods provided by law for service of process upon insurers.

K. Duty to File Evidence of Insurance and Affidavits

Within [insert number] days after the placing of any surplus lines insurance, each producing broker shall execute and each surplus lines licensee shall execute where appropriate, and file a written report regarding the insurance which shall be kept confidential by the commissioner, including the following:

(1) The name and address of the insured;

(2) The identity of the insurer or insurers;

(3) A description of the subject and location of the risk;

(4) The amount of premium charged for the insurance;

(5) Such other pertinent information as the commissioner may reasonably require; and

(6) An affidavit on a standardized form promulgated by the commissioner, as to the diligent efforts to place the coverage with admitted insurers and the results of that effort. The affidavit shall be open to public inspection. The affidavit shall affirm that the insured was expressly advised in writing prior to placement of the insurance that:

(a) The surplus lines insurer with whom the insurance was to be placed is not licensed in this state and is not subject to its supervision; and

(b) In the event of the insolvency of the surplus lines insurer, losses will not be paid by the state insurance guaranty fund.

Drafting Note: Surplus lines licensees will frequently communicate with the insured through a producing broker rather than communicate with the insured directly. In preparing affidavit forms, states may wish to recognize that, as a result of communications passing through the producing broker, the surplus lines licensee may not be in a position to affirm, based upon personal knowledge, that the insured received from the producing broker the written information required by this subsection.

L. Surplus Lines Advisory Organizations

(1) There is hereby created a nonprofit association to be known as the [insert name]. All surplus lines licensees shall be deemed to be members of the association. The association shall perform its functions under the plan of operation established pursuant to Paragraph (3) of this subsection and must exercise its powers through a board of directors established under Paragraph (2) of this subsection. The association shall be supervised by the commissioner. The association shall be authorized and have the duty to:

Drafting Note: The preceding paragraph provides that all surplus lines licensees are “deemed” to be members of the association. Some states, however, may choose not to establish a surplus lines advisory organization; in those states Subsection L would not be necessary.

(a) Receive, record, and subject to Subparagraph (b) of this paragraph, stamp all surplus lines insurance documents which surplus lines brokers are required to file with the association pursuant to the plan of operation;
Drafting Note: Subparagraph (a) of this paragraph authorizes the association to receive, record and stamp all surplus lines documents which must be submitted to the association pursuant to the plan of operation. Documents to be submitted to the association for stamping are likely to vary by state.

(b) Refuse to stamp submitted insurance documents, if the association determines that a nonadmitted insurer does not meet minimum state financial standards of eligibility, or the commissioner orders the association not to stamp insurance documents pursuant to Paragraph (9) of this subsection. The association shall notify the commissioner and provide an explanation for any refusal to stamp submitted insurance documents other than a refusal based upon the order of the commissioner;

(c) Prepare and deliver annually to each licensee and to the commissioner a report regarding surplus lines business. The report shall include a delineation of the classes of business procured during the preceding calendar year, in the form the board of directors prescribes;

(d) Encourage compliance by its members with the surplus lines law of this state and the rules and regulations of the commissioner relative to surplus lines insurance;

(e) Communicate with organizations of agents, brokers and admitted insurers with respect to the proper use of the surplus lines market;

(f) Employ and retain persons as necessary to carry out the duties of the association;

(g) Borrow money as necessary to effect the purposes of the association;

(h) Enter contracts as necessary to effect the purposes of the association; and

(i) Provide such other services to its members as are incidental or related to the purposes of the association.

(2) The association shall function through a board of directors elected by the association members, and officers who shall be elected by the board of directors.

(a) The board of directors of the association shall consist of not less than five (5) nor more than nine (9) persons serving terms as established in the plan of operation. The plan of operation shall provide for the election of a board of directors by the members of the association from its membership. The plan of operation shall fix the manner of voting and may weigh each member’s vote to reflect the annual surplus lines insurance premium written by the member.

(b) The board of directors shall elect officers as provided for in the plan of operation.

(3) The association shall establish a plan of operation. The plan of operation shall provide for the formation, operation and governance of the association. The plan and any amendments shall be effective upon approval by the commissioner, which shall not be unreasonably withheld or delayed. All association members shall comply with the plan of operation or any amendments to it. Failure to comply with the plan of operation or any amendments shall constitute a violation of the insurance law and the commissioner may issue an order requiring discontinuance of the violation.

(4) The association shall file with the commissioner:

(a) A copy of its plan of operation and any amendments to it;

(b) A current list of its members revised at least annually;
(c) The name and address of a resident of this state upon whom notices or orders of the commissioner or processes issued at the direction of the commissioner may be served; and

(d) An agreement that the commissioner may examine the association in accordance with the provisions of Paragraph (5) of this subsection.

(5) The commissioner shall, at least once in [insert number] years, make or cause to be made an examination of the association. The reasonable cost of an examination shall be paid by the association upon presentation to it by the commissioner of a detailed account of each cost. The officers, managers, agents, and employees of the association may be examined at any time, under oath, and shall exhibit all books, records, accounts, documents or agreements governing its method of operation. The commissioner shall furnish a copy of the examination report to the association and shall notify the association that it may request a hearing within thirty (30) days on the report or on any facts or recommendations contained in it. If the commissioner finds the association to be in violation of this section, the commissioner may issue an order requiring the discontinuance of the violation. A director may be removed from the association’s board of directors by the commissioner for cause, stated in writing, after an opportunity has been given to the director to be heard.

(6) There shall be no liability on the part of and no causes of action of any nature shall arise against the association, its directors, officers, agents or employees for any action taken or omitted by them in the performance of their powers and duties under this section, absent gross negligence or willful misconduct.

(7) Within [insert number] days after a surplus lines policy is procured, a licensee shall submit to the association for recording and stamping all documents which surplus lines brokers are required to file with the association. Every insurance document submitted to the association pursuant to this subsection shall set forth:

(a) The name and address of the insured;
(b) The gross premium charged;
(c) The name of the nonadmitted insurer; and
(d) The class of insurance procured.

Drafting Note: The appropriate time limits for submitting documents required for stamping will vary by state.

(8) It shall be unlawful for an insurance agent, broker or surplus lines broker to deliver in this state any insurance document which surplus lines brokers are required to file with the association unless the insurance document is stamped by the association or is exempt from such requirements. However, a licensee’s failure to comply with the requirements of this subsection shall not affect the validity of the coverage.

(9) The services performed by the association shall be funded by a stamping fee assessed for each premium-bearing document submitted to the association. The stamping fee shall be established by the board of directors of the association from time to time. The stamping fee shall be paid by the insured.

(10) The commissioner may declare a nonadmitted insurer ineligible and order the association not to stamp insurance documents issued by the nonadmitted insurer and issue any other appropriate order.
Nonadmitted Insurance Model Act

Evidence of the Insurance and Subsequent Changes to the Insurance

(1) Upon placing surplus lines insurance, the surplus lines licensee shall promptly deliver to the insured or the producing broker the policy, or if the policy is not then available, a certificate as described in Paragraph (4) of this subsection, cover note, binder or other evidence of insurance. The certificate described in Paragraph (4) of this subsection, cover note, binder or other evidence of insurance shall be executed by the surplus lines licensee and shall show the description and location of the subject of the insurance, coverages including any material limitations other than those in standard forms, a general description of the coverages of the insurance, the premium and rate charged and taxes to be collected from the insured, and the name and address of the insured and surplus lines insurer or insurers and proportion of the entire risk assumed by each, and the name of the surplus lines licensee and the licensee’s license number.

(2) A surplus lines licensee shall not issue or deliver any evidence of insurance or purport to insure or represent that insurance will be or has been written by any eligible surplus lines insurer, or a nonadmitted insurer pursuant to Section 5C(4), unless the licensee has authority from the insurer to cause the risk to be insured, or has received information from the insurer in the regular course of business that the insurance has been granted.

(3) If, after delivery of any evidence of insurance, there is any change in the identity of the insurers, or the proportion of the risk assumed by any insurer, or any other material change in coverage as stated in the surplus lines licensee’s original evidence of insurance, or in any other material as to the insurance coverage so evidenced, the surplus lines licensee shall promptly issue and deliver to the insured or the original producing broker an appropriate substitute for, or endorsement of the original document, accurately showing the current status of the coverage and the insurers responsible for the coverage.

(4) As soon as reasonably possible after the placement of the insurance, the surplus lines licensee shall deliver a copy of the policy or, if not available, a certificate of insurance to the insured or producing broker to replace any evidence of insurance previously issued. Each certificate or policy of insurance shall contain or have attached a complete record of all policy insuring agreements, conditions, exclusions, clauses, endorsements or any other material facts that would regularly be included in the policy.

(5) A surplus lines licensee who fails to comply with the requirements of this subsection shall be subject to the penalties provided in this Act.

(6) The surplus lines licensee shall give the following consumer notice to every person applying for insurance with a nonadmitted insurer. The notice shall be printed in 16-point type on a separate document affixed to the application. The applicant shall sign and date a copy of the notice to acknowledge receiving it. The surplus lines licensee shall maintain the signed notice in its file for a period of five (5) years from expiration of the policy. The surplus lines licensee shall tender a copy of the signed notice to the insured at the time of delivery of each policy the licensee transacts with a nonadmitted insurer. The copy shall be a separate document affixed to the policy.

"Notice: 1. An insurer that is not licensed in this state is issuing the insurance policy that you have applied to purchase. These companies are called "nonadmitted" or "surplus lines" insurers. 2. The insurer is not subject to the financial solvency regulation and enforcement that applies to licensed insurers in this state. 3. These insurers generally do not participate in insurance guaranty funds created by state law. These guaranty funds will not pay your claims or protect your assets if the insurer becomes insolvent and is unable to make payments as promised. 4. Some states maintain lists of approved or eligible surplus lines insurers and surplus lines brokers may use only insurers on the lists. Some states issue orders that particular surplus lines insurers can not be used. 5. For additional information about the above matters and about the insurer, you should ask questions of your insurance agent, broker or surplus lines broker. You may also contact your insurance department consumer help line."

Commented [Model 87024]: Revise based on current state requirements.
N. Licensee’s Duty to Notify Insured

(1) No contract of insurance placed by a surplus lines licensee under this Act shall be binding upon the insured and no premium charged shall be due and payable until the surplus lines licensee or the producing broker shall have notified the insured in writing, in a form acceptable to the commissioner, a copy of which shall be maintained by the licensee or the producing broker with the records of the contract and available for possible examination, that:

(a) The insurer with which the licensee places the insurance is not licensed by this state and is not subject to its supervision; and

(b) In the event of the insolvency of the surplus lines insurer, losses will not be paid by the state insurance guaranty fund.

Drafting Note: To ensure the meaningfulness of the notice required by this subsection, the commissioner might want to establish criteria related to readability, type-face and type-size of the notice.

O. Effect of Payment to Surplus Lines Licensee

A payment of premium to a surplus lines licensee acting for a person other than itself in procuring, continuing or renewing any policy of insurance procured under this section shall be deemed to be payment to the insurer, whatever conditions or stipulations may be inserted in the policy or contract notwithstanding.

P. Surplus Lines Licensees May Accept Business from Other Producers

A surplus lines licensee may originate surplus lines insurance or accept such insurance from any other producing broker duly licensed as to the kinds of insurance involved, and the surplus lines licensee may compensate the producing broker for the business.

Q. Records of Surplus Lines Licensee

Each surplus lines licensee shall keep in this state a full and true record of each surplus lines insurance contract placed by or through the licensee, including a copy of the policy, certificate, cover note or other evidence of insurance showing each of the following items applicable:

(1) Amount of the insurance, risks and perils insured;

(2) Brief description of the property insured and its location;

(3) Gross premium charged;

(4) Any return premium paid;

(5) Rate of premium charged upon the several items of property;

(6) Effective date and terms of the contract;

(7) Name and address of the insured;

(8) Name and address of the insurer;
Nonadmitted Insurance Model Act

(9) Amount of tax and other sums to be collected from the insured;

(10) Allocation of taxes by state as referred to in Subsection F of this section; and

(11) Identity of the producing broker, any confirming correspondence from the insurer or its representative, and the application.

The record of each contract shall be kept open at all reasonable times to examination by the commissioner without notice for a period not less than five (5) years following termination of the contract. In lieu of maintaining offices in this state, each nonresident surplus lines licensee shall make available to the commissioner any and all records that the commissioner deems necessary for examination.

Drafting Note: States may wish to extend the five-year period prescribed for open access to insurance records because of the long-term nature of this business.

R. Reports—Summary of Exported Business

On or before the end of the month following each [insert month, quarter, year], each surplus lines licensee shall file with the commissioner, on forms prescribed by the commissioner, a verified report in duplicate of all surplus lines insurance transacted during the preceding period, showing:

(1) Aggregate gross premiums written;

(2) Aggregate return premiums;

(3) Amount of aggregate tax remitted to this state; and

(4) Amount of aggregate tax due or remitted to each other state for which an allocation is made pursuant to Subsection F of this section.

Drafting Note: States desiring to have taxes remitted annually may call for more frequent detailed listing of business.

Section 6. Insurance Independently Procured—Duty to Report and Pay Tax

A. Each insured in this state who procures or continues or renews insurance with a nonadmitted insurer on properties, risks or exposures located or to be performed in whole or in part in this state, other than insurance procured through a surplus lines licensee, shall, within [insert number] days after the date the insurance was so procured, continued or renewed, file a written report with the commissioner, upon forms prescribed by the commissioner, showing the name and address of the insured or insureds, name and address of the insurer, the subject of the insurance, a general description of the coverage, the amount of premium currently charged, and additional pertinent information reasonably requested by the commissioner.

For the purposes of this subsection, properties, risks or exposures only partially located or to be performed in this state, which are covered under a multi-state policy placed by a surplus lines licensee in another state, shall be deemed to be insurance independently procured unless the insurer is an admitted insurer.

Drafting Note: Subsection A may need to be revised in those states exempting from taxation insurance procured by nonprofit educational institutions and their employees, from nonprofit educational insurers.

B. Gross premiums charged for the insurance, less any return premiums, are subject to a tax at the rate of [insert number] percent. At the time of filing the report required in Subsection A of this section, the insured shall pay the tax to the commissioner, who shall transmit the same for distribution as provided in this Act.

Drafting Note: Existing state laws and procedures may require that the tax report be forwarded to another state agency, such as the Department of the Treasury, rather than to the commissioner. In addition, some states may require the tax to be paid on a periodic basis (e.g. annually) rather than at the time of the filing required by Subsection A. Subsections A and B may need to be revised in these states.
C. If an independently procured policy covers properties, risks or exposures only partially located or to be performed in this state, the tax payable shall be computed on the portion of the premium properly attributable to the properties, risks or exposures located or to be performed in this state, as set forth in Sections 5F(3) and 5F(4) of this Act.

D. Delinquent taxes hereunder shall bear interest at the rate of [insert number] percent per year.

E. This section does not abrogate or modify, and shall not be construed or deemed to abrogate or modify any other provision of this Act.

Section 7. Penalties

A. A person who in this state represents or aids a nonadmitted insurer in violation of this Act may be found guilty of a criminal act and subject to a fine not in excess of $[insert amount].

Drafting Note: Some states might want to specify "misdemeanor" or "felony" rather than "criminal act" in Section 7A.

B. In addition to any other penalty provided herein or otherwise provided by law, including any suspension, revocation or refusal to renew a license, any person, firm, association or corporation violating any provision of this Act shall be liable to a civil penalty not exceeding $[insert amount] for the first offense, and not exceeding $[insert amount] for each succeeding offense.

C. The above penalties are not exclusive remedies. Penalties may also be assessed under [insert citation to trade practices and fraud statute] of the insurance code of this state.

Section 8. Violations

Whenever the commissioner believes, from evidence satisfactory to him or her, that a person is violating or about to violate the provisions of this Act, the commissioner may cause a complaint to be filed in the [insert appropriate court] Court for restitution and to enjoin and restrain the person from continuing the violation or engaging in or doing any act in furtherance thereof. The court shall have jurisdiction of the proceeding and shall have the power to make and enter an order of judgment awarding such preliminary or final injunctive relief and restitution as in its judgment is proper.

Section 9. Service of Process

A. Any act of transacting insurance by an unauthorized person or a nonadmitted insurer is equivalent to and shall constitute an irrevocable appointment by the unauthorized person or insurer, binding upon it, its executor or administrator, or successor in interest of the [insert title of appropriate state official] or his or her successor in office, to be the true and lawful attorney of the unauthorized person or insurer upon whom may be served all lawful process in any action, suit or proceeding in any court by the commissioner or by the state and upon whom may be served any notice, order, pleading or process in any proceeding before the commissioner and which arises out of transacting insurance in this state by the unauthorized person or insurer. Any act of transacting insurance in this state by a nonadmitted insurer shall signify its acceptance of its agreement that any lawful process in such court action, suit or proceeding and any notice, order, pleading or process in such administrative proceeding before the commissioner so served shall be of the same legal force and validity as personal service of process in this state upon the unauthorized person or insurer.

B. Service of process in the action shall be made by delivering to and leaving with the [insert title of appropriate state official] of the fee prescribed by law. Service upon the [insert title of appropriate state official] as attorney shall be service upon the principal.

Drafting Note: Existing state laws and procedures may require that service of process be made upon either the commissioner or another state official.
Nonadmitted Insurance Model Act

C. The [insert title of appropriate state official] shall forward by certified mail one of the copies of the process or notice, order, pleading or process in proceedings before the commissioner to the defendant in the court proceeding or to whom the notice, order, pleading or process in the administrative proceeding is addressed or directed at its last known principal place of business and shall keep a record of all process so served on the commissioner which shall show the day and hour of service. Service is sufficient, provided:

(1) Notice of service and a copy of the court process or the notice, order, pleading or process in the administrative proceeding are sent within ten (10) days by certified mail by the plaintiff or the plaintiff’s attorney in the court proceeding or by the commissioner in the administrative proceeding to the defendant in the court proceeding or to whom the notice, order, pleading or process in the administrative proceeding is addressed or directed at the last known principal place of business of the defendant in the court or administrative proceeding; and

(2) The defendant’s receipt or receipts issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person or insurer to whom the letter is addressed, and an affidavit of the plaintiff or the plaintiff’s attorney in a court proceeding or of the commissioner in an administrative proceeding, showing compliance are filed with the clerk of the court in which the action, suit or proceeding is pending or with the commissioner in administrative proceedings, on or before the date the defendant in the court or administrative proceeding is required to appear or respond, or within such further time as the court or commissioner may allow.

D. A plaintiff shall not be entitled to a judgment or a determination by default in any court or administrative proceeding in which court process or notice, order, pleading or process in proceedings before the commissioner is served under this section until the expiration of forty-five (45) days from the date of filing of the affidavit of compliance.

E. Nothing in this section shall limit or affect the right to serve any process, notice, order or demand upon any person or insurer in any other manner now or hereafter permitted by law.

F. Each nonadmitted insurer assuming insurance in this state, or relative to property, risks or exposures located or to be performed in this state, shall be deemed to have subjected itself to this Act.

G. Notwithstanding conditions or stipulations in the policy or contract, a nonadmitted insurer may be sued upon any cause of action arising in this state, or relative to property, risks or exposures located or to be performed in this state, under any insurance contract made by it.

H. Notwithstanding conditions or stipulations in the policy or contract, a nonadmitted insurer subject to arbitration or other alternative dispute resolution mechanism arising in this state or relative to property, risks or exposures located or to be performed in this state under an insurance contract made by it shall conduct the arbitration or other alternative dispute resolution mechanism in this state.

Drafting Note: Provisions of a state’s constitution, statutes, regulations, and public policy may necessitate amendment of the prior subsection.

I. A policy or contract issued by the nonadmitted insurer or one which is otherwise valid and contains a condition or provision not in compliance with the requirements of this Act is not thereby rendered invalid but shall be construed and applied in accordance with the conditions and provisions which would have applied had the policy or contract been issued or delivered in full compliance with this Act.

Section 10. Legal or Administrative Procedures

A. Before any nonadmitted insurer files or causes to be filed any pleading in any court action, suit or proceeding or in any notice, order, pleading or process in an administrative proceeding before the commissioner instituted against the person or insurer, by services made as provided in this Act, the insurer shall either:
(1) Deposit with the clerk of the court in which the action, suit or proceeding is pending, or with the Commissioner of Insurance in administrative proceedings before the commissioner, cash or securities, or file with the clerk or commissioner a bond with good and sufficient sureties, to be approved by the clerk or commissioner in an amount to be fixed by the court or commissioner sufficient to secure the payment of any final judgment which may be rendered in the action or administrative proceeding; or

(2) Procure a certificate of authority to transact the business of insurance in this state. In considering the application of an insurer for a certificate of authority, for the purposes of this paragraph the commissioner need not assert the provisions of [insert sections of insurance laws relating to retaliation] against the insurer with respect to its application if the commissioner determines that the company would otherwise comply with the requirements for a certificate of authority.

B. The Commissioner of Insurance, in any administrative proceeding in which service is made as provided in this Act, may in the commissioner’s discretion, order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of Subsection A of this section and to defend the action.

C. Nothing in Subsection A of this section shall be construed to prevent a nonadmitted insurer from filing a motion to quash a writ or to set aside service thereof made in the manner provided in this Act, on the ground that the nonadmitted insurer has not done any of the acts enumerated in the pleadings.

D. Nothing in Subsection A of this section shall apply to placements of insurance which were lawful in the state in which the placement took place and which were not unlawful placements under the laws of this state. Without limiting the generality of the foregoing, nothing in Subsection A shall apply to a placement made pursuant to Section 5 of this Act.

Section 11. Enforcement

The commissioner shall have the authority to proceed in the courts of this state or any other United States jurisdiction to enforce an order or decision in any court proceeding or in any administrative proceeding before the commissioner of Insurance.

A. Filing and Status of Foreign Decrees

A copy of a foreign decree authenticated in accordance with the statutes of this state may be filed in the office of the clerk of any [insert proper court] Court of this state. The clerk, upon verifying with the commissioner that the decree or order qualifies as a “foreign decree” shall treat the foreign decree in the same manner as a decree of a [insert proper court] Court of this state. A foreign decree so filed has the same effect and shall be deemed a decree of a [insert proper court] Court of this state, and is subject to the same procedures, defenses and proceedings for reopening, vacating or staying as a decree of a [insert proper court] Court of this state and may be enforced or satisfied in like manner.

B. Notice of Filing

(1) At the time of the filing of the foreign decree, the plaintiff shall make and file with the clerk of the court an affidavit setting forth the name and last known post office address of the defendant.

(2) Promptly upon the filing of the foreign decree and the affidavit, the clerk shall mail notice of the filing of the foreign decree to the defendant at the address given and to the commissioner of this state and shall make a note of the mailing in the docket. In addition, the plaintiff may mail a notice of the filing of the foreign decree to the defendant and to the commissioner of this state and may file proof of mailing with the clerk. Lack of mailing notice of filing by the clerk shall not affect the enforcement proceedings if proof of mailing by the plaintiff has been filed.
Nonadmitted Insurance Model Act

(3) No execution or other process for enforcement of a foreign decree filed hereunder shall issue until thirty (30) days after the date the decree is filed.

Drafting Note: This section presumes that the commissioner has authority to proceed without the cooperation of the state’s attorney general. Governing state laws might require that a person other than the commissioner or the attorney general serve as the plaintiff. The title of that person shall be substituted for “commissioner” or “plaintiff” in Section 11 whenever required by state law.

C. Stay of the Foreign Decree

(1) If the defendant shows the [insert proper court] Court that an appeal from the foreign decree is pending or will be taken, or that a stay of execution has been granted, the court shall stay enforcement of the foreign decree until the appeal is concluded, the time for appeal expires, or the stay of execution expires or is vacated, upon proof that the defendant has furnished the security for the satisfaction of the decree required by the state in which it was rendered.

(2) If the defendant shows the [insert proper court] Court any ground upon which enforcement of a decree of any [insert proper court] Court of this state would be stayed, the court shall stay enforcement of the foreign decree for an appropriate period, upon requiring the same security for satisfaction of the decree which is required in this state.

D. It shall be the policy of this state that the insurance commissioner shall cooperate with regulatory officials in other United States jurisdictions to the greatest degree reasonably practicable in enforcing lawfully issued orders of such other officials subject to public policy and the insurance laws of the state. Without limiting the generality of the foregoing, the commissioner may enforce an order lawfully issued by other officials provided the order does not violate the laws or public policy of this state.

Section 12. Suits by Nonadmitted Insurers

A nonadmitted insurer may not commence or maintain an action in law or equity, including arbitration or any other dispute resolution mechanism, in this state to enforce any right arising out of any insurance transaction except with respect to:

A. Claims under policies lawfully written in this state;
B. Liquidation of assets and liabilities of the insurer (other than collection of new premium), resulting from its former authorized operations in this state;
C. Transactions subsequent to issuance of a policy not covering domestic risks at the time of issuance, and lawfully procured under the laws of the jurisdiction where the transaction took place;
D. Surplus lines insurance placed by a licensee under authority of Section 5 of this Act;
E. Reinsurance placed under the authority of [insert citations of state’s reinsurance intermediary act and other reinsurance laws];
F. The continuation and servicing of life insurance, health insurance policies or annuity contracts remaining in force as to residents of this state where the formerly authorized insurer has withdrawn from the state and is not transacting new insurance in the state;
G. Servicing of policies written by an admitted insurer in a state to which the insured has moved but in which the company does not have a certificate of authority until the term expires;
H. Claims under policies covering wet marine and transportation insurance;
I. Placements of insurance which were lawful in the jurisdiction in which the transaction took place and which were not unlawful placements under the laws of this state.

Drafting Note: Provisions of a state’s constitution, statutes, regulations, and public policy may necessitate amendment of the opening paragraph of this section.

If any provisions of this Act, or the application of the provision to any person or circumstance, shall be held invalid, the remainder of the Act and the application of the provision to persons or circumstances other than those as to which it is held invalid, shall not be affected thereby.

Section 14. Effective Date

This Act shall take effect [insert appropriate date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1994 Proc. 3rd Quarter 14, 16-17, 24, 28-46 (adopted).
1999 Proc. 3rd Quarter 25, 26, 1080, 1135, 1151-1153 (amended).

This model draws from and replaces three earlier NAIC models:

Model Surplus Lines Law

Unauthorized Insurers Model Act

Model Nonadmitted Insurance Act
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November 18, 2020

Commissioner Jim Donelon, Chair  
Director Larry Deiter, Vice Chair  
Surplus Lines (C) Task Force  
National Association of Insurance Commissioners  

Re: Comments on Nonadmitted Insurance Model Act

Dear Commissioner Donelon and Director Deiter:

The Wholesale & Specialty Insurance Association1 (WSIA) appreciates the opportunity to comment on proposed changes to the Nonadmitted Insurance Model Act (#870) which was last amended in 2002, prior to the passage of the federal Nonadmitted and Reinsurance Reform Act (NRRA). While all states have already undertaken legislative and/or administrative changes to implement the provisions of the NRRA, we applaud the Task Force for undertaking the process of updating the model to correspond with NRRA requirements and for looking at additional modernizations to state surplus lines law.

We appreciate and agree with many of the suggestions addressed in the Drafting Group’s findings within Attachment Two of the materials for the November 18, 2020 Surplus Lines Task Force meeting. Many of these are in line with WSIA’s Uniformity and Regulatory Principles that we recently updated in May of 2020 and have provided as Attachment A of this letter. We look forward to discussing these principles with you over the course of the review of Model 870. We will keep our initial comments on these findings brief, knowing that we will have a future opportunity to provide more specific comments and draft language and therefore our intent is to outline some of the key areas we see an opportunity to address through this process.

**Home state taxation principle**

The NRRA provides a consistent, uniform structure for the regulation and taxation of a surplus lines insurance policy, where the insured’s home state is the exclusive jurisdiction to regulate and tax the policy. Surplus lines premium tax should be calculated by taxing 100% of the premium based on the tax rate and rules of the insured’s home state. We believe it is appropriate to revise the model to include the critical NRRA definitions related to

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1 The Wholesale & Specialty Insurance Association (WSIA) is a world-class member service organization representing the entirety of the wholesale, specialty and surplus lines industry. WSIA was formed in 2017 through the merger of the American Association of Managing General Agents (AAMGA) and the National Association of Professional Surplus Lines Offices (NAPSLO). WSIA members strive to build profitable business relationships in the wholesale, specialty and surplus lines insurance industry. WSIA is comprised of approximately 735 member firms, including U.S. Wholesale, U.S. Insurance Market, Associate and Service members, representing tens of thousands of individuals brokers, insurance company professionals, underwriters and insurance professionals worldwide conducting business in the U.S. surplus lines market.
taxation, including affiliate, affiliated group, control and home state and clarify that the home state has sole authority to tax and regulate a surplus lines transaction.

**Insurer eligibility**
Under the NRRA, surplus lines insurers are deemed to be an eligible surplus lines insurer in the insured’s home state when they meet the insurer eligibility provision of the NRRA. We believe it is appropriate to revise the Model Law to remove all extraneous language to avoid confusion and to simply reflect the NRRA’s Uniform Standards for Surplus Lines Eligibility. We would support a drafting note that states may maintain voluntary listings of eligible surplus lines insurers, where the insurer elects to provide additional information beyond the criteria in the NRRA, and conversely, encourage elimination of mandatory eligibility requirements that exceed those contained in the NRRA.

We would also suggest that it is appropriate for the model to include references to Domestic Surplus Lines Insurers (DSLI) status, which is now permitted by 21 states, to promote general clarity and understanding. The eligibility of DSLI’s is the same under the NRRA as carriers without the status but it is may be helpful to include the definition in this model.

**Exempt commercial purchaser**
The NRRA provided a streamlined ability for commercial purchasers to procure surplus lines insurance without meeting diligent search requirements if the insured meets specified qualifications as a sophisticated buyer. We believe it is appropriate that the model include the NRRA definition of exempt commercial purchaser and a provision for the streamlined procurement of surplus lines insurance for these insureds.

**Encourage further modernization**
Several provisions of the current model have been made obsolete through the enhanced uniformity of the NRRA. We encourage revising or adding the following provisions in an effort to further modernize state surplus lines laws:

- **Allocation reporting**
  We agree with the drafting group comment that under home state taxation, allocation of premium for tax purposes is obsolete and we encourage eliminating any such references.

- **Evidence of diligent search**
  We encourage the drafting group to consider amendments to Section 5K that assist in modernizing the reporting process for surplus lines brokers. The term “affidavit” can often imply a notarization requirement and we would request that that term be revised to “signed statement” to more accurately reflect the majority of the requirements. We also encourage a drafting note suggesting states should eliminate notarization requirements for these documents. Additionally we encourage states to consider their revising their requirements for filing evidence of a diligent search in general as several states have recently undertaken. Rather than require individual signed statements for every surplus lines transaction to be filed directly with the department of insurance, we suggest a more streamlined approach that many states have taken which is requiring the surplus lines broker to maintain evidence of a diligent search in their own files, subject to review by the commissioner upon request. We would encourage the group to consider a drafting note that encourages this process.

- **Eliminate zero premium reports**
  We would encourage the group to consider an amendment and/or drafting note regarding the elimination of zero premium reports. Brokers should not be required to report to a state that they have
collected zero dollars in premium during a period they maintain an active surplus lines license. These reports are obsolete because the pre-NRRA system requiring the broker to remit a portion of the tax to each exposure state has now been eliminated.

- **Producer Licensing**
  We support including the NRRA definition and sections referencing surplus lines producer licensing. We are pleased that the Producer Licensing (D) Task Force agreed to undertake work this year to analyze and recommend areas that, in the absence of the National Association of Registered Agents & Brokers (NARAB) becoming operational in the immediate future, there may be ways the states can increase uniformity and efficiencies in this area.

- **Penalties**
  Several states have recently taken legislative action to allow their Commissioner discretion in assessing penalties for certain actions, most notably in late filings. This provides the Commissioner the opportunity to determine if certain fines should be adjusted or waived, whereas in some situations they have no option but to follow mandatory fine schedules. We believe it may be appropriate to consider including model language to allow Commissioner discretion when appropriate.

In general, we think the most critical changes to Model 870 are those that address and incorporate the NRRA. We believe there is an opportunity to also work to further modernize some of the processes that interact with this model, which we outlined in our recent comment letter to the Innovation & Technology (EX) Task Force. As we noted above, WSIA has adopted principles that we believe can serve as guidance for additional uniformity in the regulation of surplus lines and increase the efficiency of the transaction for the consumer, regulator and industry. As the drafting group moves forward with its work, we welcome the opportunity to provide further perspective and support.

Thank you for the opportunity to comment and your consideration of these matters. Please let us know if we can answer any questions.

Sincerely,

Keri A. Kish    John H. Meetz    Brady R. Kelley
Director of Government Relations    State Relations Manager    Executive Director
keri@wsia.org    john@wsia.org    brady@wsia.org
816.799.0855    816.799.0863    816.799.0860
WSIA Regulatory Principles

Adopted May 1, 2020

WSIA believes the below principles are necessary to maintaining an effective and efficient regulatory environment for the wholesale, specialty and surplus lines insurance industry to operate within in order to provide consumers with appropriate insurance solutions.

I. Freedom from Regulation of Surplus Lines Rates and Forms
Freedom from regulation of rates and forms distinguishes the surplus lines market from the admitted market and is the essential element that enables the surplus lines industry to serve the consumer and function as a market for hard to place risks. It should be defended at all times in all states, even for seemingly minor infringements.

II. Deference to Terms Negotiated in Insurance Contracts
Insurance policies should not be retroactively mandated to cover claims that were not originally anticipated as a term of the contract. Legislative and regulatory activity mandating insurance policy interpretation to include specific coverage, regardless of clear wording of the policy, violates well-established constitutional and legal precedent. Any attempt to require insurers to pay for coverage that was never sold or to cover claims never intended when the policy was underwritten and priced, must be firmly opposed.

III. Primacy of Surplus Lines
State based residual market mechanisms should not be given risk placement preference before surplus lines. The sequence of risk placement should be as follows: admitted market > surplus lines market > state based residual market.

IV. The Principle of Export
The principle of export means that surplus lines transactions involve state regulated surplus lines brokers, exporting business to nonadmitted companies not licensed by the state. This principle forms the regulatory framework of the surplus lines market and defines the role of the surplus lines broker in the transaction as the regulated entity. It separates the company from direct, 50 state regulation – including rates and forms and establishes context of the taxation of the transaction.

V. Uniform and Reciprocal Licensing of Surplus Lines Brokers Between the States
A uniform and reciprocal 50 state licensing system for surplus lines brokers is essential to effectively operate within the wholesale, specialty and surplus lines insurance industry. Implementation of the National Association of Registered Agents and Brokers (NARAB) is critical to achieve a 50-state system.

VI. Nonadmitted and Reinsurance Reform Act of 2010 (NRRA)
The Nonadmitted and Reinsurance Reform Act of 2010 (NRRA) provided a foundation for an effective national system based on the home state approach, leading to a modern regulatory framework and improved uniformity. The intent and clear mandates of the NRRA and the resulting uniformity and efficiencies in the regulation of multistate surplus lines transactions must be preserved. Any changes to the original law, at either the state or federal level, that may jeopardize the significant improvements, efficiencies, and uniformity, must be opposed.

VII. State Regulation
WSIA is committed to maintaining the state-based system of insurance regulation because it is the most favorable system for the wholesale, specialty and surplus lines market. The surplus lines marketplace is an essential part of
the national insurance market and operates best in the state-based regulatory system. However, WSIA believes the current state-based system must implement additional uniformity in order to continue to effectively operate in a state-based system. Uniformity among and reciprocity between the states in areas of producer licensing and taxation is critical. The implementation of national standards would improve the efficiency and effectiveness of the state regulatory system; however, no standard, state or federal, should be enacted that curtails, hinders or otherwise prevents the surplus lines market from performing its vital role as a safety-valve and supplemental market for insurance consumers.

VIII. Export Lists and Commercial Lines Deregulation – Automatic Export
State export lists provide states effective and efficient means to regulate the flow of surplus lines business in and out of the state based on the known underwriting appetite of the standard market. All states with diligent effort requirements should utilize Export Lists. In states where transactions involving commercial policyholders have implemented commercial lines deregulation and/or NRRA exempt commercial purchaser laws, risk should automatically qualify for export to the surplus lines market without conducting a diligent search.

IX. Elimination of Carrier/Broker Reconciliation
The NRRA directs the taxation of all surplus lines premium to the home state of the insured where the full amount of tax paid can be directly and effectively audited by the state. States should rely on broker filings, with brokers remitting 100% of the tax to the home state on 100% of the premium for the home state of the insured. Additional auditing and comparisons of broker and carrier information is unnecessary and does not yield appropriate comparisons for purposes of accurate audit results.

X. Federal Regulation
WSIA does not believe that a federal based system of regulation can be effective in the oversight of an industry established to address a state-based system of compensations. Proponents of Optional Federal Charter (OFC) believe that regulation of rates and forms will be eliminated by securing such charters. A system of OFCs would be an unproven regulatory system and wouldn’t provide the best regulatory structure for the wholesale, specialty and surplus lines market and distribution system. If OFCs were to be implemented, it would be essential that the regulatory structure permit a holding company to simultaneously hold federal and state charters so that the insurance could be placed under the regulatory system that offers rates, terms and conditions most consistent with the policyholder’s needs. WSIA is supportive of the role of the Federal Insurance Office (FIO) in studying and overseeing the efficiency and modernization of the system of insurance regulation in the United States; however, we believe any federal policy regarding insurance regulation must continue a course aimed at strengthening state insurance regulation and coordinating the efforts of federal agencies with state regulatory systems. FIO’s federal subpoena authority as it relates to insurance data should be eliminated because federal entities should secure such data through the appropriate state insurance regulator.

XI. Guaranty Fund
Surplus lines guaranty funds are unnecessary for the following reasons:
- They promote false security because the coverage is typically inadequate for commercial lines;
- They promote the use of financially weak companies;
- Potential premium assessments are an unfair burden on surplus lines consumers; and
- The surplus lines marketplace is financially secure and dominated by companies with ratings that average significantly higher than the overall market.
WSIA Guidelines for Uniform State-Based Regulatory Requirements of the Surplus Lines Market

Adopted May 1, 2020

The surplus lines insurance market provides coverages and capacity that are crucial to the national insurance market. With years of sophisticated underwriting experience and highly-stable, proven financial solvency records, the market acts as both a safety-valve and incubator for hard-to-place, unique and emerging risks and ensures these risks are maintained in the private market.

Surplus lines insurance operates most effectively in a state-based system of regulation. As consumers’ needs become more complex, and reliance on the surplus lines market increases, so does the need for efficient and uniform regulation for surplus lines transactions. The Nonadmitted and Reinsurance Reform Act (NRRA) sought to achieve a simpler and more efficient system of regulation and taxation of the industry by establishing the “home state” as the only jurisdiction to regulate and tax surplus lines transactions. State implementation of the following regulatory requirements will maintain the intent of the NRRA and establish a uniform, nationwide approach to the regulation and taxation of the surplus lines industry.

The uniformity brought about by the home state tax approach should be implemented in other regulatory requirements to enhance the already effective system. WSIA members seek to maintain individual state based regulation with nationwide uniform treatment of the following regulatory compliance requirements.

I. Taxation and insurer eligibility in the insured’s home state

The NRRA provides a consistent, uniform structure for the regulation and taxation of a surplus lines insurance policy, where the insured’s home state is the exclusive jurisdiction to regulate and tax the policy. While all states recognize and regulate the surplus lines transaction under the NRRA, not all provisions are uniformly applied.

A. Taxation
   1. Home state of the insured
      Determination of an insured’s home state should be made exclusively as defined in the NRRA for all surplus lines policies. When the insured is a member of an unaffiliated group, the home state should be the state in which the group is domiciled.

   2. Risks located outside of the United States
      Surplus lines premium taxes should only be collected for risks that reside within the United States. A state should exclude any portion of risk that is outside of the U.S. in determination of the amount of surplus lines tax to be collected. If 100% of a U.S. insured’s policy resides outside of the United States, the state should not collect surplus lines premium tax.

   3. Home state tax calculation
      Surplus lines premium tax should be calculated by taxing 100% the premium based on the tax rate and rules of the insured’s home state.
4. **Taxable premium**

States should implement one uniform definition of “premium tax” for determining taxable premium so that surplus lines premium taxes are calculated and treated uniformly. A consistent definition would ensure a more efficient process for consumers, states and the industry.

**B. Insurer Eligibility**

Strong solvency review by domiciliary states for U.S. surplus lines carriers, and by the NAIC International Insurers Department (IID) and its members for non-U.S. surplus lines carriers, is critical to the continued success of the surplus lines marketplace. U.S. domestic and non-U.S. carriers should have the same standard for doing business and demonstrate strong solvency history to support a robust surplus lines industry. All U.S. insureds purchasing surplus lines coverage should feel confident in the strength and solvency of the surplus lines market. Industry and consumers alike benefit from strong carrier solvency.

1. **Eligibility criteria**

Surplus lines insurers should be deemed eligible in any state where they meet the insurer eligibility provision of the NRRA.

2. **Mandatory eligibility criteria and listings**

Mandatory eligibility listings and criteria exceeding those set by the NRRA conflict with the NRRA and should be suspended.

3. **Voluntary eligibility criteria and listings**

States may maintain voluntary listings of eligible surplus lines insurers, where the insurer elects to provide additional information beyond the criteria in the NRRA. States implementing voluntary listings with additional solvency review should be limited to information readily available through the domiciliary state or NAIC database. No additional information beyond data collected for domiciliary state solvency regulation should be required.

**II. Tax payment dates**

A. States should choose an annual, biannual or quarterly requirement for the “due by” date for surplus lines premium tax. The required dates should be limited to four potential dates throughout the year, including the first day of March, June, September or December. States may require estimated quarterly tax payment for three dates and a “true up” or “final” on the fourth date. States should continue to accept payments on a monthly basis and should not limit when a payment can be remitted.

**III. Treatment of surplus lines fees**

A. **Surplus lines broker policy fees**

A surplus lines broker should be allowed to charge a reasonable fee for the placement of a surplus lines policy as recognition for services performed as part of securing a surplus lines policy from a nonadmitted carrier that are unique to the surplus lines transaction. The fee should be made transparent to the consumer.

B. **Surplus lines policy fees taxation**

While we believe surplus lines policy fees are not premium and should not be subject to surplus lines premium tax, states should clearly indicate if taxes are to be applied to surplus lines policy fees.
Attachment A

IV. Elimination of zero premium reporting
   A. Brokers should not be required to report to a state that they have collected zero dollars in premium during a period they maintain an active surplus lines license. These reports are obsolete because the pre-NRRA system requiring the broker to remit a portion of the tax to each exposure state has now been eliminated.

V. Electronic Distribution of Insurance Materials and Payments
   A. States should accept all required reports and filings electronically. In states unable to immediately implement electronic filing, the electronic and hard-copy form should be the same.
   B. States should allow surplus lines premium tax payments through electronic means.
   C. Electronic and digital signatures should be permitted by all states to acknowledge agreement, acceptance and notice for any documentation required of an insurer, producer or insured.
   D. Electronic notification to an insured by an insurer or producer should be permitted by all states.
   E. All states should permit electronic or digital notarization.

VI. Forms
   A. Diligent effort recordings (affidavits)
      If required by a state, a record of diligent effort should be maintained in a surplus lines broker’s file and available to the state upon request or during an audit. It should not be necessary to notarize or file these records with a state.
   B. Premium reports
      States should implement one uniform form and report format for use by all states for purposes of reporting and remitting surplus lines premium tax.

VII. Automatic Export
Implementing uniform processes and procedures and increasing state reliance upon Export Lists is desired. Export lists are an efficient and effective way for risks to enter the surplus lines market but are currently only utilized by 18 states. Commissioners should be made aware when there is not an adequate standard market and s/he should have the ability to designate that risk for automatic export in order to ensure the greatest efficiency for her/his consumers and the overall insurance market. In the absence of Export Lists, statutory declarations for automatic export are desired (e.g., exemption from diligent effort for private flood insurance placements).

VIII. Notice to Insureds
   A. States should require one, uniform notice to surplus lines insureds, in the same font size and color, with the same required information.

   “This insurance policy is permitted to be placed in this state on a nonadmitted basis by an insurer meeting the criteria within [insert insured’s home state surplus lines code section]. The insurer is not licensed in this state and does not participate in the State Guaranty Fund. For additional information about this insurer, contact your insurance general agent, broker or surplus lines broker. You may also contact your insurance department consumer help line.”
TITLE INSURANCE (C) TASK FORCE

Title Insurance (C) Task Force July 13, 2021, Minutes
Title Insurance (C) Task Force June 7, 2021, Minutes (Attachment One)
Title Insurance Consumer Shopping Tool Template Revisions (Attachment Two)
The Title Insurance (C) Task Force met July 13, 2021. The following Task Force members participated: Judith L. French, Chair, represented by Michelle Brugh Rafeld (OH); David Altmaier, Vice Chair, represented by Jeffrey Joseph (FL); Lori K. Wing-Heier represented by Alex Romero (AK); Colin M. Hayashida represented by Paul Yuen (HI); Vicki Schmidt represented by Heather Droge (KS); James J. Donelon represented by Warren Byrd (LA); Kathleen A. Birrane represented by Erica Baily (MD); Grace Arnold represented by Paul Hanson (MN); Chlora Lindley-Myers represented by Carrie Couch (MO); Mike Causey represented by Timothy Johnson (NC); Marlene Caride represented by Randall Currier (NJ); Russell Toal and Mickey VanCuren (NM); Barbara D. Richardson represented by Hermoliva Abejar (NV); Jessica K. Altman represented by Michael McKenney (PA); Larry D. Deiter represented by Maggie Dell (SD); Scott A. White represented by Mike Beavers (VA); and Michael S. Pieciak represented by Kevin Gaffney (VT). Also participating were: Steven Giampaolo (CO); and Stephanie Noren (OR).

1. **Adopted its June 7 Minutes**

   The Task Force met June 7 to expose revisions to the *Title Insurance Consumer Shopping Tool Template* (Shopping Tool) for a public comment period ending July 5.

   Mr. Byrd made a motion, seconded by Mr. Joseph, to adopt the Task Force’s June 7 minutes (Attachment One). The motion passed unanimously.

2. **Adopted Revisions to the *Title Insurance Consumer Shopping Tool Template***

   Ms. Rafeld stated that revisions are specific to the Task Force’s 2021 charge to revise the Shopping Tool to include questions and answers about title insurance-related fraud topics, including but not limited to, closing protection letters (CPLs) and wire fraud. The Shopping Tool with revisions red lined (Attachment Two) was exposed on June 7 for a public comment period ending July 5. No comments on the exposed revisions were received. Ms. Rafeld asked if there are any verbal comments anyone might have but did not have time to submit in a letter.

   Ronald J. Blitenthal (Old Republic) suggested “relaying” be replaced with “claiming” on page 11. Brenda J. Cude (University of Georgia and NAIC Consumer Representative) concurred.

   Mr. Byrd made a motion, seconded by Mr. Johnson, to adopt the Shopping Tool revisions, with the additional edit of replacing “relaying” with “claiming” on page 11. The motion passed unanimously.

3. **Heard a Presentation on Business Email Compromises and Other Cybercrimes**

   Amanda Fritz and Katrina Pistun (Federal Bureau of Investigation—FBI) stated that cyberattacks are becoming more common, and it is really about what we can do to protect ourselves. Back in 2005, mobile phones were not commonplace. Eight years later, almost everyone has a mobile device. Today, just about everything you can think of, from doorbells to thermostats to smart watches, is attached to the internet. All these devices open a larger attack field, placing us in a more vulnerable state. The cybercriminals that are in it for financial gain are the hardest hackers to defend against because they are trusted individuals within a company that usually become disgruntled. Cybercriminals target all business types, including financial organizations (37%); retail (24%); manufacturing, utilities, and transportation (20%); and information and professional services (20%). Cybercrime is expected to cost the world $1 trillion this year. The FBI Internet Crime Complaint Center (IC3) Database received almost 800,000 cybercrime and fraud complaints in 2020, with losses over $4.2 billion. There have been $13.3 billion in losses since 2016, with business email compromises accounting for the largest share of losses. Business email compromise occurs when an email is reporting to be from a known source making a legitimate request but is actually coming from compromised email accounts where the email is being sent by a bad actor. Recent trends include targeting real estate transactions (e.g., title companies, real estate agents, attorneys) and spoof emails; i.e., one small piece of a familiar email address is changed to trick someone. For example, a vendor that regularly interacts with a company sends an invoice, but the bank account number has been modified, tricking the homebuyer receiving the message to wire their down payment. The bad actor will set the emails that are of interest to this particular actor to be auto forwarded to a different email address controlled by the bad actor. Then, they are automatically deleted from the sender’s legitimate inbox, allowing the bad actor to then go
ahead and respond to those emails without the victim having any idea what is going on. Ransomware, a form of malware that
denies the availability of critical data systems by encrypting the data, is a growing threat. The ransom criminal actors’ demand
has increased from hundreds of dollars to millions of dollars. The increase in ransom is due to the added threat of having an
organization’s sensitive data released to the public. To avoid infection, systems should be locked down and backed up often.
Systems can be rebuilt without paying a ransom if the backup data was encrypted. The FBI was able to seize about half of
Colonial Pipeline’s $4.4 million ransom payment. Reports from Microsoft and Google say that multi-factor authentication will
stop nine out of 10 cyberattacks. The victim should, after experiencing business email compromise: 1) immediately notify their
bank and request a recall of the transfer; 2) submit a complaint to the FBI so the IC3 Recovery Asset Team can take action;
and 3) reset passwords, use multi-factor authentication, and review logs. That deals with ransomware, but it denies the
availability of critical data systems by encrypting the data.

Mr. Byrd asked how one could set up multi-factor identification. Ms. Fritz said most email providers have a setting option for
multi-factor identification. For instance, an email or text is sent with another code that must be entered, in addition to the
username and password, before access is granted to the account.

4. Heard from State Insurance Regulators About Title Insurance Fraud Trends

Ms. Rafeld stated that a request was sent out on Jan. 28 to Antifraud (D) Task Force members asking them to share reports of
title insurance fraud and/or mortgage fraud trends in their state. This item relates to the Task Force’s charge to assist the
Antifraud (D) Task Force in combating fraud.

Ms. Noren stated that before Oregon cracked down, it was seeing a rise in fraudulent settlement activity. In one case shortly
before Christmas in 2018, a family purchasing a home received an email they presumed was from their title insurance company
with instructions to wire $123,000. The email address looked exactly like that of its title insurance company. By the time the
consumer figured out it was a scam, the money had been transferred to five different banks and then out of the country. The
title insurance company actually hired the consumer to be a spokesperson for their campaign against cybercrime. The
investigation revealed that the title company’s email was actually clear and had not been hacked. It was likely a personal email
address from someone within the company who was involved in it somehow. The email accounts of the financial services
company were protected, but it appears it came from a cell phone.

Ms. Rafeld stated that Ohio had a similar case approximately two years ago where the consumer’s email had been hacked. The
funds were traced to a bank in Texas where they were frozen and then returned to the consumer.

Ms. Couch stated that Missouri is seeing a downward trend, but a couple months ago it had an incident with a title company
that issued a check to the seller in an in-person closing. By the time the seller tried to deposit the check at the bank, the title
company received an email asking for a stop payment to be put on the check because it had been wired to another account. The
excuse in the email was that they were doing an audit on the seller's bank account. The title company automatically placed the
stop payment and wired the funds without contacting the seller. The seller tried to contact the title company to resolve the
matter when their checks started bouncing. The Department of Insurance (DOI) became involved after the consumer was
unsuccessful with the title company. The title company suffered the loss and had to make the seller whole. In most cases, the
extra step of calling somebody and confirming the requested transaction was not taken. The title company had cyber coverage
but was unable to make a claim, as it had not taken those extra verification steps. There was also an instance where a seller
contacted the DOI from Australia saying he had never received funds from the sale of a piece of property. It appeared that the
email account of the real estate agent that was involved had been hacked, and instructions were included to send money to a
different bank account. Educating agents and closers on the need to be diligent about following up with phone calls is very
important.

Ms. Rafeld stated that she agreed, and she has found that many titles and real estate agents do not use secure email accounts.

Mr. VanCuren stated that $1.2 million has been stolen from consumers in New Mexico. There was $300,000 taken out of New
Mexico from a closing deal in a small town. In another case, an agent in a small county lost thousands of dollars and now has
to sell the company to cover the loss. Another agent incurred substantial costs, getting their systems running again after a
cyberattack.

Mr. Giampaolo stated that Colorado has been concerned with defalcations. In April 2020, the DOI issued advisories on its
website and emailed title insurance underwriters to encourage the offering of CPLs to both buyers and sellers of real estate
transactions. The market has been robust, and defalcations have not been an issue.
Ms. Rafeld stated that even though it is mandated, CPLs are not always offered in Ohio. The proactive steps Colorado took were a good idea, given the high number of home purchases and refinances in the current market.

Having no further business, the Title Insurance (C) Task Force adjourned.

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Title Insurance (C) Task Force
E-Vote
June 7, 2021

The Title Insurance (C) Task Force conducted an e-vote that concluded June 7, 2021. The following Task Force members participated: Judith L. French, Chair, represented by Michelle Brugh Rafeld (OH); David Altmaier, Vice Chair, represented by Anoush Brangaccio (FL); Peni Itula Sapini Teo (AS); Karima M. Woods represented by Angela King (DC); Colin M. Hayashida represented by Martha Im (HI); Vicki Schmidt represented by Heather Droge (KS); James J. Donelon represented by Warren Byrd (LA); Grace Arnold represented by Paul Hanson (MN); Chlora Lindley-Myers represented by Carrie Couch (MO); Troy Downing (MT); Mike Causey represented by Timothy Johnson (NC); Russell Toal represented by Jennifer Catechis (NM); Jessica K. Altman represented by Mark Lersch (PA); and Scott A. White represented by Mike Beavers (VA).

1. Exposed the Proposed Revisions to the Title Insurance Consumer Shopping Tool Template

The Task Force considered exposing revisions to the Title Insurance Consumer Shopping Tool Template. The revisions include questions and answers (Q&As) about title insurance-related fraud topics, including, but not limited to, closing protection letters (CPLs) and wire fraud.

The motion passed, with a majority of the Task Force members voting in favor of exposing revisions to the Title Insurance Consumer Shopping Tool Template for a public comment period ending July 5.

Having no further business, the Title Insurance (C) Task Force adjourned.
How to Buy Title Insurance in [Insert State]

This guide:
- Covers the basics of title insurance.
- Explains the need for title insurance.
- Offers tips to shop for title insurance and closing services.
- Gives you questions you should ask before you buy title insurance.

[Name]          [DOI Logo]
[Superintendent of Insurance]

[DOI Website Address]

Drafting Note: This template has been developed for state departments of insurance who are interested in providing a consumer education publication regarding title insurance. The template was developed as a comprehensive guide that can be edited/personalized to meet the individual needs of a state.
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Disclaimer:

The information included in this publication is meant to serve as a guide and is not a substitute for legal or professional advice. Please contact a professional if you have any questions.
Introduction

A real estate transaction may be one of the largest investments you’ll ever make. Because the decisions you make when you buy or refinance a home can have effects for years to come, it’s important to take time to learn about the process so you can make good decisions.

You may want to hire a licensed professional to help you with the many steps to buy or refinance a home or piece of property. Before you agree to do business with anyone, however, be sure the individual is qualified and licensed.

Buying or Refinancing a Home or Property

So you’re ready to buy or refinance a home or piece of property. Now what?

If you’ve found the perfect home or property and the seller has accepted your offer, the next steps will most likely be:

- You’ll get a loan from a mortgage lender.
- A professional will inspect and appraise the home or property.
- You’ll choose an individual or business, known as a closing agent, to organize and finalize your real estate transaction.
- You’ll choose a “closing date” to sign paperwork and take ownership of your new home.
- You’ll buy homeowners insurance through a licensed property and casualty insurance agent.
- You’ll decide if you need flood and/or earthquake insurance, which you can buy through a licensed property and casualty agent.
- You’ll decide if you’ll need title insurance, which you can buy through a licensed title agent or company.
- A professional may “survey” the property. A survey is a professional drawing of the property’s boundaries. It also shows where a home is located on the property.
- You may be able to buy a home warranty that covers the mechanical breakdown of individual parts of a home, such as the electrical and plumbing systems. A warranty doesn’t cover the home’s structure, may or may not cover appliances, ends at a specific point in time (for example, one year) and has exclusions and limitations that you should review. Home warranties might not be regulated as insurance in your state.
- A final walk through of the home you’re buying will be scheduled.
- You’ll sign legal paperwork to finalize your new loan.

If you’re refinancing your home or property:

- You’ll get a new loan from a mortgage lender.
- A professional may inspect and appraise your home or property.
- You’ll give the lender information about your homeowners, flood and/or earthquake insurance coverage.
- You’ll decide if you need title insurance, which you can buy from a licensed title agent or company.
- A closing date will be selected.
- You’ll sign legal paperwork to finalize your new loan.

When you buy or refinance a home or piece of property, you’ll need to decide whether to buy title insurance.

What is title insurance? Why do you need it? This guide will answer those questions and more.
What is Title Insurance, and What Does it Cover?

A title documents your legal ownership or interest in property.

Title insurance is an insurance policy that covers past title problems that come up after you buy or refinance a property.

Lost, forged or incorrectly filed deeds, property access issues and liens on a property are just a few of the title problems that could come up after you buy or refinance a home or piece of land.

For example, if you received a letter telling you there’s an unpaid mortgage on the property you just bought, you could submit a claim to your title insurance company. The title insurance company would pay the legal costs to settle the dispute and/or to resolve the problem.

Without title insurance, you might have to pay all of the legal costs to settle the dispute. And if you lose the dispute, you could lose money, the equity you have in your home, and possibly ownership.

Two Types of Title Insurance—Owner’s and Lender’s Policies

There are two types of title insurance policies:

- **An Owner’s Policy**
- **A Lender’s Policy**

An owner’s policy protects you for the full price you paid for the home plus legal costs if a past title or ownership issue comes up after you buy your home. An owner’s policy is issued for the amount you paid to buy your home, and the policy will cover you as long as you own an interest in the property. You are not required to purchase an owner’s policy, but if you choose not to, you may lose the money you’ve paid for your home.

If a basic owner’s policy doesn’t cover a specific title issue, often you can add coverage, known as a policy endorsement. For example, if you’re buying a new home and the owner’s policy doesn’t cover claims (often known as a mechanic’s lien), you can add a policy endorsement to ensure you are covered. Some endorsements are free while others can be added for an additional fee.

An enhanced owner’s policy, which has a higher level of coverage than a standard owner’s policy, also may be available in your area. Enhanced owner’s policies cost about 20% more than a standard owner’s policy, but they cover extra risks. An enhanced owner’s policy also may continue to provide coverage after a property has been transferred.

If you borrow money to buy your home or property, your lender is likely to require you to buy a lender’s policy. A lender’s policy only protects the lender if a title or ownership problem comes up after the property is purchased. A lender’s policy is issued for the amount of the mortgage, and the coverage goes down as you pay down your loan. Unlike an owner’s policy, the lender’s policy ends when you pay off your mortgage. You may be expected to pay the premium for a lender’s policy.

Because a lender’s policy only protects the lender from title problems, you’ll also need an owner’s policy if you want to protect yourself.

What Doesn’t Title Insurance Cover?

Title insurance policies do not cover ownership issues that come about after you’ve bought a home.

For example, if your neighbor builds a fence on your property after you’ve bought your home, your title insurance policy will not cover the costs to settle the dispute.
Also, most title insurance policies don’t cover issues such as easements, boundary line disputes, zoning violations and air or mineral rights. 

Your title insurance policy may spell out other issues that won’t be covered. And if there’s a title issue specific to the home you’re buying or refinancing, your title policy may not cover it. Ask for a list of what will and will not be covered, and be sure to read your policy.

Who Sells Title Insurance?

Only licensed title insurance companies, agencies and agents can sell title insurance in [INSERT STATE]. 

Drafting Note: If a state permits other individuals and entities to sell title insurance, this sentence should be amended to include those parties.

You can buy title insurance directly from a title insurance company or a title agent who sells title insurance for a company.

The Right to Choose Your Own Title Agent/Company

You have the right to shop for and choose your provider of title insurance and settlement services.

A good time to shop for title insurance is when you choose a real estate agent, and a lender has prequalified you for a loan. You’ll have an idea of the price you can pay for a home/property and a title insurance agent or company can use that information to estimate your title insurance costs.

There are several ways you can find a title insurance agent or company:

- You can ask the sellers who they used when they bought the home.
- You can check the [INSERT NAME OF DOI] website, [INSERT WEB ADDRESS].
- You can check online for title insurance agents, agencies and companies in your area.
- You can ask for recommendations from your real estate agent, attorney, mortgage lender, financial institution or builder.

If your real estate agent, attorney, builder or lender offers to arrange title insurance for you, or suggests you use a specific title agent or company, ask if they have a business arrangement with the title company or agent they’re recommending and if they’ll make money from the referral. Federal law requires real estate professionals, title agents and lenders to tell you about any business arrangements they may have.

Also, beware of statements such as:

- “Everyone charges the same price.”
- “We’ll give you a discount on something else if you use our title agent.”
- “If you choose another title agent, your purchase may be delayed.”

These types of statements may be used to convince you to give up your right to choose a title agent or company, and you may pay more for title insurance than if you had shopped around.

Who Pays for Title Insurance?

If you’re buying a home, who pays for title insurance depends in part on local custom. It may be something, however, that you can negotiate with the seller of the property. When buying a home, be sure to ask your real estate agent what the custom is in your area and if you’ll likely be the one to pay for title insurance.
If you’re refinancing your home, it’ll be your responsibility to buy and pay for the title insurance policy.

A title insurance policy is paid for with a one-time premium payment.

What Does Title Insurance Cost?

The cost of title insurance is usually tied to the value of the home.

If you’re buying an owner’s policy, the price of your policy will depend on the home’s selling price.

The price of title insurance also can include more than just insurance. One cost included in the price is a title search. When a title search is conducted, a title agent or company reviews local records, such as deeds, mortgages, wills, divorce decrees, court judgments and tax records looking for any title issues with the property. In [INSERT STATE NAME], a title search must be done before a company can issue a title insurance policy.

If you’re buying a lender’s policy, the price of title insurance will depend on your loan amount.

Ask if You’re Eligible for Discounts

When you buy title insurance, ask if you’re eligible for any discounts.

If there was a previous title policy on the home (because the home changed owners or you’re refinancing), you may get a discount known as a “reissue rate.”

If you decide to buy both an owner’s and lender’s policy, you may get a discount if you buy both policies together.

The Difference Between Title and Homeowners Insurance

Title insurance is different from homeowners insurance.

- Title insurance protects you against past title problems. Homeowners insurance protects you against future issues that cause damage to your home or personal property. Homeowners insurance also limits your personal legal responsibility (or liability) if someone is injured while they’re on your property.
- Licensed title agents and companies sell title insurance. Insurance agents licensed to sell property, and casualty insurance sell homeowners insurance.
- You pay the premium for title insurance with a one-time payment, when you buy or refinance a home. A homeowners insurance policy is paid for on an ongoing basis and is up for renewal each year.
- Homeowners insurance does not protect your ownership in the property and does not replace the need for title insurance.

Questions to Ask Before You Buy Title Insurance

When you shop for title insurance, be sure to ask the title agent or company the following questions:

- How long have you been licensed to sell title insurance in [INSERT STATE]?
- What title insurance company do you sell policies for?
- Are title insurance premiums regulated in [INSERT STATE]?
- Are any discounts available?
- Are you related or affiliated in any way with my real estate agent, mortgage lender, builder, or attorney?
- Will anyone be paid a referral fee or commission or be compensated if I buy title insurance from you or a company you represent?
- In addition to title insurance premiums, what other fees and charges will I pay?
- What policy endorsements are available?
- Do you charge a cancellation fee if I don’t buy title insurance from you after you do a title search?
Will I need to pay for a survey before you can sell me title insurance?

The Real Estate Closing

The last step to buying or refinancing a home / property is known as the closing.

Shortly after the seller accepts your offer to buy their home or the lender approves your refinancing, a closing date will be set.

A closing can be done in person, electronically or by mail. As part of the closing, you’ll be asked to sign the legal paperwork required to finalize the real estate transaction. On the day of the closing, you (as well as the seller) will be expected to pay any money owed.

If an in person closing is scheduled, expect the closing to last an hour or two. In addition to you, the seller, real estate agent(s), attorney, title agent and lender may attend the closing.

During the closing, you’ll be signing documents that are legal binding contracts. Take time to understand what they mean. If you don’t understand something, ask someone to explain it to you, or ask for time to contact a trusted friend, family member, attorney or advisor for help.

One document you’ll be asked to review and sign is the closing disclosure. The closing disclosure shows all of the money to be paid to complete the transaction. Some of the costs listed on the closing disclosure will include:

- Outstanding mortgages to be paid.
- Money to be exchanged between the buyer and seller.
- The amount of the new loan(s).
- Loan origination charges.
- Property appraisal fees.
- Credit report fees.
- Real estate agent fees.
- Tax preparation fees.
- Property taxes owed.
- Escrow funds.
- Title insurance premiums.
- Courier fees.
- Settlement or closing fees.
- Closing protection fees.
- Document or recording fees.

Federal law gives you the right to see the closing disclosure at least three business days before closing. It’s highly recommended that you ask for a copy of the closing disclosure ahead of time so you have a chance to review it and ask questions.

If everything isn’t in order by your scheduled closing date, your closing date may be moved to another date.

After the closing, you’ll be given copies of all the documents you signed.
Closing Agents

_Closing agents_ handle real estate closings and coordinate all of the steps required to make the real estate transaction official. They’re responsible for getting mortgage and loan pay-off amounts from the seller’s lender(s) and the amount of property taxes owed. They also give instructions to the buyer and seller, hold money until the home’s title is transferred, prepare documents for the buyer and seller to sign, pay out money owed and file documents with the county recorder, who updates records to show a property has changed owners.

Some title agents do more than just sell title insurance. They also conduct real estate closings by serving as a closing agent. Their responsibilities as a closing agent are separate from what they do as a title agent.

Other professionals, such as attorneys, also can be closing agents.

**Questions to Ask When You Choose a Closing Agent**

When you choose a closing agent, be sure to ask the following questions:

- Can you give me a list of all the fees and charges I would pay if you were my closing agent?
- What fees and charges are negotiable?
- Are your closing staff licensed title insurance agents?
- How and when do you conduct closings?
- Who will handle my closing?
- When will you give me a copy of the settlement statement? ¹
- Do you have references or testimonials available?
- Do you offer closing protection coverage?
- How much does closing protection cost?

_Closing Protection Letters_

Title insurance doesn’t protect the lender or buyer against mistakes made during the closing, or if money is stolen or paid to the wrong parties. For an added fee, title insurance agents and companies that conduct real estate closings offer closing protection letters. If you buy a closing protection letter, the title insurance company will reimburse you for any money you lose from negligence, fraud, theft of funds or errors the closing agent made. Without this, you’d have to sue the agent to get back any money lost.

If you buy closing protection coverage, be sure to ask for a copy of the closing protection letter for your records.

_Drafting Note:_ States who do not require closing protection should delete this section.

**Shop Around for Title Insurance and Closing Services**

As rates and fees for title insurance and closing services may vary, you should shop for title insurance and closing services. Use the chart that follows to learn how much you’ll be charged for certain rates, fees and services.
## Cost Comparison Chart

<table>
<thead>
<tr>
<th>Company Name</th>
<th>Company Name</th>
<th>Company Name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title Insurance</strong></td>
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<td></td>
</tr>
<tr>
<td>Premium Price (Lender's Title Policy)</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Premium Price (Owner's Title Policy)</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Endorsement Price</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Title Search Fee</td>
<td>$</td>
<td>$</td>
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<tr>
<td>Closing Protection Letter</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Deed Preparation Fee</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Other</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Other</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>Closing Costs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government Recording Charge</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Tax &amp; Other Certifications</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Overnight Mail</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Wire Fee</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Transfer Tax</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Notary Fee</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Settlement Fee</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Document Preparation Fee</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Email/Electronic Doc Fee</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Other</td>
<td>$</td>
<td>$</td>
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<tr>
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<td>$</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>
**Beware Of Real Estate Wire Fraud Schemes**

Money often needs to change hands quickly in a real estate transaction. One way to move money quickly is to have a financial institution wire it. Your real estate broker or agent, the title and closing agent, or an attorney will give you the details you need for a wire transfer.

Criminals can hack into professionals’ email systems to send emails that look as though they are coming from someone you’re working with. The emails can have fake instructions about wiring money for your upcoming closing. If you follow these instructions, your money will go to the scammer’s bank account. If that happens, you could lose your money.

To avoid being a victim of real estate wire fraud, you should:

- Call or personally meet with the professionals who will conduct the closing to learn how the closing will take place and how funds will be transferred.
- Get the names, telephone numbers, and mailing and email addresses for all of the professionals who will be involved with your closing.
- Be suspicious of all telephone or email messages about a change in the closing process. If you get such a message, call the professional you’re working with. Use the contact information they gave you, not the contact information in the message.
- Carefully examine all email addresses and telephone numbers associated with a message about your closing to verify the message really came from an individual you’ve been dealing with.
- Never respond to a message or click on a link if you’re asked to verify or provide bank account information.

**What To Do If You Believe You’re The Victim of a Real Estate Wire Fraud Scheme**

Report suspected wire fraud immediately!

- Contact your bank or wire transfer company to report your suspicions and ask for a wire recall.
- Ask your bank to notify the financial institution that received your funds.
- Call your local Federal Bureau of Investigation (FBI) office and report the crime.
- File a report with the FBI’s Internet Crime Complaint Center by visiting www.ic3.gov

*Drafting note: States who have Fraud units who investigate real estate wire fraud may wish to add a Step 5. Consumers should contact the Department of Insurance.*

**Final Tips to Remember**

- Deal only with licensed professionals who’re in good standing in [INSERT STATE].
- As soon as you make an offer on a house or choose a lender to refinance with, start shopping for title insurance.
- Decide up front who’ll pay for the title insurance policies.

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• Whoever buys the title insurance policy has the right to choose the title agent or title company.
• A professional who recommends a title insurance company or agent to you may receive a commission or referral fee.
• Ask the seller which title insurance company they used.
• Ask friends or family who recently bought a home if they would recommend their title agent/company.
• If you buy an owner’s policy, be sure the coverage is equal to the price you paid for your home.
• Comparison shop, and get at least three quotes before you buy title insurance and closing services.
• Ask about available discounts.
• Ask title and closing agents for an itemized list of their fees and charges.
• Ask for a copy of the title commitment at least three weeks before your closing date.
• Know exactly what your title insurance policy will cover.
• If your title agent also will be the closing agent, ask if closing protection coverage is available.
• Ask the closing agent for a settlement statement at least one business day before your scheduled closing.
• Be suspicious of all communications relying there’s been a change to the closing process.
• Knowledge is power, so don’t be afraid to ask questions!
• Read and understand all documents before signing them.
• Request copies of all documents.
• Keep a copy of your title insurance policy for as long as you own your property.
• Immediately report suspected real estate wire fraud.

How to File a Title Insurance Claim

If an issue arises about your home’s title, contact your title insurance company as soon as possible. If you don’t know the name of your title insurance company, check the paperwork you signed when you bought or refinanced your home. You also can contact your title agent or closing agent for help.

The [INSERT DOI NAME] is Here to Help

For more information about buying insurance, please visit [INSERT DOI WEBSITE ADDRESS], or call [INSERT TELEPHONE NUMBER].

As a consumer protection agency, the [INSERT DOI NAME] also can help if you believe an insurance agent or company has misled you or acted improperly.

To file a complaint, please visit our website at [INSERT WEB ADDREESS], or send a written complaint and any supporting documents to:

[DOI Logo]
[DOI Address]
[City, State Zip Code]
[DOI Telephone Numbers]
[DOI Website]
[DOI Facebook / Twitter Contact Information]

Other Resources Available

DRAFT: 3-23-245-25-21

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To verify the license status of the professionals who will be helping you with your real estate transaction, please contact:

<table>
<thead>
<tr>
<th>Profession</th>
<th>Name</th>
<th>Address</th>
<th>City, State &amp; Zip Code</th>
<th>Website</th>
<th>Telephone Number</th>
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<tbody>
<tr>
<td>Real Estate Agent</td>
<td>[STATE AGENCY NAME]</td>
<td>[STATE AGENCY ADDRESS]</td>
<td>[CITY, STATE &amp; ZIP CODE]</td>
<td>[AGENCY WEBSITE]</td>
<td>[AGENCY TELEPHONE NUMBER]</td>
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<tr>
<td>Bank/Mortgage Lender</td>
<td>[STATE AGENCY NAME]</td>
<td>[STATE AGENCY ADDRESS]</td>
<td>[CITY, STATE &amp; ZIP CODE]</td>
<td>[AGENCY WEBSITE]</td>
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</tr>
<tr>
<td>Real Estate Appraiser</td>
<td>[STATE AGENCY NAME]</td>
<td>[STATE AGENCY ADDRESS]</td>
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<td>[AGENCY WEBSITE]</td>
<td>[AGENCY TELEPHONE NUMBER]</td>
</tr>
<tr>
<td>Insurance Agent /</td>
<td>[STATE AGENCY NAME]</td>
<td>[STATE AGENCY ADDRESS]</td>
<td>[CITY, STATE &amp; ZIP CODE]</td>
<td>[AGENCY WEBSITE]</td>
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<td>Insurance Company</td>
<td>[STATE AGENCY NAME]</td>
<td>[STATE AGENCY ADDRESS]</td>
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<tr>
<td>Title Agent</td>
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<td>Title Insurance Company</td>
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<tr>
<td>Attorney</td>
<td>[STATE AGENCY NAME]</td>
<td>[STATE AGENCY ADDRESS]</td>
<td>[CITY, STATE &amp; ZIP CODE]</td>
<td>[AGENCY WEBSITE]</td>
<td>[AGENCY TELEPHONE NUMBER]</td>
</tr>
</tbody>
</table>

To find other useful information regarding the home buying process, please contact:

U.S. Department of Housing and Urban Development
451 7th Street S.W.
Washington, DC 20410
202-708-1112
www.hud.gov

Consumer Financial Protection Bureau
P.O. Box 4503
Iowa City, Iowa 52244
855-411-2372
855-237-2392 (Fax)
http://www.consumerfinance.gov

National Flood Insurance Program
500 C Street SW
Washington, DC 20472
800-621-FEMA
www.FloodSmart.gov

[OTHER SOURCE NAME & INFO]

DRAFT: 3-23-215-25-21
WORKERS’ COMPENSATION (C) TASK FORCE

Workers’ Compensation (C) Task Force July 21, 2021, Minutes
The Workers’ Compensation (C) Task Force of the Property and Casualty Insurance (C) Committee met virtually July 21, 2021. The following Working Group members participated: Lori K. Wing-Heier, Chair, represented by Anna Latham (AK); Glen Mulready, Vice Chair represented by Kim Bailey, Cuc Nguyen, Andrew Schallhorn (OK); Jim L. Ridling represented by Jennifer Brown, Jimmy Gunn and Eric Wright (AL); Alan McClain and Crystal Phelps (AR); Evan G. Daniels represented by Erin Klug Tom Zuppan (AZ); Ricardo Lara represented by Yvonne Hauscarriague, Giovanni Muzzarelli and Mitra Sanandajifar (CA); Andrew N. Mais represented by Susan Gozzo Andrews, and Amy Waldbauer (CT); David Altmaier represented by Greg Jaynes and Sandra Starnes (FL); John F. King represented by Steve Manders (GA); Colin M. Hayashida represented by Grant Shintaku (HI); Dean L. Cameron represented by Michele MacKenzie and Randy Pipal (ID); Dana Popish Severingham represented by Reid McClintock, Judy Mottar and Julie Rachford (IL); Vicki Schmidt represented by James Norman (KS); James J. Donelon represented by Warren Byrd and Tom Travis (LA); Eric A. Cioppa represented by Brock Bubar and Robert Wake (ME); Grace Arnold represented by Steve Klebba, Tammy Lohmann and Phil Vigliaturo (MN); Chlora Lindley-Myers represented by LeAnn Cox; (MO); Mike Causey represented by Tracy Bieln and Fred Fuller (NC); Marlene Caride represented by Mark McGill and Carl Sornson (NJ); Russell Toal represented by Bogdanka Kurahovic (NM); Barbara D. Richardson and Gennady Stolyarov (NV); Andrew Stolfi represented by Brian Fordham and T.K. Keen (OR); Jessica K. Altman represented by Mark Lersch and Mike McKenney (PA); Elizabeth Kelleher Dwyer represented by Beth Vollucci (RI); Raymond G. Farmer represented by Will Davis (SC); Larry D. Deiter and Maggie Dell (SD); Michael S. Pieciak represented by Kevin Gaffney and Pat Murray (VT); and James A. Dodrill (WV). Also participating were: Robert Lutton (MI); Bob Biskupiak (MT); Nicole Elliott (TX); Tracy Klausmeier (UT); and Rebecca Nichols (VA).

1. **Adopted its March 15 Minutes**

Mr. Travis made a motion, seconded by Ms. Bailey, to adopt the Task Force’s March 15 minutes (see NAIC Proceedings—Spring 2021, Workers’ Compensation (C) Task Force). The motion passed.

2. **Heard a Presentation on Regarding the Classification of Telecommuters and the Potential Implications of an Increase in Telecommuting on Workers’ Compensation**

Jeff Eddinger (National Council on Compensation Insurance—NCCI) said in 2019 less than 6% of American workers worked primarily from home, although 25% of workers did some work from home. He said that most remote workers in 2019 were not eligible to be classified as telecommuters in workers’ compensation. Mr. Eddinger said less than 1% of the payroll fell into the clerical telecommuting class code, which is 8871, where a clerical employee telecommutes at least 50% of the time. He said by comparison the clerical class code 8810 accounts for almost 30% of total payroll.

Mr. Eddinger said in May 2020, about 35% of the employed work force reported that they had worked from home in the previous four weeks due to COVID-19. At the time there was a McKinsey study done that estimated that about 29% of the work done in the U.S. would be done remotely with no loss in productivity, and that an additional 10% of the work could be done remotely if necessary.

Mr. Eddinger said most of the remote work was done in business and professional occupations. He said by December 2020 the remote working population dropped to about 24%. Mr. Eddinger said during 2020 the NCCI did not observe any significant change or shift from 8810 to the telecommuting class code.

Mr. Eddinger said a 2020 survey found that more than 80% of employees that can work from home would like to do so at least one day a week and 32% would prefer to work remotely full-time. He said a survey of U.S. companies found that employers expect 19% of their workforce to be fully remote after the pandemic, compared to 7% of the workforce being fully remote prior to the pandemic. Mr. Eddinger said that businesses that support traditional office work, such as transportation, leisure, hospitality and energy, are likely the ones that would be impacted to employees showing up to their work locations.

Mr. Eddinger said there may not be a dramatic shift in payroll to the telecommuting class code since many clerical jobs are embedded in other governing class codes. He said for example, insurance company workers who have been working remotely, or who may telecommute in the future, will still be classified under the insurance company class code, 8723. Mr. Eddinger said the jobs most likely to be performed remotely tend to have lower injury rates. He said there were however some important
workers’ compensation implications. Mr. Eddinger said home offices are less likely to be ergonomically compliant, which could lead to an increase in repetitive stress injuries. He said additionally workers in improvised offices may be more prone to slip and falls. However, workers that are not driving are at less risk for work-related car accidents.

Mr. Eddinger said if more permanent changes do occur there could be some payroll that would shift from 8810 to the telecommuting class code. He said that since clerical jobs have relatively low frequency, there would have to be a significant shift in the mix of claims in order for any measurable impact to overall workers’ compensation costs. Mr. Eddinger said even if the number of repetitive stress injuries doubled, there would be a negligible impact in the office and clerical industry group. He said there are still a lot of unknowns, but NCCI does not expect to see any significantly large impacts to workers’ compensation even if remote does catch on as expected. NCCI will continue to monitor remote work.

Mr. Stolyarov said he was interested in NCCI’s assessment of the impact due to a lot more business being conducted remotely. He said not only are more workers telecommuting currently but will continue to telecommute. Mr. Stolyarov said there have been many discoveries, such as one does not necessarily have to fly to another city to conduct certain types of business. He said with less car travel and less air travel by these workers, would NCCI expect for this to have a favorable impact on workers’ compensation loss costs in the long term.

Mr. Eddinger said in his opinion the less traveling that is necessary will reduce work-related travel injuries. He said motor vehicle accidents are one of the worst workers’ compensation injuries and one of the riskiest temporary jobs that any employee in the U.S. could hold and sees downward pressure in travel injuries.

Commissioner Richardson asked if employers would see a push in providing home office equipment as part of a telework process or is it the opinion of NCCI that the claims will be low enough that this is not a mitigation effort that needs to take place. Mr. Eddinger said he did not have an answer as to what employers might do for their remote employees; however, he would not rule out this possibility. He said employers did a lot of education in the past when repetitive injuries were in the headlines regarding employee workstations, taking breaks and walking and making sure their posture was good, so he believes we are in a better position today than we were in the past. Mr. Eddinger said education regarding home office ergonomics will go a long way in mitigating an increase in these types of losses.

Commissioner Richardson said the federal government has concluded that remote work does not require an employee to come into the office at all. She asked if NCCI believed there would be any uptick in fraud claims because you do not know where workers are, what they are doing, or how the fit into the workers’ compensation controls. Mr. Eddinger said he has no way of knowing this and would not want to guess if it would be an issue; however, employers will probably want to think about how they handle claims from home versus claims that occurred in the office.

Having no further business, the Workers’ Compensation (C) Task Force adjourned.

W:\National Meetings\2021\Summer\TF\WC\0721 WCTF Minutes.docx
MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

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The Market Regulation and Consumer Affairs (D) Committee met in Columbus, OH, Aug. 16, 2021. The following Committee members participated: Barbara D. Richardson, Chair (NV); Sharon P. Clark, Vice Chair (KY); Alan McClain (AR); Evan G. Daniels (AZ); Trinidad Navarro (DE); Dana Popish Severinghaus represented by Erica Weyhenmeyer (IL); Chlora Lindley-Myers and Cynthia Aman (MO); Chris Nicolopoulos (NH); Jon Godfread (ND); Carter Lawrence (TN); Jonathan T. Pike (UT); and Michael S. Pieciak (VT). Also participating were: Damion Hughes (CO); Elizabeth Kelleher Dwyer (RI); Mike Kreidler and John Haworth (WA); and Rebecca Rebholz (WI).

1. **Adopted its July 27 Minutes**

The Committee met July 27 and took the following action: 1) adopted it Spring National Meeting minutes; 2) adopted revised charges for the Antifraud (D) Task Force; 3) adopted the short-term, limited-duration Market Conduct Annual Statement (MCAS) data call and definitions; 4) adopted the Travel Insurance MCAS data call and definitions; 5) adopted digital claims data in the private passenger auto and homeowners data call and definitions; and 6) heard presentations from a state insurance regulator, an NAIC funded consumer representative, and an industry trade representative on the benefits and challenges of collecting market conduct data annually on a transactional level.

Commissioner Clark made a motion, seconded by Commissioner Godfread, to adopt the Committee’s July 27 minutes (Attachment One). The motion passed unanimously.

2. **Heard a Presentation from the UConn School of Law on Claim Optimization and the Insurance Promise**

Peter Kochenburger (UConn School of Law) said the insurance promise includes insurers paying the full value of covered claims without exceeding the policy limits. He noted there are disparities in knowledge and economic power between insurers and most insureds. He said the insurance company cannot use the claim process to rewrite the policy to leverage lower payments than the value of what the claim is worth.

Mr. Kochenburger said artificial intelligence (AI) has provided insurers with the potential to evaluate the willingness of insureds or claimants to accept values less than the fair and equitable amount. He said this would violate the *Unfair Claims Settlement Practices Act* (#900). While Mr. Kochenburger admitted that it is unknown if claim optimization is occurring, he said it is used in other consumer transactions; it has been used in underwriting for price optimization; and the marketing by InsurTech vendors suggests this is being built into InsurTech tools. Mr. Kochenburger encouraged state insurance regulators to determine the extent of use of predictive analytics in claim settlements and require insurers to report on the algorithmic models used in claim handling.

Angela Gleason (American Property Casualty Insurance Association—APCIA) said the term “claim optimization” is leveraging the negative connotations of price optimization to imply consumers are being harmed. She said insurance companies go above and beyond to treat their insureds and claimants fairly. She said consumers are always encouraged to question how claims are valued by the insurance company and always have the recourse to shop for other insurance.

Birny Birnbaum (Center for Economic Justice—CEJ) said shopping for other insurance is not an option after filing a claim. He asked if the implication of claim optimization is that insureds in similar situations are being treated differently according to factors unrelated to the claim. Mr. Kochenburger said that is correct. Mr. Birnbaum also asked if a publicly owned insurance company would be failing its investors if it did not use claim optimization. Mr. Kochenburger said that was the case because the company would be operating illegally if it did do so and that was not in the best interest of investors. Finally, Mr. Birnbaum asked if the collection of more granular data would assist state insurance regulators in monitoring and assessing the use of claim settlement models in claim settlements. Mr. Kochenburger said it would. He noted that it is not easy to evaluate whether a claim is settled fairly and that there are always good faith disputes, so the more granular data that is available, the better.

Erica Eversman (Automotive Education & Policy Institute—AEPI) said the ability to shop around for other insurance coverage is not an option for a consumer after the claim. She noted that the three major claim evaluation vendors are beholden to the insurance companies.
3. **Adopted its Task Force and Working Group Reports**

Commissioner Richardson said the Market Information Systems (D) Task Force adopted a proposal for coding changes to the Regulatory Information Retrieval System (RIRS). She said when the Committee votes to approve the Working Group and Task Force reports, it will also be voting to adopt the RIRS coding changes proposal. She also noted that the Market Actions (D) Working Group and the Advisory Organization Examination Oversight (D) Working Group met in regulator-to-regulator session due to the nature of their discussions focusing on specific company practices. She said there are no written or verbal reports for these two working groups.

a. **Antifraud (D) Task Force**

Commissioner Navarro said the Antifraud (D) Task Force met July 26 and took the following action: 1) heard an update from the Antifraud Education Enhancement (D) Working Group. He said the Working Group held a webinar on Feb. 11 regarding the mobile capabilities CARCO can provide state departments of insurance (DOIs) to assist in fighting insurance fraud. He said the Working Group also conducted an insurance fraud investigator safety course on June 2.

Commissioner Navarro said Task Force also received a report from the Antifraud Technology (D) Working Group. He said the Working Group advised that the adopted revisions to the Antifraud Plan Guideline (#1690) was the first step in its charge to create an antifraud plan repository that will be used by insurers to create and store an electronic fraud plan for distribution to states. He said the Working Group formed a subject matter expert (SME) group to create a template for industry to use when creating their antifraud plans. The SME group expects to complete its work by October.

Commissioner Navarro said the Task Force received an update on the NAIC Online Fraud Reporting System (OFRS) redesign. He said beta testing began with a small group of state insurance fraud directors. The beta testing will be opened to additional state insurance regulators and industry representatives to finalize the testing period.

Commissioner Navarro said the Task Force also received reports from the National Insurance Crime Bureau (NICB) and the Coalition Against Insurance Fraud (CAIF).

b. **Market Information Systems (D) Task Force**

Commissioner Kreidler said the Market Information Systems Task Force met July 28 and took the following action: 1) adopted its Spring National Meeting minutes; and 2) reviewed the status of outstanding User System Enhancement Requests (USER).

Commissioner Kreidler said the Task Force also heard the report of the Market Information Systems Research and Development (D) Working Group. He said the Working Group is researching the potential of incorporating AI into the NAIC Market Information Systems (MIS). The Working Group heard a presentation from NAIC financial regulation staff regarding their testing of the use of AI to construct predictive models of insolvency risk, and it also heard from CEJ regarding how AI can be used in market analysis. Commissioner Kreidler said the Working Group’s next step is to form an SME group to develop recommendations for incorporating AI into the MIS.

Commissioner Kreidler said that prior to the Spring National Meeting, the Market Information Systems Research and Development (D) Working Group adopted RIRS coding changes proposal. He said the RIRS coding changes include: 1) a new field to distinguish routine administrative actions from actions that are a result of an infraction or financial impairment; 2) a new field to link related to RIRS records; 3) a new Line of Business field; and 4) revisions to the Origin of Action, Reason for Action, and Disposition for Action codes to create a more logical data structure. Commissioner Kreidler said the Task Force adopted the proposal.

c. **Producer Licensing (D) Task Force**

Superintendent Dwyer said the Producer Licensing (D) Task Force met Aug. 4 and adopted its March 21 minutes. She also said the Task Force discussed state implementation of online examinations with 40 jurisdictions offering online examinations for producer licensing. She said this is a significant change as only Washington offered online examinations prior to the COVID-19 pandemic. She said states are reporting similar pass rates for online and in-person examinations and that approximately 35% to 40% of examinations are now taken through the online format. Notably, she said Washington reported that 80% of its examinations are administered through the online format. Superintendent Dwyer said the Task Force also discussed security concerns with online examinations and will be obtaining additional information from the examination vendors on what percentage of online examinations had security concerns.

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Superintendent Dwyer said the Task Force discussed the pending referral from the Special (EX) Committee on Race and Insurance regarding the elimination of bias in producer licensing examinations. She said examination vendors have been solicited on the processes they follow to eliminate bias in examinations. She said the Task Force is also reaching out to continuing education (CE) providers and will have additional discussions on this topic at its next meeting.

Superintendent Dwyer said the Task Force discussed the review of the NAIC’s Guidelines for State Insurance Regulators to the Violent Crime Control and Law Enforcement Act of 1994 and the need to revise the guidelines to make them more useful in the state’s day-to-day review of 1033 waiver requests.

Superintendent Dwyer said the Task Force also heard an update on a new program in Pennsylvania for prospective insurance agents with criminal records and how their specific convictions, history, and background may affect their ability to successfully obtain a producer license. He said the Pennsylvania program allows a person with a criminal conviction to provide this information to the Pennsylvania DOI through an electronic portal. The DOI then reviews the information and provides non-binding feedback to the prospective applicant on how the criminal conviction might affect their ability to obtain an insurance producer license before the applicant spends the time and effort with pre-licensing education and taking a producer licensing exam.

Superintendent Dwyer said the Task Force briefly discussed the draft procedure for amending NAIC Uniform Producer Licensing Applications. He said the procedures are being developed to ensure the consideration of changes to the uniform applications support the NAIC members’ goal of providing stable applications and encourage the use of electronic technology for licensing. She said the Task Force is seeking comments on the procedures through Sept. 3.

Finally, Superintendent Dwyer said the Task Force discussed the status of the Producer Licensing Uniformity (D) Working Group and the Uniform Education (D) Working Group. She noted that the chair position for the Producer Licensing Uniformity (D) Working Group remains open and that the leadership for both Working Groups continues to be in a state of flux.

d. Market Conduct Examination Guidelines (D) Working Group

Mr. Hughes said the Market Conduct Examination Guidelines (D) Working Group met June 10 and took the following action: 1) reviewed and discussed its 2021 charges; 2) prioritized potential Working Group tasks; and 3) identified NAIC models acts and model laws adopted in 2020. Mr. Hughes said the Working Group also asked for state insurance regulators to volunteer to review the adopted model laws and model acts to determine whether revisions to the corresponding sections of the NAIC Market Regulation Handbook are warranted.

Finally, Mr. Hughes said the Working Group discussed a new title insurance in-force policy standardized data request (SDR) for inclusion in the Market Regulation Handbook.

e. Market Analysis Procedures (D) Working Group

Mr. Haworth said the Market Analysis Procedures (D) Working Group met July 1 and took the following action: 1) adopted its Spring National Meeting minutes; and 2) continued its discussion on the training needs for market analysts. He said ideas include: 1) having monthly analysis groups to share techniques and tips; 2) leveraging the materials from the NAIC’s Market Analysis Techniques online course and adapt them for new analysts; 3) creating more and better tutorials and help in i-Site+; 4) incorporating Tableau visuals into the Market Analysis Review System (MARS) and other market analysis tools; and 5) providing more training on analyzing financial information and MCAS ratios.

Mr. Haworth said the Working Group also opened discussions on the next line of business to add to the MCAS and is asking for written and verbal suggestions. Additionally, Mr. Haworth said the Working Group began discussions on its members’ initial impressions of the current MCAS submissions. He said the conversations are on a high-level aggregated level.

Finally, Mr. Haworth said the Working Group considered whether MCAS submissions should be required to be reported by the residency of the policyholder or by where the policy was issued. He said the current MCAS instructions specify the data should be reported in the same manner as the company reports its financial annual statement. He the Working Group agreed to continue with these instructions without amendment.
f. **Market Conduct Annual Statement Blanks (D) Working Group**

Ms. Rebholz said that since the Spring National Meeting, the Market Conduct Annual Statement Blanks (D) Working Group met five times.

Ms. Rebholz said that during those meetings, the Working Group adopted the travel MCAS data call and definitions and the short-term, limited-duration (STLD) MCAS data call and definitions on May 25—prior to the June 1 deadline. She said the first MCAS due date for the travel MCAS blank will be on April 30, 2023, and the STLD MCAS blank will be June 30, 2023. She said both will cover the 2022 data year.

Ms. Rebholz said the Working Group also adopted the addition of digital claim data to the auto and homeowners (HO) MCAS blanks. She said these were adopted on June 30. The first due date for the data will be April 30, 2024, covering the 2023 data year.

Ms. Rebholz said the Working Group is continuing its development of accelerated underwriting data elements to the life and annuity MCAS blanks. She said the Working Group is monitoring the work of the Accelerated Underwriting (A) Working Group so it can coordinate the MCAS definition of accelerated underwriting with the definition they adopt.

Ms. Rebholz said the Working Group has spent considerable time drafting revisions to the definition of “lawsuit” in the various MCAS blanks. She said this includes adding non-claims-related lawsuits to the auto and HO MCAS blanks and editing the definition to conform to the type of product being reported on. She said that due to the continued discussions, the Working Group postponed collection of non-claims-related lawsuit information to the 2023 data year. Ms. Rebholz also said that due to the complexity of the lawsuit reporting issues, the Working Group formed an SME drafting group to consider options to present to the Working Group. She said the SME group is also tasked with considering the best way to collect vendor information on the digital claims data elements.

Finally, Ms. Rebholz said that because the STLD MCAS blank was adopted by the Committee in July, the Working Group will continue the development of MCAS blanks for other health products not covered in the current health or STLD MCAS data call and definitions.

g. **Privacy Protections (D) Working Group**

Ms. Amann said that since the Spring National Meeting the Privacy Protections (D) Working Group met July 12, June 14, and May 10.

Ms. Amann said that during its May 10 meeting, the Working Group took the following action: 1) adopted its Spring National Meeting minutes; 2) reviewed the 2021 NAIC strategy for consumer data privacy protections; 3) discussed the verbal gap analysis of consumer issues; 4) discussed the draft of the initial privacy policy statement; and 5) requested comments in the form of parameters and examples on the privacy policy statement.

Ms. Amann said that during its June 14 meeting, the Working Group took the following action: 1) adopted it May 10 minutes; and 2) discussed the comments received from America’s Health Insurance Plans (AHIP), the Blue Cross and Blue Shield Association (BCBSA), and the Coalition of Health Companies on the privacy policy statement.

Ms. Amann said that during its July 12 meeting, the Working Group took the following action: 1) adopted its June 14 minutes; 2) received comments from the American Council of Life Insurers (ACLI) about the six consumer privacy rights identified in the NAIC strategy for consumer data privacy protections; 3) heard a presentation from NAIC funded consumer representatives on the consumer perspective on consumer data privacy rights; 4) requested comments on the private policy statement.

Ms. Amann said the privacy policy statement template located on the Working Group web page is being combined with the received comments into a draft for exposure. She said there will be an accelerated review by the Working Group.

Mr. Birnbaum asked how the Working Group will be addressing the data ownership issue referred to the Working Group by the Innovation and Technology (EX) Task Force. Ms. Amann said the Working Group first needs to receive permission from the Committee before it can act on the referral.

Commissioner Godfread made a motion, seconded by Commissioner Navarro, to adopt the following reports, including the proposal for coding changes to the RIRS (Attachment Two) adopted by the Market Information Systems (D) Task Force:

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.

W:/National Meetings/2021/Summer/Cmte/D/Draft 8-D Cmte.dotx
The Market Regulation and Consumer Affairs (D) Committee met July 27, 2021. The following Committee members participated: Barbara D. Richardson, Chair (NV); Sharon P. Clark, Vice Chair (KY); Alan McClain represented by Russ Galbraith (AR); Evan G. Daniels represented by Maria Ailor (AZ); Trinidad Navarro (DE); Dana Popish Severyinghaus represented by Erica Weyhenmeyer (IL); Chlora Lindley-Myers represented by Jo LeDuc (MO); Chris Nicolopoulos represented by Edwin Pugsley (NH); Carter Lawrence represented by Vickie Trice (TN); and Jonathan T. Pike represented by Tanji J. Northrup (UT). Also participating were: Hermoliva Abejar (NV); Matt Gendron (RI); and Rebecca Rebholz (WI).

1. **Adopted its Spring National Meeting Minutes**

   Mr. Pugsley made a motion, seconded by Ms. Trice, to adopt the Committee’s April 13 minutes (see *NAIC Proceedings – Spring 2021, Market Regulation and Consumer Affairs (D) Committee*). The motion passed unanimously.

2. **Adopted Revised Charges for the Antifraud (D) Task Force**

   Commissioner Richardson said at the Spring National Meeting, Commissioner Navarro discussed the issue of the improper marketing of health insurance plans and reported that the Antifraud (D) Task Force was considering a proposal to form a working group under the Task Force. She asked Commissioner Navarro for an update.

   Commissioner Navarro said the Task Force met May 25 to consider a motion for the creation of an Improper Marketing of Health Plans (D) Working Group with two charges:

   1) Coordinate with regulators, both on a state and federal level, to provide assistance and guidance monitoring the improper marketing of health plans, and coordinate appropriate enforcement actions, as needed, with other NAIC Committees, task forces, and working groups; and

   2) Review existing NAIC Models and Guidelines that address the use of lead generators for sales of health insurance products and identify models and guidelines that need to be updated or developed to address current marketplace activities.

   Commissioner Navarro said the Task Force unanimously adopted the creation of the new Working Group with the two charges.

   Commissioner Navarro made a motion, seconded by Ms. Northrup, to create the Improper Marketing of Health Plans (D) Working Group reporting to the Antifraud (D) Task Force with the two charges adopted by the Task Force. The motion passed unanimously.

3. **Adopted the STLD MCAS Data Call and Definitions**

   Ms. Rebholz said the Short-Term Limited-Duration (STLD) data call and definitions (Attachment One-A) were adopted by the Market Conduct Annual Statement Blanks (D) Working Group on May 26.

   Ms. Rebholz said the drafting group’s original intent was to develop a blank to cover all other health products that were not currently part of the Market Conduct Annual Statement (MCAS) Health blank; but because of interest in obtaining data on the STLD line of business in each state, the drafting group decided to focus only on STLD insurance to meet the June 1 deadline for adoption. She said the drafting group used the 2019 STLD data call as its jumping off point, but it significantly expanded the information to be collected.

   Ms. Rebholz said the STLD MCAS is divided into six sections: 1) interrogatories; 2) policy/certificate administration; 3) prior authorizations; 4) claims administration; 5) consumer complaints and lawsuits; and 6) marketing and sales. She said the data in each section will be reported in three categories: 1) STLD insurance products sold through associations used in the state; 2) STLD insurance products sold through associations not used in the state; and 3) STLD insurance products not sold through an association. Each of these categories are divided into: 1) products with a term of less than or equal to 90 days; 2) products with a term of less than or equal to 180 days; and 3) products with a term of 181 to 364 days.
Ms. Rebholz said the instructions specify that the threshold is $50,000 in premium within each jurisdiction, and the STLD products should be reported by the residency of the individual insured.

Ms. Rebholz noted that the STLD MCAS blank is the product of a large group of state insurance regulators, industry, and consumer representatives who put in many hours of work. She thanked Katie Dzurec (PA) for chairing the drafting group.

Ms. LeDuc recognized the need for the STLD blank and supported its creation, but she noted that there was not enough time between its exposure to the Working Group and its adoption on May 26. She said some of the information is confusing, and she said it could result in data that is not useful. Ms. Rebholz said the draft blanks were exposed as the work of the drafting group. Commissioner Richardson said if the blank was not adopted at this meeting, the initial collection of data would be delayed another year, and she suggested that any possible data issues that arise could be fixed in subsequent years. Commissioner Clark said the data collected is pertinent and should not be delayed.

Commissioner Clark made a motion, seconded by Commissioner Navarro, to adopt the STLD MCAS data call and definitions. The motion passed unanimously with Missouri abstaining.

4. **Adopted the Travel Insurance MCAS Data Call and Definitions**

Ms. Rebholz said the Market Conduct Annual Statement Blanks (D) Working Group adopted the Travel Insurance MCAS data call and definitions (Attachment One-B) on May 26.

Ms. Rebholz said the Working Group identified trip cancellation, trip interruption, trip delay, baggage loss or delay, emergency medical and dental, emergency transportation and repatriation, and other as the coverage breakouts for this MCAS blank, with additional breakouts for domestic and international coverages. She noted that emergency medical is broken out by primary and excess coverage.

Ms. Rebholz said the claims, underwriting, lawsuit, and complaint data elements are like other MCAS lines of business and, where possible, definitions from the *Travel Insurance Model Act* (#632) were used for consistency purposes.

Ms. Rebholz said since travel insurance is represented by a small number of companies and the policies are generally small in amount, there is no premium threshold for reporting. She said the Working Group decided to require reporting for all companies licensed and reporting for any travel insurance within any of the participating MCAS jurisdictions.

Commissioner Clark made a motion, seconded by Mr. Pugsley, to adopt the Travel Insurance MCAS data call and definitions. The motion passed unanimously.

5. **Adopted Digital Claims Data in the PPA and Homeowners MCAS**

Commissioner Richardson said she is asking the Committee to consider adoption of the digital claims data elements (Attachment One-C) and the effective date of the digital claims data elements.

Commissioner Richardson said the *MCAS Data Element Revision Process* states that for any revisions to be effective for the following calendar year, the revisions must be adopted by the Market Conduct Annual Statement Blanks (D) Working Group by June 1 and the Committee by Aug. 1. She said the purpose of the deadlines is to allow companies time to make systems adjustments prior to the need to track the data elements beginning the following calendar year.

Commissioner Richardson said in the case of the digital claims data, the Working Group was ready to adopt the changes prior to June 1, but a late series of questions and suggested revisions were received just before its May 27 conference call. She said the chair of the Working Group correctly decided that it was more important to fully address all the questions and suggestions rather than push through the adoption on May 27. The changes were adopted by the Working Group on June 30.

Commissioner Richardson noted that the data elements themselves were developed with contributions by industry, have been posted on the Working Group web page since May, and did not change significantly since they were considered for adoption by the Working Group in May. She said if the Committee adopted the changes, it would meet its Aug. 1 deadline, and she would ask the Committee to consider an exception to the *MCAS Data Element Process* to adopt the changes to be effective for the 2022 data year.
Ms. Rebholz said in the Private Passenger Auto (PPA) and Homeowners blanks, the claims related data elements are broken out into types of claims, such as collision, comprehensive, property damage, and uninsured motorists and underinsured motorists (UMPD) for the PPA blank and dwelling and personal property for the Homeowners blank. She said on June 30, the Working Group adopted new claims data elements to identify digital claims, hybrid claims, and non-digital claims.

Ms. Rebholz said the definitions of digital, hybrid, and non-digital claims are in the data call and definitions. She said a digital claim is defined as a claim involving a claim settlement determination, which was accepted by the insured or claimant without adjustment, whereby the entire claim was handled without human intervention on the part of the insurance company in the loss appraisal process, settlement determination, and/or the production of the initial loss settlement offer.

Ms. Rebholz said on June 30, two revisions were made to the digital claims data elements. She said the first change was to the interrogatories. She said the interrogatories originally asked the company to identify digital claim vendors. This was revised to add, “and for each vendor, identify the vendor’s specific role in the digital claims process” at the end of the interrogatory language. The Working Group decided it would later determine how to implement the reporting within this interrogatory. Ms. Rebholz said there was interest in receiving information for this interrogatory separately for each vendor being reported, but this poses an issue at the NAIC, since the MCAS data collection tool does not currently allow for a variable number of entries for a particular data element. She said the second change was to clarify the types of claims to be broken out between digital and traditional claims handling.

Ms. Abejar said there were discussions regarding the value of having vendor information and the value of the information. She noted that if the Working Group decides to ask for algorithms used in the digital claim settlement process, it should recognize that algorithms are code that are connected to insurance company databases and cybersecurity, and they would need to be protected.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said she participated in the drafting of the digital claims data elements and definitions, and she commended the collaborative process. She said she disagreed with setting aside the June 1 deadline for the Working Group adoption of the new data elements. She said industry focused on the definitions of “lawsuit” because the digital claims data elements were not passed prior to June 1. She noted that the changes recommended to the digital claims data elements were proposed by the state insurance regulators.

Birny Birnbaum (Center for Economic Justice—CEJ) supported the new digital claims data elements. He said the additions are critical because of the significant increase in digital claims settlements since the COVID-19 pandemic. He said without the data, the MCAS claims ratios for the PPA and Homeowners blanks will be skewed if digital claims are not broken out. Regarding the effective date, he said the changes made by the Working Group after June 1 were editorial. The date that is relied on the most is the Aug. 1 date for the Committee adoption. He said there is no harm to industry, and they are not deprived of due process.

Ms. Brown agreed that there is an increase in digital claim settlements, but the defined due dates in the revision process do matter. She said after the June 1 deadline passed, industry turned its attention to other MCAS data discussions.

Commissioner Clark made a motion, seconded by Mr. Pugsley, to adopt the digital claims data elements for the PPA and Homeowners MCAS blanks. The motion passed unanimously.

Commissioner Richardson said the options for the effective date of the digital claims elements are to: 1) make an exception to the June 1 deadline of the Working Group and have the addition of the digital claims elements be effective for the 2022 data year; or 2) have the effective date be for the 2023 data year, in which case the data would not be reported until the following year on April 30, 2024.

Commissioner Clark made a motion to make an exception to the June 1 deadline of the Working Group and have the addition of the digital claims elements be effective for the 2022 data year. There was no second.

Commissioner Richardson said the effective date for the digital claims data elements will be the 2023 data year.
6. Discussed State Insurance Regulator, Consumer, and Industry Perspectives of Collecting Transaction-Level Market Conduct Data from Insurers

Commissioner Richardson said in 2020, the Market Conduct Annual Statement Blanks (D) Working Group considered options for the collection of transaction-level data. She said although the Working Group members expressed an interest in collecting transaction-level data, the Working Group determined that the collection of this type of data did not fit into the current structure of MCAS reporting, and review of this type of data at the state level would put a strain on available resources. Commissioner Richardson said the Working Group concluded its discussions on the topic and deferred further discussion to the Committee during the Committee’s 2020 Fall National Meeting conference call.

Commissioner Richardson said there was a brief discussion by the Committee during the 2020 Fall National Meeting, and it decided to defer the discussion on transaction-level data collection. She said that is the reason for this meeting’s discussion of the three perspectives on this issue. She said the Committee will hear from Ms. Brown, Mr. Gendron, and Mr. Birnbaum.

Ms. Brown said when the issue of transactional-level reporting was discussed at the Market Analysis Procedures (D) Working Group and the Market Conduct Annual Statement Blanks (D) Working Group, state insurance regulators decided they were not interested in pursuing data collection at that level of granularity.

Ms. Brown said market analysis is the beginning of the market regulation process. The current market analysis process allows market analysts to identify companies without deploying significant resources. In addition to the MCAS, she said market analysts also consider data from other sources such as complaints. She said the MCAS was created as a summary data tool, recognizing that if additional information was needed, more granular data could be requested. Asking for granular data at the beginning of the process is too burdensome. Ms. Brown said Mr. Birnbaum had spoken with NAIC staff, who assured him they were willing and able to collect transaction-level data, but the data is for the use of state insurance regulators, and they have concerns about their ability to use data at that granularity. She noted, as an example, the large amount of data generated by the addition and deletion of autos to all an insurer’s policies. She questioned its utility for state insurance regulators.

Ms. Brown said the burden on insurers to provide transactional data would be enormous. Currently, there are hundreds and thousands of MCAS filings prepared by companies. In addition to being a burden on companies, state insurance regulators say they do not have the resources to cull through the data. She said the costs outweigh the benefits.

Ms. Brown said data at the transaction level is usually done at the examination phase, where more protections are available for proprietary information. She said the reverse engineering of transactional data is a valid concern of companies.

Mr. Gendron said transactional data is valuable and has its place in market analysis and examinations, but this occurs after the initial baseline analysis to determine which companies need more in-depth analysis. He said after the baseline analysis is done, more detailed analysis is done on about 100 companies. This detailed analysis begins with summary-level data to see if the concerns can be identified without the need for more granular-level data. Mr. Gendron said MCAS data is a main source of the summary-level data. He said about half of those companies will have follow-ups, including records testing.

Mr. Gendron said market conduct teams have competing priorities, including doing baseline analysis, summary-level analysis, market conduct examinations, inquiries along the continuum of market actions, special projects, participating in NAIC working groups, continuing education (CE), and lending expert assistance to other departments.

Mr. Gendron identified the benefits of requesting transactional data as: 1) having that level of data ready when needed; 2) having consistent and comparable data by creating industry standards for data elements, definitions, and formats; 3) more opportunities to monitor MCAS data quality; and 4) more opportunities for novel data analysis by state insurance regulators. Mr. Gendron also cited concerns with requesting transactional data as: 1) additional information to filter; 2) the protection of the data; 3) the cost to companies being passed on to consumers; 4) the opportunity cost for states as they learn how to manage and analyze transactional data; 5) uncertainty about what analysis would warrant the increase in data collection; and 6) it being unclear what additional quality control steps would need to be undertaken.

Mr. Birnbaum defined transactional data as separate records for each sales transaction and each claims transaction. He noted that new data elements can always be added with disturbing existing data elements. He said for market analysis, transaction-level data is more effective for market analysis by: 1) providing more granular data enabling analysts to discover issues rather than confirm issues; 2) providing more timely analysis in contrast to MCAS data, which is often stale when received; 3)
providing opportunities for predictive analytics; 4) allowing the ability to identify proxy discrimination and disparate impact; 5) being more consistent; and 6) being more efficient for market analysis.

Mr. Birnbaum said providing transactional data is less costly for insurance companies and state insurance regulators. For companies, it is less costly because it has simpler data reports and is consistent with other insurers. It is also less costly to revise data elements. Mr. Birnbaum also noted that providing transaction-level data will result in fewer special data call and regulatory inquiries. For the state insurance regulators, Mr. Birnbaum said transaction-level data collection is less costly because the data is more reliable, and less time needs to be spent on data validation. It also allows for more refined analysis that allows for better deployment of resources. Mr. Birnbaum said there is less need for planning and executing special data calls. Finally, he said state insurance regulators can utilize an existing statistical agent framework instead of a new data infrastructure.

Mr. Birnbaum said since 2004, industry has increasingly used third-party data, predictive models, and generalized linear models. Currently, industry utilizes dozens of non-insurance sources and has enhanced, real-time consumer insurance data. Mr. Birnbaum said companies have real-time data access available for decision making. With the increase in data companies can apply micro-segmentation to marketing, pricing, claims settlements, and anti-fraud efforts. Mr. Birnbaum said today, companies are routinely using advanced data analytics, such as data mining, generalized additive models, neural networks, machine learning (ML), and artificial intelligence (AI).

Mr. Birnbaum said in contrast, the market analysis of today is essentially the same as the market analysis of 2004. It still utilizes complaints, enforcement actions, new reports, lawsuits, and summary-level MCAS data on a limited number of lines of business.

Mr. Birnbaum said in 2000, the NAIC said market analysis would move market regulation from the auditing model to a more data-driven, analytical approach; but by not incorporating more transaction-level data, it cannot fulfill that goal. He concluded by saying transaction data collection on consumer market outcomes is the most important action needed to fulfill the promise of market analysis.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.
Draft: 5/26/21

Adopted by the Executive (EX) Committee and Plenary, XX, XX, 2021
Adopted by the Market Regulation and Consumer Affairs (D) Committee, July, 27, 2021
Adopted by the MCAS Blanks (D) Working Group, May 26, 2021

**Short-Term Limited Duration Insurance Market Conduct Annual Statement**

**Data Call & Definitions**

**Line of Business:** Short-Term Limited Duration Insurance

**Reporting Period:** January 1, 2022 through December 31, 2022

**Filing Deadline:** June 30, 2023

**Contact Information**

| MCAS Administrator | The person responsible for assigning who may view and input company data. |
| MCAS Contact | The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator. |
| MCAS Attestor | The person who attests to the completeness and accuracy of the MCAS data. |

**Schedule 1 - Interrogatories**

| 1-01 | List the states where your STLDI products are marketed | Comment |
| 1-02 | Does the company offer STLDI policies/certificates with up to a 90-day duration? | Yes/No |
| 1-03 | Does the company offer STLDI policies/certificates with 91- to 180-day duration? | Yes/No |
| 1-04 | Does the company offer STLDI policies/certificates with 181- to 364-day duration? | Yes/No |
| 1-05 | Number of STLDI forms offered to residents in this state | Comment |
| 1-06 | Number of STLDI forms offered in all states | Comment |
| 1-07 | Number of STLDI forms filed in this state | Comment |
| 1-08 | Number of STLDI forms filed in all states | Comment |
| 1-09 | List the states where your STLDI products are filed (provide SERFF tracking number and form number, if applicable). If a company issues the product in a state that does not require a filing, please identify the product and describe the basis for not filing | Comment |
| 1-10 | How many policy forms have waiting periods that apply to the entire policy/certificate? | Number |
| 1-11 | How many policy forms have waiting periods that apply per specific benefits? | Number |
| 1-12 | Do any waiting periods exceed the policy/certificate term? | Y/N |
| 1-13 | If the answer to #12 is yes, please explain | Comment |
| 1-14 | Does the company issue STLDI products through associations? If yes, list the associations | Yes/No |
| 1-15 | If #14 is yes, list the associations | Comment |
| 1-16 | If #14 is yes, do you have a contractual relationship with each Association? | Yes/No |
## Short-Term Limited Duration Insurance Market Conduct Annual Statement

### Data Call & Definitions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-17</td>
<td>If #14 is yes, does the contract cover the marketing of your product?</td>
</tr>
<tr>
<td>1-18</td>
<td>If #14 is yes, does the contract cover the collection of dues and fees?</td>
</tr>
<tr>
<td>1-19</td>
<td>If #14 is yes, does the contract cover commissions?</td>
</tr>
<tr>
<td>1-20</td>
<td>If #14 is yes, what other operational areas are covered in the contract?</td>
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<tr>
<td>1-21</td>
<td>Does the company issue STLDI products through trusts?</td>
</tr>
<tr>
<td>1-22</td>
<td>If #21 is yes, how many?</td>
</tr>
<tr>
<td>1-23</td>
<td>Does the company issue STLDI products through administrators?</td>
</tr>
<tr>
<td>1-24</td>
<td>If #23 is yes, how many?</td>
</tr>
<tr>
<td>1-25</td>
<td>Does the company contract with third-party administrators for administrative services related to STLDI products?</td>
</tr>
<tr>
<td>1-26</td>
<td>If yes, does your delegation structure include claims related to STLDI products?</td>
</tr>
<tr>
<td>1-27</td>
<td>If yes, does your delegation structure include complaints related to STLDI products?</td>
</tr>
<tr>
<td>1-28</td>
<td>If yes, does your delegation structure include medical underwriting related to STLDI products?</td>
</tr>
<tr>
<td>1-29</td>
<td>If yes, does your delegation structure include pricing related to STLDI products?</td>
</tr>
<tr>
<td>1-30</td>
<td>If yes, does your delegation structure include producer appointments related to STLDI products?</td>
</tr>
<tr>
<td>1-31</td>
<td>If yes, does your delegation structure include marketing, advertisement, lead generation, or enrollment related to STLDI products?</td>
</tr>
<tr>
<td>1-32</td>
<td>Does your company audit Third parties to whom you have delegated responsibilities?</td>
</tr>
<tr>
<td>1-33</td>
<td>If # 33 is yes, please provide frequency of audits</td>
</tr>
<tr>
<td>1-34</td>
<td>If the response to 1-36 is Yes, identify the products or plans subject to underwriting upon renewal/reissue</td>
</tr>
<tr>
<td>1-35</td>
<td>Are any renewals/reissues subject to optional or mandatory underwriting?</td>
</tr>
<tr>
<td>1-36</td>
<td>Are there limitations on the number renewals per individual?</td>
</tr>
<tr>
<td>1-37</td>
<td>Does your company offer renewal(s) without underwriting for an additional charge?</td>
</tr>
<tr>
<td>1-38</td>
<td>If the response to 1-39 is Yes, identify the products or plans subject to underwriting for an additional charge</td>
</tr>
<tr>
<td>1-39</td>
<td>Are the limitations on renewals based on state, federal, or company rules?</td>
</tr>
<tr>
<td>1-40</td>
<td>Does your company distribute its product through independent agents?</td>
</tr>
<tr>
<td>1-41</td>
<td>Does your company distribute its products through captive agents?</td>
</tr>
<tr>
<td>1-42</td>
<td>Does your company distribute its products through its employees?</td>
</tr>
</tbody>
</table>
Short-Term Limited Duration Insurance Market Conduct Annual Statement

Data Call & Definitions

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1-45</td>
<td>What triggers a pre-existing exclusion review (dollar, diagnosis, prescription, other)</td>
</tr>
<tr>
<td>1-46</td>
<td>Additional State Specific Comments (optional)</td>
</tr>
</tbody>
</table>

Products

<table>
<thead>
<tr>
<th>Product Identifiers</th>
<th>Explanation of Product Identifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>STLDI &lt;=90</td>
<td>Short-Term Limited Duration Insurance not sold through an Association with a term less than or equal to 90 days</td>
</tr>
<tr>
<td>STLDI &lt; 180</td>
<td>Short-Term Limited Duration Insurance not sold through an Association with a term greater than 90 and less than or equal to 180 days</td>
</tr>
<tr>
<td>STLDI 181 - 364</td>
<td>Short-Term Limited Duration Insurance not sold through an Association with a term greater than 180 days and less than 364 days</td>
</tr>
<tr>
<td>STLDI Not Sitused &lt;=90</td>
<td>Short-Term Limited Duration Insurance sold through an Association not sitused in this state with a term less than or equal to 90 days</td>
</tr>
<tr>
<td>STLDI Not Sitused &lt; 180</td>
<td>Short-Term Limited Duration Insurance sold through an Association not sitused in this state with a term greater than 90 and less than or equal to 180 days</td>
</tr>
<tr>
<td>STLDI Not Sitused 181 - 364</td>
<td>Short-Term Limited Duration Insurance sold through an Association not sitused in this state with a term greater than 180 days and less than 364 days</td>
</tr>
<tr>
<td>STLDI Sitused &lt;=90</td>
<td>Short-Term Limited Duration Insurance sold through an Association sitused in this state with a term less than or equal to 90 days</td>
</tr>
<tr>
<td>STLDI Sitused &lt; 180</td>
<td>Short-Term Limited Duration Insurance sold through an Association sitused in this state with a term greater than 90 and less than or equal to 180 days</td>
</tr>
<tr>
<td>STLDI Sitused &gt;181 - 364</td>
<td>Short-Term Limited Duration Insurance sold through an Association sitused in this state with a term greater than 180 days and less than 364 days</td>
</tr>
</tbody>
</table>
## Short-Term Limited Duration Insurance Market Conduct Annual Statement

### Data Call & Definitions

#### Schedule 2 – Policy/Certificate Administration

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-1</td>
<td>Net Written Premium</td>
</tr>
<tr>
<td>2-2</td>
<td>Earned premiums for Reporting Year</td>
</tr>
<tr>
<td>2-3</td>
<td>Number of Policies/Certificates In Force at the Beginning of the Period</td>
</tr>
<tr>
<td>2-4</td>
<td>Number of Covered Lives on Policies/Certificates In Force at the Beginning of the Period</td>
</tr>
<tr>
<td>2-5</td>
<td>Number of new policy/certificate applications received during the period</td>
</tr>
<tr>
<td>2-6</td>
<td>Number of new policy/certificates issued during the period</td>
</tr>
<tr>
<td>2-7</td>
<td>Number of new policies/certificates denied during the period</td>
</tr>
<tr>
<td>2-8</td>
<td>Number of Covered Lives on New Policies/Certificates Issued During the Period</td>
</tr>
<tr>
<td>2-9</td>
<td>Member months for policies/certificates newly issued during the period</td>
</tr>
<tr>
<td>2-10</td>
<td>Number of policy/certificate renewal/reissue applications received during the period</td>
</tr>
<tr>
<td>2-11</td>
<td>Number of policies/certificates renewed/reissued during the period</td>
</tr>
<tr>
<td>2-12</td>
<td>Number of policies/certificates non-renewed or denied at the option of insurer during the period</td>
</tr>
<tr>
<td>2-13</td>
<td>Number of Covered Lives on Renewed/Reissued Policies/Certificates During the Period</td>
</tr>
<tr>
<td>2-14</td>
<td>Number of renewals/reissues allowed?</td>
</tr>
<tr>
<td>2-15</td>
<td>Member months for policies/certificates renewed/reissued during the period</td>
</tr>
<tr>
<td>2-16</td>
<td>Member months for policies/certificates renewed/reissued which had an option to renew/reissue without underwriting</td>
</tr>
<tr>
<td>2-17</td>
<td>Number of Member Months of on Other Than New Policies/Certificates or Renewal/Reissued Policies/Certificates During the Period</td>
</tr>
<tr>
<td>2-18</td>
<td>Number of policy/certificate terminations and cancellations initiated by the policyholder/certificateholder</td>
</tr>
<tr>
<td>2-19</td>
<td>Number of Covered Lives on Policies/Certificates Cancelled at the Initiation of the policyholder/certificateholder During the Period</td>
</tr>
<tr>
<td>2-20</td>
<td>Number of policies/certificates cancelled during the free look period</td>
</tr>
<tr>
<td>2-21</td>
<td>Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificateholder During the Free Look Period During the Period</td>
</tr>
<tr>
<td>2-22</td>
<td>Number of Covered Lives on Policies/Certificates Cancelled at the Initiation of the policyholder/certificateholder During the Free Look Period During the Period</td>
</tr>
<tr>
<td>2-23</td>
<td>Number of policy/certificate terminations and cancellations due to non-payment of premium</td>
</tr>
<tr>
<td>2-24</td>
<td>Number of Lives on Policies/Certificates Cancelled Due to Non-Payment of Premium During the Period</td>
</tr>
<tr>
<td>2-25</td>
<td>Number of Policies/Certificates Cancelled by Insurer for Any Reason Other Than Non-Payment of Premium During the Period</td>
</tr>
</tbody>
</table>
### Short-Term Limited Duration Insurance Market Conduct Annual Statement

#### Data Call & Definitions

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-26</td>
<td>Number of Policies/Certificates Cancelled by Insurer Following Filing of a Claim or Prior Authorization Request by the policyholder/certificateholder During the Period</td>
</tr>
<tr>
<td>2-27</td>
<td>Number of Lives on Policies/Certificates Cancelled by Insurer Following Filing of a Claim or Prior Authorization Request by the policyholder/certificateholder During the Period</td>
</tr>
<tr>
<td>2-28</td>
<td>Number of rescissions</td>
</tr>
<tr>
<td>2-29</td>
<td>Number of insured lives impacted on terminations and cancellations initiated by the policyholder/certificateholder</td>
</tr>
<tr>
<td>2-30</td>
<td>Number of insured lives impacted on terminations and cancellations due to nonpayment</td>
</tr>
<tr>
<td>2-31</td>
<td>Number of insured lives impacted by rescissions</td>
</tr>
<tr>
<td>2-32</td>
<td>Number of Policies/Certificates in Force at the End of the Period</td>
</tr>
<tr>
<td>2-33</td>
<td>Number of Covered Lives on Policies/Certificates in Force at the End of the Period</td>
</tr>
</tbody>
</table>

#### Schedule 3 – Prior Authorizations

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-1</td>
<td>Number of Prior Authorization Requests Pending at the Beginning of the Period</td>
</tr>
<tr>
<td>3-2</td>
<td>Number of prior authorizations requested during period</td>
</tr>
<tr>
<td>3-3</td>
<td>Number of prior authorizations approved during period</td>
</tr>
<tr>
<td>3-4</td>
<td>Number of prior authorizations denied during period</td>
</tr>
<tr>
<td>3-5</td>
<td>Number of claims where prior authorization penalties were assessed</td>
</tr>
<tr>
<td>3-6</td>
<td>Number of Prior Authorization Requests Pending at the End of the Period</td>
</tr>
<tr>
<td>3-7</td>
<td>Median Number of Days from Receipt of Prior Authorization Request to Decision</td>
</tr>
<tr>
<td>3-8</td>
<td>Average Number of Days from Receipt of Prior Authorization to Decision</td>
</tr>
</tbody>
</table>

#### Schedule 4 – Claims Administration (Including Pharmacy)

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-1</td>
<td>Number of Claims Pending at the Beginning of the Period</td>
</tr>
<tr>
<td>4-2</td>
<td>Number of claims received</td>
</tr>
<tr>
<td>4-3</td>
<td>Total number of claims denied, rejected or returned</td>
</tr>
<tr>
<td>4-4</td>
<td>Number of denied, rejected, or returned due to claims submission coding error(s)</td>
</tr>
<tr>
<td>4-5</td>
<td>Number of denied, rejected, or returned for lack of Prior Authorization</td>
</tr>
<tr>
<td>4-6</td>
<td>Number of denied, rejected, or returned as Non-Covered or beyond benefit limitation</td>
</tr>
<tr>
<td>4-7</td>
<td>Number of denied, rejected, or returned as Not medically necessary</td>
</tr>
<tr>
<td>4-8</td>
<td>Number of denied, rejected, or returned as Subject to pre-existing condition exclusion</td>
</tr>
</tbody>
</table>
Short-Term Limited Duration Insurance Market Conduct Annual Statement

Data Call & Definitions

4-9 Number denied, rejected, or returned due to failure to provide adequate documentation
4-10 Number denied, rejected, or returned due to being within the waiting period
4-11 Number of denied, rejected, or returned (in whole or in part) because maximum limit exceeded
4-12 Number of denied, rejected, or returned for Out-of-Network provider
4-13 Number of Claims Pending at End of Period
4-14 Median Number of Days from Receipt of Claim to Decision for Denied Claims
4-15 Average Number of Days from Receipt of Claim to Decision for Denied Claims
4-16 Median Number of Days from Receipt of Claim to Decision for Approved Claims
4-17 Average Number of Days from Receipt of Claim to Decision for Approved Claims
4-18 Number of Claim Decisions Appeals Pending At Beginning of Period
4-19 Number of Claim Decision Appeals Received During the Period
4-20 Number of Claim Decision Appeals Resulting in Decisions Upheld During the Period
4-21 Number of Claim Decision Appeals Resulting in Decisions Overturned or Modified During the Period
4-22 Number of Claim Decision Appeals Rejected and Not Considered for Any Reason
4-23 Number of Claim Decision Appeals Pending at End of Period
4-24 Average Number of Days from Receipt of Appeal to Decision
4-25 Number of claims paid

Schedule 5 – Consumer Complaints and Lawsuits

5-1 Number of complaints received by Company (other than through the DOI)
5-2 Number of complaints received through DOI
5-3 Number of complaints resulting in claims reprocessing
5-4 Number of Lawsuits Open at Beginning of the Period
5-5 Number of Lawsuits Opened During the Period
5-6 Number of Lawsuits Closed During the Period
5-7 Number of Lawsuits Closed During the Period with Consideration for the Consumer
5-8 Number of Lawsuits Open at End of Period

Schedule 6 – Marketing and Sales

6-1 Number of Individual Applications Pending at the Beginning of the Period
Short-Term Limited Duration Insurance Market Conduct Annual Statement

Data Call & Definitions

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-2</td>
<td>Number of applications received</td>
</tr>
<tr>
<td>6-3</td>
<td>Number of Renewal/Reissue Individual Applications Received During the Period</td>
</tr>
<tr>
<td>6-4</td>
<td>Number of New Individual Applications Denied During the Period for Any Reason</td>
</tr>
<tr>
<td>6-5</td>
<td>Number of New Individual Applications Denied During the Period - Health Status or Condition</td>
</tr>
<tr>
<td>6-6</td>
<td>Number of Renewal/Reissue Individual Applications Denied During the Period for Any Reason</td>
</tr>
<tr>
<td>6-7</td>
<td>Number of Renewal/Reissue Individual Applications Denied During the Period - Health Status or Condition</td>
</tr>
<tr>
<td>6-8</td>
<td>Number of New Individual Applications Approved During the Period</td>
</tr>
<tr>
<td>6-9</td>
<td>Number of Renewal/Reissue Individual Applications Approved During the Period</td>
</tr>
<tr>
<td>6-10</td>
<td>Number of Individual Applications Pending at the End of the Period</td>
</tr>
<tr>
<td>6-11</td>
<td>Number of applications initiated via phone</td>
</tr>
<tr>
<td>6-12</td>
<td>Number of applications completed via phone</td>
</tr>
<tr>
<td>6-13</td>
<td>Number of applications initiated face-to-face</td>
</tr>
<tr>
<td>6-14</td>
<td>Number of applications completed face-to-face</td>
</tr>
<tr>
<td>6-15</td>
<td>Number of applications initiated online (Electronically)</td>
</tr>
<tr>
<td>6-16</td>
<td>Number of applications completed online (Electronically)</td>
</tr>
<tr>
<td>6-17</td>
<td>Number of New Individual Applications initiated by Mail During the Period</td>
</tr>
<tr>
<td>6-18</td>
<td>Number of New Individual Applications completed by Mail During the Period</td>
</tr>
<tr>
<td>6-19</td>
<td>Number of New Individual Applications initiated by Any Other Method During the Period</td>
</tr>
<tr>
<td>6-20</td>
<td>Number of New Individual Applications completed by Any Other Method During the Period</td>
</tr>
<tr>
<td>6-21</td>
<td>Commissions paid during reporting period (Dollar Amount of Commissions Incurred During the Period)</td>
</tr>
<tr>
<td>6-22</td>
<td>Unearned Commissions returned to company on policies/certificates sold during the period</td>
</tr>
<tr>
<td>6-23</td>
<td>Other remunerations collected during the period (Dollar Amount of Fees Charged to Applicants and Policyholders During the Period)</td>
</tr>
</tbody>
</table>

**Participation Requirements:** All companies licensed and reporting at least $50,000 of Short-Term Limited Duration Insurance (STLDI) premium for all coverages reportable in MCAS within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)
Draft: 5/26/21

Adopted by the Executive (EX) Committee and Plenary, XX, XX, 2021
Adopted by the Market Regulation and Consumer Affairs (D) Committee, July, 27, 2021
Adopted by the MCAS Blanks (D) Working Group, May 26, 2021

**Short-Term Limited Duration Insurance Market Conduct Annual Statement**

**Data Call & Definitions**

**Report by Residency**: This MCAS blank is designed to collect data from the perspective of individual insureds in each state that the form is marketed in. When reporting for forms issued to discretionary groups, associations, or trusts – data should be provided on each state of residence of the insureds, rather than only where the discretionary group, association or trust is sitused.
Short-Term Limited Duration Insurance Market Conduct Annual Statement
Data Call & Definitions

General Definitions:

**Short-Term Limited-Duration Insurance** - Health coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract. (state and federal government guidelines may have renewal duration limitations)

**Association** – For purposes of this MCAS blank, a non-employer group that secures benefits for its members.

**Individual STLDI Product** – Policies marketed, sold, and issued to individual consumers, regardless of whether or not the policy forms have been filed with any State’s department of insurance. An individual STLDI policy is not issued to a trust, association, or administrator.

**Group STLDI Product/Coverage** - Policies issued to a trust, association, or administrator for the purpose of marketing, selling, and issuing certificates to individual consumers, regardless of whether or not the policy forms have been filed with any State’s department of insurance and regardless of where the association, trust, or administrator is situated.

**New Policies/Certificates Issued** - STLDI policy/certificate issued to an individual or family for whom no prior short-term coverage has been placed with the same insurer within the previous 63 days

**Policies / Certificates** - Refers to the coverage documents provided to individuals or families (i.e., state residents) who are enrolled in coverage (not the association)

**Policyholder / Certificateholder** – Refers to the individual who is afforded benefits of the coverage according to the laws of the state in which they reside (i.e., not the association). Policyholder is the individual when purchased in the individual market. Certificateholder is the individual when purchased through an Association, which is the policyholder.

**Renewal / Reissue** - STLDI policy/certificate issued to an individual or family for whom prior short-term coverage has been placed with the same insurer within 63 days of the prior coverage. If a policy is re-underwritten based on health factors or provides different benefits, it should be reported as a new policy/certificate issued.

**Schedule 2 Definitions (Policy/Certificate Administration):**

**Rescission** – A rescission is a cancellation or discontinuance of coverage that is retroactive to the issue date. (Does not include cancellations for non-payment.)

**Written Premium** - Provide the total annual written premium for all policies and/or certificates issued to insureds residing in the state for which reporting is being completed.
Short-Term Limited Duration Insurance Market Conduct Annual Statement

Data Call & Definitions

Earned Premium – Total premium earned from all policies/certificates written by the insurer during the specified period.

Free Look – A set number of days provided in an insurance policy/certificate that allows time for the purchaser to review the contract provisions with the right to return the policy/certificate for a full refund of all premium paid. Report the number of policies/certificates that were returned by the insured under the free look provision during the period, regardless of the original issuance date.

Member months– The sum of total number of lives insured on policies/certificates issued on a pre-specified day of each month of the reported year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.

Schedule 3 and 4 Definitions (Prior Authorization and Claims Administration):

Prior Authorization – A decision by a carrier or its designee in advance of the provision of a health care service that the service (including specialist care, habilitation and rehabilitation services, and mental health and substance use disorder services), treatment plan, or medical device and equipment is medically necessary or a covered service. Sometimes called preauthorization, prior approval or precertification, this includes any provision requiring the insured to notify the company prior to treatment.

Claim – For the purposes of this data call a claim means any individual line of service within a bill for services.

Claim Clarifications:
- Claims received, paid and denied should be reported according to the data year of the receipt, payment or denial.
- Claims are to be reported at the service line level.
- Capitated claims are to be reported if an Explanation of Benefits (EOB) is generated.
- Duplicate claims should not be reported.

 Claims Received - provide the total number of claims received during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed

 Claims Denied - provide the total number of claims denied during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed; includes rejected and returned claims, whether in whole or in part
Short-Term Limited Duration Insurance Market Conduct Annual Statement

Data Call & Definitions

Clarification:

- The nine claim denial reporting categories are not exhaustive. Claim denials reported in the categories should be a subset of the reported total denials.

Claims Paid - provide the total number of claims paid during the reporting period for individual policyholders and/or group certificateholders residing in the state for which reporting is being completed.

Waiting Period: Period of time a covered person who is entitled to receive benefits for sicknesses must wait before coverage is provided. This applies to waiting periods that are per policy or per condition.

Schedules 5 Definitions (Consumer Requested Reviews/Grievance/Complaints):

Lawsuit—An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

For purposes of reporting lawsuits for Short-Term Limited Duration Insurance products:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a claimant/beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit seeks damages under two or more policies or contracts, count the number of policies or contracts involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies or contracts, count the action as three lawsuits;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Lawsuits Closed During the Period with Consideration for the Consumer—A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting insurer before the lawsuit was brought.
Draft: 5/26/21

Adopted by the Executive (EX) Committee and Plenary, XX, XX, 2021
Adopted by the Market Regulation and Consumer Affairs (D) Committee, July, 27, 2021
Adopted by the MCAS Blanks (D) Working Group, May 26, 2021

Short-Term Limited Duration Insurance Market Conduct Annual Statement
Data Call & Definitions

Schedule 6 Definitions (Marketing and Sales)

**Commissions** - The total amount of compensation paid to any individual or entity for their consideration in marketing, selling, and attracting potential insureds, by whatever means this compensation is provided. Do not include monetary valuables paid to any individual or entity that is generally not able to be converted into actual money. NOTE: For products *not* related to the actual sale of a contract, do not include any amounts paid for the specific purpose of marketing, encouraging or promoting.

**Other Remuneration** - Any monetary consideration provided by the insurer through the course of the insurance transaction. This is not commissions and are separate amounts paid for as a result of the insurance transaction.
Property & Casualty Market Conduct Annual Statement  
Travel Insurance Data Call & Definitions

**Line of Business:** Travel  
**Reporting Period:** January 1, 2022 through December 31, 2022  
**Filing Deadline:** April 30, 2023

**Contact Information**

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCAS Administrator</td>
<td>The person responsible for assigning who may view and input company data.</td>
</tr>
<tr>
<td>MCAS Contact</td>
<td>The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.</td>
</tr>
<tr>
<td>MCAS Attestor</td>
<td>The person who attests to the completeness and accuracy of the MCAS data.</td>
</tr>
</tbody>
</table>

**Schedule 1 – Interrogatories**

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-01</td>
<td>Were there policies/certificates in force during the reporting period that provide travel insurance coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-02</td>
<td>Has the company had a significant event/business strategy that would affect data for this reporting period?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-03</td>
<td>If yes, add additional comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1-04</td>
<td>Has this block of business or part of this block of business been sold, closed or moved to another company during the reporting period?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-05</td>
<td>If yes, add additional comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1-06</td>
<td>How does the company treat subsequent supplemental or additional payments on previously closed claims?</td>
<td>Comment</td>
</tr>
<tr>
<td>1-07</td>
<td>Does the company use third party administrators (TPAs) for purposes of supporting the travel insurance business being reported?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-08</td>
<td>If yes, provide the names and functions of each TPA.</td>
<td>Comment</td>
</tr>
<tr>
<td>1-09</td>
<td>Does the company use managing general agents (MGAs) for purposes of supporting the travel insurance business being reported?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-10</td>
<td>If yes, provide the names and functions of each MGA.</td>
<td>Comment</td>
</tr>
<tr>
<td>1-11</td>
<td>Does the company use travel administrators for purposes of supporting the travel insurance business being reported?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-12</td>
<td>If yes, provide the names and functions of each travel administrator.</td>
<td>Comment</td>
</tr>
<tr>
<td>1-13</td>
<td>Number of Travel Retailers offering and disseminating Travel Insurance on</td>
<td>Comment</td>
</tr>
</tbody>
</table>
Property & Casualty Market Conduct Annual Statement

Travel Insurance Data Call & Definitions

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-14</td>
<td>Additional state specific Claims comments (optional)</td>
</tr>
<tr>
<td>1-15</td>
<td>Additional state specific Lawsuit and Complaints comments (optional)</td>
</tr>
<tr>
<td>1-16</td>
<td>Additional state specific Underwriting comments (optional)</td>
</tr>
</tbody>
</table>

Coverages

- Trip Cancellation
- Trip Interruption
- Trip Delay
- Baggage Loss/Delay
- Emergency Medical/Dental
- Emergency Transportation/Repatriation
- Other

Other Breakouts:
1) Each coverage listed is also broken out by Domestic vs. International coverage
2) Emergency Medical/Dental coverage is also broken out by Primary vs. Excess/Secondary coverage

Schedule 2—Travel Claims Activity, Counts Reported by Claimant, by Coverage

Report the number of reserves/lines/features opened for each coverage part per claim.

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-17</td>
<td>Number of claims open at the beginning of the period</td>
</tr>
<tr>
<td>2-18</td>
<td>Number of claims opened during the period</td>
</tr>
<tr>
<td>2-19</td>
<td>Number of claims closed during the period, with payment</td>
</tr>
<tr>
<td>2-20</td>
<td>Number of claims closed during the period, without payment</td>
</tr>
<tr>
<td>2-21</td>
<td>Number of claims open at the end of the period</td>
</tr>
<tr>
<td>2-22</td>
<td>Median days to final payment</td>
</tr>
<tr>
<td>2-23</td>
<td>Number of claims closed with payment within 0-30 days</td>
</tr>
<tr>
<td>2-24</td>
<td>Number of claims closed with payment within 31-90 days</td>
</tr>
<tr>
<td>2-25</td>
<td>Number of claims closed with payment beyond 90 days</td>
</tr>
<tr>
<td>2-26</td>
<td>Number of claims closed without payment within 0-30 days</td>
</tr>
</tbody>
</table>
Property & Casualty Market Conduct Annual Statement

Travel Insurance Data Call & Definitions

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-27</td>
<td>Number of claims closed without payment within 31-90 days</td>
</tr>
<tr>
<td>2-28</td>
<td>Number of claims closed without payment beyond 90 days</td>
</tr>
<tr>
<td>2-29</td>
<td>Dollar amount of claims closed with payment</td>
</tr>
</tbody>
</table>

Schedule 3 – Lawsuits and Complaints

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-30</td>
<td>Number of lawsuits open at the beginning of the period</td>
</tr>
<tr>
<td>3-31</td>
<td>Number of lawsuits opened during the period</td>
</tr>
<tr>
<td>3-32</td>
<td>Number of lawsuits closed during the period</td>
</tr>
<tr>
<td>3-33</td>
<td>Number of lawsuits open at the end of the period</td>
</tr>
<tr>
<td>3-34</td>
<td>Number of lawsuits closed with consideration for the consumer</td>
</tr>
<tr>
<td>3-35</td>
<td>Number of complaints received directly from the DOI</td>
</tr>
<tr>
<td>3-36</td>
<td>Number of complaints received directly from any person or entity other than the DOI</td>
</tr>
</tbody>
</table>

Schedule 4 – Underwriting

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-37</td>
<td>Number of individual policies in force at the beginning of the period</td>
</tr>
<tr>
<td>4-38</td>
<td>Number of group policies (other than blanket policies) in force at the beginning of the period</td>
</tr>
<tr>
<td>4-39</td>
<td>Number of blanket policies in force at the beginning of the period</td>
</tr>
<tr>
<td>4-40</td>
<td>Number of individuals insured under all policies at the beginning of the period</td>
</tr>
<tr>
<td>4-41</td>
<td>Number of individual policies and certificates from group policies cancelled by the consumer during the period</td>
</tr>
<tr>
<td>4-42</td>
<td>Number of individual policies and certificates from group policies expired during the period</td>
</tr>
<tr>
<td>4-43</td>
<td>Number of individual policies and certificates from group policies in force at end of the period</td>
</tr>
<tr>
<td>4-44</td>
<td>Dollar amount of direct premium written during the period for individual policies</td>
</tr>
<tr>
<td>4-45</td>
<td>Dollar amount of direct premium written during the period for group policies (other than blanket)</td>
</tr>
<tr>
<td>4-46</td>
<td>Dollar amount of direct premium written during the period for blanket policies</td>
</tr>
</tbody>
</table>

In determining what business to report for a particular jurisdiction, unless otherwise indicated
Property & Casualty Market Conduct Annual Statement
Travel Insurance Data Call & Definitions

in these instructions, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages. Specifically, the business to be reported is the direct business of the reporting company. Reinsurance ceded is not deducted and reinsurance assumed is not included.

Participation Requirements: All companies licensed and reporting any travel insurance within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)
Property & Casualty Market Conduct Annual Statement
Travel Insurance Data Call & Definitions

Definitions:

Travel Insurance means insurance coverage for personal risks incident to planned travel.

Include:
- Interruption or cancellation of trip or event;
- Loss of baggage or personal effects;
- Damages to accommodations or rental vehicles;
- Sickness, accident, disability or death occurring during travel;
- Emergency evacuation;
- Repatriation of remains; or
- Any other contractual obligations to indemnify or pay a specified amount to the traveler upon determinable contingencies related to travel as approved by the Commissioner.

Exclude:
- major medical plans that provide comprehensive medical protection for travelers with trips lasting longer than six (6) months, including for example, those working or residing overseas as an expatriate, or any other product that requires a specific insurance producer license.

Blanket Travel Insurance means a policy of Travel Insurance issued to any Eligible Group providing coverage for specific classes of persons defined in the policy with coverage provided to all members of the Eligible Group without a separate charge to individual members of the Eligible Group.

Coverages
For the following terms, the NAIC asks that the insurer use definitions that meet industry standards. To the extent the insurer’s definitions differ from industry standards, the NAIC asks that the insurer provide those definitions.

Trip Cancellation
Trip Interruption
Trip Delay
Baggage Loss/Delay
Emergency Medical / Dental
Emergency Transportation/Repatriation
Primary Coverage
Excess/Secondary Coverage

Cancellations – Includes all cancellations of the policies/certificates where the cancellation was executed during the reporting year regardless of the date of placement of the coverage.
Property & Casualty Market Conduct Annual Statement

Travel Insurance Data Call & Definitions

Claim – A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy/certificate. Each claimant/insured reporting a loss is counted separately.

Exclude:
- An event reported for “information only.”
- An inquiry of coverage if a claim has not actually been presented (opened) for payment.
- A potential claimant if that individual has not made a claim nor had a claim made on his or her behalf.

Claims Closed With Payment – Claims closed with payment where the claim was closed during the reporting period regardless of the date of loss or when the claim was received. The number of days to closure, however, should be measured as the difference between the date of the final payment and the date the claim was reported or between the date of the final payment and the date the request for supplemental payment was received. See also “Date of Final Payment.”

Exclude:
- Claims where payment was made for company loss adjustment expenses if no payment was made to an insured/claimant.
- Claims that are closed because the amount claimed is below the insured’s deductible.

Clarifications:
- If a claim is reopened for the sole purpose of refunding the insured’s deductible, do not count it as a paid claim.
- For claims where the net payment is $0 due to subrogation recoveries, report the number of claims in which any amount was paid to the insured; do not net the payment with subrogation recoveries when counting the number of paid claims.

Calculation Clarification:
- For each coverage identifier, the sum of the claims settled with payment across each closing time interval should equal the total number of claims closed with payment during the reporting period.

Handling additional payment on previously reported claim/subsequent supplemental payment for claims closed with payment during the reporting period:
- If a claim is reopened for a subsequent supplemental payment, count the reopened claim as a new claim. Calculate a separate aging on the supplemental payment from the time the request for supplemental payment was received to the date the final
Property & Casualty Market Conduct Annual Statement

Travel Insurance Data Call & Definitions

payment was made.

Claims Closed Without Payment – Claims closed with no payment made to an insured or third party. The number of days to closure is the difference between the date the claim was closed and the date the claim was reported and/or reopened. See also “Date of Final Payment.”

Include:

• All claims that were closed during the reporting period regardless of the date of loss or when the claim was received.
• Claims where no payment was made to an insured/claimant even though payment was made for company loss adjustment expenses.
• A demand for payment for which it was determined that no relevant policy/certificate was in-force at the time of the loss if a claim file was set up and the loss was investigated.
• Claims that are closed because the amount claimed is below the insured’s deductible.
• Claims closed because primary coverage was available elsewhere.

Complaints Received Directly from any Person or Entity Other than the Department of Insurance – any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the jurisdiction’s insurance laws. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose.

Include:

• Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.)
• Complaints received from third parties

Complaints Received Directly from the Department of Insurance – All complaints:

• As identified by the DOI as a complaint.
• Sent or otherwise forwarded by the DOI to the reporting company.

Date of Final Payment – The date final payment was issued to the insured/claimant.

Calculation Clarification:

• If partial payments were made on the claim, the claim would be considered closed with payment if the final payment was made during the reporting period regardless of the date of loss or when the claim was received.
• Report a claim as “closed with payment” or “closed without payment” if it is closed in the company’s claims system during the reporting period (even if the final payment was issued in a prior reporting period.)
• If a claim remains open at the end of the reporting period (even though a final payment
Property & Casualty Market Conduct Annual Statement
Travel Insurance Data Call & Definitions

has been issued) it should be reported as open. Only when the claim is closed in the company’s claims system, would you report the days to final payment.

Example:
- A claim is open on 11/1/00 and final payment is made on 12/1/00. The claim is left open until 2/1/01 to allow time for supplemental requests.
  - The claim would be reported as open in the “00” MCAS submission and closed in the “01” MCAS submission.
  - The number of days to final payment would be calculated as 30 days and reported in the “01” MCAS submission.

Date the Claim was Reported – The date an insured or claimant first reported his or her claim to either the company or insurance agent.

Domestic Coverage: Coverage for travel originating and contained within the United States including travel directly to and from mainland United States to Hawaii, Alaska and United States territories.

Group Travel Insurance means Travel Insurance issued to any Eligible Group as defined by state law.

International Coverage: Coverage for any travel other than Domestic.

Premium Written During Period – The total premium written before any reductions for refunds for travel insurance during the reporting period.

In-force – A master policy, individual policy, or certificate in effect during the reporting period.

Lawsuit – An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

For purposes of reporting lawsuits in the Travel MCAS blank:
- Include only lawsuits brought by an applicant for insurance or a policyholder or a claimant/beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit seeks damages under two or more policies, count the number of policies involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies, count the action as three lawsuits;
Property & Casualty Market Conduct Annual Statement

Travel Insurance Data Call & Definitions

- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each jurisdiction in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Lawsuits Closed During the Period with Consideration for the Consumer – A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant or policyholder in an amount greater than offered by the reporting company before the lawsuit was brought.

Median Days to Final Payment – The median value for all claims closed with payment during the period.

Calculation for losses with one final payment date during the reporting period:
- Date the loss was reported to the company to the date of final payment.

Calculation for losses with multiple final payment dates during the reporting period:
- Date the request for supplemental payment received to the date of final payment (for each different final payment date.)

Exclude:
- Subrogation payments.

Calculation Clarification / Example:
- To determine the Median Days to Final Payment you must first determine the number of days it took to settle each claim. This is the difference between the date the loss was reported to the company, or the date the request for supplemental payment was received, to the date of final payment. The Median Days to Final Payment is the median value of the number of days it took to settle all claims closed with payment during the period.

Median - A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.
Consider the following simple example of the number of days it took to settle each of the following seven claims:

<table>
<thead>
<tr>
<th>Claim</th>
<th>Nbr 1</th>
<th>Nbr 2</th>
<th>Nbr 3</th>
<th>Nbr 4</th>
<th>Nbr 5</th>
<th>Nbr 6</th>
<th>Nbr 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days to Settle</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>20</td>
</tr>
</tbody>
</table>

In this situation, the Median Days to Final Payment would be 5 because it is the middle value. There are exactly 3 values below the median (2, 4, & 4) and 3 values above the median (6, 8, & 20). If the data set had included an even number of values, then the median would be the average of the two middle values as demonstrated below.

<table>
<thead>
<tr>
<th>Claim</th>
<th>Nbr 1</th>
<th>Nbr 2</th>
<th>Nbr 3</th>
<th>Nbr 4</th>
<th>Nbr 5</th>
<th>Nbr 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days to Settle</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>20</td>
</tr>
</tbody>
</table>

Median Days to Final Payment = (5 + 6)/2 = 5.5

The median should be consistent with the paid claim counts reported in the closing time intervals.

Example: A carrier reports the following closing times for paid claims.

Closing Time # of Claims

<table>
<thead>
<tr>
<th>Closing Time</th>
<th># of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30</td>
<td>22</td>
</tr>
<tr>
<td>31-60</td>
<td>13</td>
</tr>
<tr>
<td>61-90</td>
<td>18</td>
</tr>
<tr>
<td>91-180</td>
<td>11</td>
</tr>
<tr>
<td>181-365</td>
<td>12</td>
</tr>
<tr>
<td>&gt;365</td>
<td>15</td>
</tr>
</tbody>
</table>

The sum of the claims reported across each closing time interval is 91, so that the median is the 46th claim. This claim falls into the closing time interval “61-90 days.” Any reported median that falls outside of this range (i.e. less than 61 or greater than 90) will indicate a data error.

**NAIC Company Code** – The five-digit code assigned by the NAIC to all U.S. domiciled companies which filed a Financial Annual Statement with the NAIC.

**NAIC Group Code** – The code assigned by the NAIC to identify those companies that are a part of a given holding company structure. A zero indicates that the company is not part of a holding
Draft: 5/26/21

Adopted by the Executive (EX) Committee and Plenary, XX, XX, 2021
Adopted by the Market Regulation and Consumer Affairs (D) Committee, July, 27, 2021
Adopted by the MCAS Blanks (D) Working Group, May 26, 2021

Property & Casualty Market Conduct Annual Statement
Travel Insurance Data Call & Definitions

company.

Travel Retailer means a business entity that makes, arranges or offers planned travel and may offer and disseminate Travel Insurance as a service to its customers on behalf of and under the direction of a Limited Lines Travel Insurance Producer.

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Property & Casualty Market Conduct Annual Statement
Homeowner Data Call & Definitions

Line of Business: Homeowners
Reporting Period: January 1, 20XX through December 31, 20XX
Filing Deadline: April 30, 20XX

Contact Information

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCAS Administrator</td>
<td>The person responsible for assigning who may view and input company data.</td>
</tr>
<tr>
<td>MCAS Contact</td>
<td>The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.</td>
</tr>
<tr>
<td>MCAS Attestor</td>
<td>The person who attests to the completeness and accuracy of the MCAS data.</td>
</tr>
</tbody>
</table>

Schedule 1—Interrogatories

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-01</td>
<td>Were there policies in-force during the reporting period that provided Dwelling coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-02</td>
<td>Were there policies in-force during the reporting period that provided Personal Property coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-03</td>
<td>Were there policies in-force during the reporting period that provided Liability coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-04</td>
<td>Were there policies in-force during the reporting period that provided Medical Payments coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-05</td>
<td>Were there policies in-force during the reporting period that provided Loss of Use coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-06</td>
<td>Was the Company still actively writing policies in the state at year end?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-07</td>
<td>Does the Company write in the non-standard market?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-08</td>
<td>If yes, what percentage of your business is non-standard?</td>
<td>Comment</td>
</tr>
<tr>
<td>1-09</td>
<td>If yes, how is non-standard defined?</td>
<td>Comment</td>
</tr>
<tr>
<td>1-10</td>
<td>Has the company had a significant event/business strategy that would affect data for this reporting period? Yes/No</td>
<td>Comment</td>
</tr>
<tr>
<td>1-11</td>
<td>If yes, add additional comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1-12</td>
<td>Has this block of business or part of this block of business been sold, closed or moved to another company during the reporting period?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-13</td>
<td>If yes, add additional comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1-14</td>
<td>How does company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? Re-open original claim/open new claim</td>
<td>Comment</td>
</tr>
</tbody>
</table>
Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

<table>
<thead>
<tr>
<th></th>
<th>Does the company use Managing General Agents (MGAs)?</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If yes, list the names of the MGAs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Does the company use Third Party Administrators (TPAs)?</td>
<td>Yes/No</td>
</tr>
<tr>
<td></td>
<td>If yes, list the names of the TPAs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Does the company use digital claim settlement?</td>
<td>Yes/No</td>
</tr>
<tr>
<td></td>
<td>If yes, list the vendors providing third-party data and algorithms used in the digital claim settlement process, and for each vendor identify the vendor’s role in the digital claims process.</td>
<td>Comment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Claims Comments</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Underwriting Comments</td>
<td>Comment</td>
</tr>
</tbody>
</table>

Coverages

<table>
<thead>
<tr>
<th>Coverages</th>
<th>Reported also at the Digital Claim Handling Process Level of Detail *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dwelling (includes – Other Structures)</td>
<td>X</td>
</tr>
<tr>
<td>Personal Property</td>
<td>X</td>
</tr>
<tr>
<td>Liability</td>
<td></td>
</tr>
<tr>
<td>Medical Payments</td>
<td></td>
</tr>
<tr>
<td>Loss of Use</td>
<td></td>
</tr>
</tbody>
</table>

* Includes Digital Claims, Hybrid Claims and Non-Digital Claims (Applies only to claims related data elements)

Additionally, an “All” breakout will be included for the reporting of Median Days to Final Payment.
Property & Casualty Market Conduct Annual Statement
Homeowner Data Call & Definitions

Schedule 2—Homeowners Claims Activity, Counts Reported by Claimant and by Coverage

Report the number of reserves/lines/features opened for each coverage part per claim. For example, if one claim results in a reserve/line/feature opened for two liability claimants, two medical payment claims, one dwelling claim for the insured, and one personal property claim for the insured, you would report as follows: Dwelling – 1; Personal Property – 1; Liability – 2; Medical Payments – 2. The number of days to final payment (if payment is made) would be calculated separately for each claimant.

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-23</td>
<td>Number of claims open at the beginning of the period</td>
</tr>
<tr>
<td>2-24</td>
<td>Number of claims opened during the period</td>
</tr>
<tr>
<td>2-25</td>
<td>Number of claims closed during the period, with payment</td>
</tr>
<tr>
<td>2-26</td>
<td>Number of claims closed during the period, without payment</td>
</tr>
<tr>
<td>2-27</td>
<td>Number of claims open at the end of the period</td>
</tr>
<tr>
<td>2-28</td>
<td>Median days to final payment</td>
</tr>
<tr>
<td>2-29</td>
<td>Number of claims closed with payment within 0-30 days</td>
</tr>
<tr>
<td>2-30</td>
<td>Number of claims closed with payment within 31-60 days</td>
</tr>
<tr>
<td>2-31</td>
<td>Number of claims closed with payment within 61-90 days</td>
</tr>
<tr>
<td>2-32</td>
<td>Number of claims closed with payment within 91-180 days</td>
</tr>
<tr>
<td>2-33</td>
<td>Number of claims closed with payment within 181-365 days</td>
</tr>
<tr>
<td>2-34</td>
<td>Number of claims closed with payment beyond 365 days</td>
</tr>
<tr>
<td>2-35</td>
<td>Number of claims closed without payment within 0-30 days</td>
</tr>
<tr>
<td>2-36</td>
<td>Number of claims closed without payment within 31-60 days</td>
</tr>
<tr>
<td>2-37</td>
<td>Number of claims closed without payment within 61-90 days</td>
</tr>
<tr>
<td>2-38</td>
<td>Number of claims closed without payment within 91-180 days</td>
</tr>
<tr>
<td>2-39</td>
<td>Number of claims closed without payment within 181-365 days</td>
</tr>
<tr>
<td>2-40</td>
<td>Number of lawsuits open at beginning of the period</td>
</tr>
<tr>
<td>2-41</td>
<td>Number of lawsuits opened during the period</td>
</tr>
<tr>
<td>2-42</td>
<td>Number of lawsuits closed during the period</td>
</tr>
<tr>
<td>2-43</td>
<td>Number of lawsuits open at end of period</td>
</tr>
<tr>
<td>2-44</td>
<td>Number of lawsuits closed with consideration for the consumer.</td>
</tr>
</tbody>
</table>
Property & Casualty Market Conduct Annual Statement
Homeowner Data Call & Definitions

Schedule 3—Homeowners Underwriting Activity

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-46</td>
<td>Number of dwellings which have policies in-force at the end of the period</td>
</tr>
<tr>
<td>3-47</td>
<td>Number of dwelling fire policies in force at the end of the period.</td>
</tr>
<tr>
<td>3-48</td>
<td>Number of homeowner policies in force at the end of the period.</td>
</tr>
<tr>
<td>3-49</td>
<td>Number of tenant/renter/condo policies in force at the end of the period.</td>
</tr>
<tr>
<td>3-50</td>
<td>Number of all other residential property policies in force at the end of the period.</td>
</tr>
<tr>
<td>3-51</td>
<td>Number of new business policies written during the period</td>
</tr>
<tr>
<td>3-52</td>
<td>Dollar amount of direct premium written during the period</td>
</tr>
<tr>
<td>3-53</td>
<td>Number of Company-Initiated non-renewals during the period</td>
</tr>
<tr>
<td>3-54</td>
<td>Number of cancellations for non-pay or non-sufficient funds</td>
</tr>
<tr>
<td>3-55</td>
<td>Number of cancellations at the insured’s request</td>
</tr>
<tr>
<td>3-56</td>
<td>Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated company</td>
</tr>
<tr>
<td>3-57</td>
<td>Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to an affiliated company</td>
</tr>
<tr>
<td>3-58</td>
<td>Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to an affiliated company</td>
</tr>
<tr>
<td>3-59</td>
<td>Number Of Complaints Received Directly From Any Person or Entity Other than the DOI</td>
</tr>
</tbody>
</table>
Property & Casualty Market Conduct Annual Statement
Homeowner Data Call & Definitions

Definitions:

In determining what business to report for a particular state, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages. Exclude lender-placed or creditor-placed policies.

Please note: In the Underwriting Section there are questions asking for policies in-force by type of policy. These are asking for a count of the policies in-force that meet the specifications to be included on the MCAS. Please use the following as a guide to determine which policy types should be reported for each question:

(3-45) Number of dwelling fire policies in force at the end of the period.
Include dwelling policies that meet the definition of a dwelling policy as defined within this document. This would typically include policies written on forms DP-1, DP-2 and DP-3.

(3-46) Number of homeowner policies in force at the end of the period.
Include homeowner policies that meet the definition of a homeowner policy as defined within this document. This would typically include policies written on forms HO-1, HO-2, HO-3, HO-5, HO-7 and HO-8.

(3-47) Number of tenant/renter/condo policies in force at the end of the period.
Include tenant/renter/condo policies that meet the definition of a tenant/renter/condo policy as defined within this document. This would typically include policies written on forms HO-4 and HO-6.

(3-48) Number of all other residential property policies in force at the end of the period.
Include other policies that meet the specifics of MCAS reporting, but that do not fall into one of the categories requested in questions 3-45, 3-46 and 3-47. If your company only write policies that fall into the forms specified for questions 3-45, 3-46 and 3-47, this number will be 0.

Cancellations – Includes all cancellations of the policies where the cancellation effective date is during the reporting year. The number of cancellations should be reported on a policy basis regardless of the number of dwellings insured under the policy.

Report cancellations separately for:

- Policies cancelled for non-payment of premium or non-sufficient funds.
  - These should be reported every time a policy cancels for the above reasons. (i.e., if a policy cancels for non-pay three times in a policy period, and is reinstated each time; each cancellation should be counted.)
- Policies cancelled at the insured’s request.
- Policies cancelled for underwriting reasons.

Exclude:

- Policies cancelled for ‘re-write’ purposes where there is no lapse in coverage.
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Cancellations within the first 59 days – Company-initiated cancellations for new business where the notice of cancellation was issued within the first 59 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the ‘underwriting’ period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Cancellations from 60 to 90 days – Company-initiated cancellations where the notice of cancellation was issued 60 to 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the ‘underwriting’ period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Cancellations greater than 90 days – Company-initiated cancellations where the notice of cancellation was issued more than 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the ‘underwriting’ period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Claim - A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy. Each claimant/insured reporting a loss is counted separately.

Include:

- Both first and third party claims.

Exclude:

- An event reported for “information only”.
- An inquiry of coverage if a claim has not actually been presented (opened) for payment.
- A potential claimant if that individual has not made a claim nor had a claim made on his or her behalf.

Claims Closed With Payment – Claims closed with payment where the claim was closed during the reporting period regardless of the date of loss or when the claim was received. The number of days to closure, however, should be measured as the difference between the date of the final payment and the date the claim was reported or between the date of the final
Property & Casualty Market Conduct Annual Statement

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Payment and the date the request for supplemental payment was received. See also “Date of Final Payment”.

Exclude:
- Claims where payment was made for company loss adjustment expenses if no payment was made to an insured/claimant.
- Claims that are closed because the amount claimed is below the insured’s deductible.

Clarification:
- If a claim is reopened for the sole purpose of refunding the insured’s deductible, do not count it as a paid claim.
- For claims where the net payment is $0 due to subrogation recoveries, report the number of claims in which any amount was paid to the insured; do not net the payment with subrogation recoveries when counting the number of paid claims.

Calculation Clarification:
- For each coverage identifier, the sum of the claims closed with payment across each closing time interval should equal the total number of claims closed with payment during the reporting period.

Handling Additional Payment on Previously Reported Claim / Subsequent Supplemental Payment for claims closed with payment during the reporting period:
- If a claim is reopened for a subsequent supplemental payment, count the reopened claim as a new claim. Calculate a separate aging on that supplemental payment from the time the request for supplemental payment was received to the date of the final payment was made.

Claims Closed Without Payment – Claims closed with no payment made to an insured or third party. The number of days to closure is the difference between the date the claim was closed and the date the claim was reported and/or reopened. See also “Date of Final Payment”.

Include:
- All claims that were closed during the reporting period regardless of the date of loss or when the claim was received.
- Claims where no payment was made to an insured/claimant even though payment was made for company loss adjustment expenses.
- A demand for payment for which it was determined that no relevant policy was in-force at the time of the loss if a claim file was set up and the loss was investigated.
- Claims that are closed because the amount claimed is below the insured’s deductible.
Property & Casualty Market Conduct Annual Statement
Homeowner Data Call & Definitions

Calculation Clarification:
- For each coverage identifier, the sum of the claims closed without payment across each closing time interval should equal the total number of claims closed without payment during the reporting period.

Complaint – any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state’s insurance laws. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose.
Include:
- Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.)
- Complaints received from third parties.

Coverage - Dwelling (includes – Other Structures) – Coverage for dwellings under Homeowners Policies and Dwelling Fire and Dwelling Liability Policies. It includes coverage for Other Structures.

Coverage - Loss of Use – Loss of Use provided under Homeowners Policies.

Coverage - Personal Property – Personal Property provided under Homeowners Policies.

Coverage - Liability – Liability insurance provided under Homeowners Policies.

Coverage - Medical Payments – Medical Payments provided under Homeowners Policies.

Date of Final Payment – The date final payment was issued to the insured/claimant.

Calculation Clarification:
- If partial payments were made on the claim, the claim would be considered closed with payment if the final payment date was made during the reporting period regardless of the date of loss or when the claims was received.
- Report a claim as “closed with payment” or “closed without payment” if it is closed in the company’s claims system during the reporting period (even if the final payment was issued in a prior reporting period.
- If a claim remains open at the end of the reporting period (even though a final payment has been issued) it should be reported as open. Only when the claim is closed in the company’s claims system, would you report the days to final payment.

Example:
- A claim is open on 11/1/00 and final payment is made on 12/1/00. The claim is left open until 2/1/01 to allow time for supplemental requests.
  - The claim would be reported as open in the “00” MCAS submission and closed in the “01” MCAS submission.
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- The number of days to final payment would be calculated as 30 days and reported in the “01” MCAS submission.

**Date the Claim was Reported** – The date an insured or claimant first reported his or her loss to either the company or insurance agent.
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Digital Claim Handling Process Level of Detail Breakdown:

**Digital Claim** – A claim involving a claim settlement determination which was accepted by the insured/claimant without adjustment whereby the entire claim was handled without human intervention on the part of the insurance company in the loss appraisal process, settlement determination, and/or in the production of the initial loss settlement offer. Digital claims utilize only digital information to establish the extent of damage and to produce a loss settlement determination through the application of one or more automated loss algorithms applied to digital information. No human inspection or appraisal of the damaged property is conducted by the insurance company, independent adjuster, or other person relied upon by the insurance company during the life cycle of the claim.

Examples of digital claim information include, but are not limited to, photos taken by a claimant or insured, photos taken by a plane or drone, and/or data provided by in-vehicle or in-property sensors.

**Hybrid Claim** – A claim whereby the initial loss settlement determination began as a digital claim, however, at some point in the claim life cycle required the use of human resources in the loss appraisal process, settlement determination, and/or in the production of the initial or subsequent loss settlement offer.

**Non-Digital Claim** – means any claim other than a Digital Claim or Hybrid Claim.

**Direct Written Premium** - The total amount of direct written premium for all polices covered by the market conduct annual statement (new and renewal) written during the reporting period.

**Calculation Clarification:**
- Premium amounts should be determined in the same manner as used for the financial annual statement.
- If premium is refunded or additional premium is written during the reporting period (regardless of the applicable policy effective date), the net effect should be reported.
- If there is a difference of 20% or more between the Direct Written Premium reported for market conduct annual statement and the Direct Written Premium reported on the financial annual statement, provide an explanation for the difference when filing the market conduct annual statement in order to avoid inquiries from the regulator receiving the market conduct annual statement filing.
- Reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier, nor, shall any deductions be
Property & Casualty Market Conduct Annual Statement

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made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded.

Dwelling – A personally occupied residential dwelling.

Calculation Clarification:
  • A 2 or 3 family home covered under one policy would be considered 1 dwelling.

Dwelling Fire Policies – Coverage for dwellings and their contents. It may also provide liability coverage and is usually written when a residential property does not qualify according to the minimum requirements of a homeowner’s policy, or because of a requirement for the insured to select several different kinds of coverage and limits on this protection.

Include:
  • Dwelling Fire and Dwelling Liability policies should be included ONLY IF the policies written under these programs are for personally occupied residential dwellings, not policies written under a commercial program and/or on a commercial lines policy form.

Homeowners Policies – Policies that combine liability insurance with one or more other types of insurance such as property damage, personal property damage, medical payments and additional living expenses.

Include:
  • Mobile/Manufactured homes intended for use as a dwelling regardless of where [or what line] on the Statutory Annual Statement state page associated premium is reported.
  • Renters insurance, Policies covering log homes, land homes, and site built homes are included.
  • Inland Marine or Personal Articles endorsements.
  • Include policies written on the HO-1, HO-2, HO-3, HO-5, HO-7 and HO-8 policy forms.

Exclude:
  • Farmowners is not included as it is considered to be Commercial Lines for purposes of this project.
  • Umbrella policies.
  • Lender-placed or creditor-placed policies.

Inland Marine or Personal Articles Endorsements – Provides coverage via endorsement to a homeowners policy for direct physical loss to personal property as described in the endorsement.

Exclude:
  • Stand-alone Inland Marine Policies.
Adopted by the Executive (EX) Committee and Plenary, XX, XX, 2021
Adopted by the Market Regulation and Consumer Affairs (D) Committee, July, 27, 2021
Adopted by the MCAS Blanks (D) Working Group, June 30, 2021

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Homeowner Data Call & Definitions

Note: Revisions to the 2021 data year Lawsuits definitions were adopted by the Market Regulation and Consumer Affairs (D) Committee and NAIC EX/ Plenary during the 2020 NAIC Fall National Meeting.

Lawsuit – A court proceeding to recover a right to a claim, including lawsuits for arbitration cases.

Exclude:
- Subrogation claims where lawsuit is filed by the company against the tortfeasor.
- Non-lawsuit legal activity or litigation filed by an insurer, including, but not limited to: request to compel an independent medical examination, an examination under oath, and declaratory judgment actions filed by an insurer.

Calculation Clarification:
- Lawsuits should be reported on the same basis as claims. One lawsuit should be reported for each / claimant / coverage combination, regardless of the number of actual suits filed.
- One lawsuit with two claimants would be reported as two lawsuits as any awards/payments made would be made to the claimants individually.
- One lawsuit filed seeking damages for multiple coverages should be reported as one lawsuit for each applicable coverage.
- Lawsuits should be reported in the state in which the claim was reported on this statement.
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Include an explanatory note with your submission state the number of class action lawsuits included in the data and the general cause of the action.

Lawsuits Closed During the Period with Consideration for the Consumer—A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the claimant in an amount greater than offered by the reporting insurer before the lawsuit was brought.

Liability Insurance – Coverage for all sums that the insured becomes legally obligated to pay because of bodily injury or property damage, and sometimes other torts to which an insurance policy applies.

Loss Of Use – Coverage for additional living expenses incurred by the insured or fair rental value when the insured dwelling becomes uninhabitable as the result of an insured loss or when access to the dwelling is barred by civil authority.
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**Homeowner Data Call & Definitions**

**Median Days to Final Payment** – The median value for all claims closed with payment during the period.

Calculation for losses with one final payment date during the reporting period:
- Date the loss was reported to the company to the date of final payment.

Calculation for losses with multiple final payment dates during the reporting period:
- Date the request for supplemental payment received to the date of final payment (for each different final payment date.)

Exclude:
- Subrogation payments.

Calculation Clarification / Example:
- To determine the Median Days to Final Payment you must first determine the number of days it took to settle each claim. This is the difference between the date the loss was reported to the company, or the date the request for supplemental payment was received, to the date of final payment. The Median Days to Final Payment is the median value of the number of days it took to settle all claims closed with payment during the period.

**Median** - A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.

Consider the following simple example of the number of days it took to settle each of the following seven claims:

<table>
<thead>
<tr>
<th>Claim Nbr</th>
<th>Nbr 1</th>
<th>Nbr 2</th>
<th>Nbr 3</th>
<th>Nbr 4</th>
<th>Nbr 5</th>
<th>Nbr 6</th>
<th>Nbr 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days to Settle</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>20</td>
</tr>
</tbody>
</table>

In this situation, the Median Days to Final Payment would be 5 because it is the middle value. There are exactly 3 values below the median (2, 4, & 4) and 3 values above the median (6, 8, & 20). If the data set had included an even number of values, then the median would be the average of the two middle values as demonstrated below.
Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

Median Days to Final Payment = (5 + 6)/2 = 5.5

The median should be consistent with the paid claim counts reported in the closing time intervals.
Property & Casualty Market Conduct Annual Statement
Homeowner Data Call & Definitions

Example: A carrier reports the following closing times for paid claims.

Closing Time # of Claims

<table>
<thead>
<tr>
<th>Closing Time</th>
<th># of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30</td>
<td>22</td>
</tr>
<tr>
<td>31-60</td>
<td>13</td>
</tr>
<tr>
<td>61-90</td>
<td>18</td>
</tr>
<tr>
<td>91-180</td>
<td>11</td>
</tr>
<tr>
<td>181-365</td>
<td>12</td>
</tr>
<tr>
<td>&gt;365</td>
<td>15</td>
</tr>
</tbody>
</table>

The sum of the claims reported across each closing time interval is 91, so that the median is the 46\textsuperscript{th} claim. This claim falls into the closing time interval “61-90 days.” Any reported median that falls outside of this range (i.e. less than 61 or greater than 90) will indicate a data error.

Medical Payments Coverage – Provides coverage for medical expenses resulting from injuries sustained by a claimant regardless of liability.

NAIC Company Code – The five-digit code assigned by the NAIC to all U.S. domiciled companies which filed a Financial Annual Statement with the NAIC.

NAIC Group Code – The code assigned by the NAIC to identify those companies that are a part of a given holding company structure. A zero indicates that the company is not part of a holding company.

New Business Policy Written – A newly written agreement that puts insurance coverage into effect during the reporting period.

Exclude:
- ‘Re-written’ policies unless there was a lapse in coverage.

Non-Renewals – A policy for which the insurer elected not to renew the coverage for circumstances allowed under the “non-renewal” clause of the policy.

Include:
- All company-initiated non-renewals of the policies where the non-renewal effective date is during the reporting period.

Exclude:
- Policies where a renewal offer was made and the policyholder did not accept the offer.
- Instances where the policyholder requested that the policy not be renewed.

Calculation Clarification:
- The number of nonrenewals should be reported on a policy basis regardless of the number of dwellings insured under the policy.
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Other Structures – Structures on the residence premises (1) separated from the dwelling by a clear space or (2) connect to the dwelling by a fence, wall, wire, or other form of connection but not otherwise attached.

Personal Property Damage Coverage – Provides coverage for damage to dwelling contents or other covered personal property caused by an insured peril.

Personally Occupied – A dwelling in which the person owning the policy personally occupies the dwelling and lives there.

Property Damage Coverage – Provides coverage for damage to the dwelling and/or other insured structures caused by an insured peril.

Policy In-force – A policy in which the coverage is in effect as of the end of the reporting period.

Tenant/Renters/Condo Policies – Policies that provide coverage for the personal property of tenants, renters, condominium and cooperative unit owners. Include policies typically written on the HO-4 and HO-6 policy forms.
Property & Casualty Market Conduct Annual Statement
Private Passenger Auto Data Call & Definitions

Line of Business: Private Passenger Auto

Reporting Period: January 1, 20XX through December 31, 20XX

Filing Deadline: April 30, 20XX

Contact Information

<table>
<thead>
<tr>
<th>MCAS Administrator</th>
<th>The person responsible for assigning who may view and input company data.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCAS Contact</td>
<td>The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.</td>
</tr>
<tr>
<td>MCAS Attestor</td>
<td>The person who attests to the completeness and accuracy of the MCAS data.</td>
</tr>
</tbody>
</table>

Schedule 1—Interrogatories

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-01</td>
<td>Were there policies in-force during the reporting period that provided Collision coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-02</td>
<td>Were there policies in-force during the reporting period that provided Comprehensive/Other Than Collision coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-03</td>
<td>Were there policies in-force during the reporting period that provided Bodily Injury coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-04</td>
<td>Were there policies in-force during the reporting period that provided Property Damage coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-05</td>
<td>Were there policies in-force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMBI) coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-06</td>
<td>Were there policies in-force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMPD) coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-07</td>
<td>Were there policies in-force during the reporting period that provided Medical Payments coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-08</td>
<td>Were there policies in-force during the reporting period that provided Combined Single Limits coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-09</td>
<td>Were there policies in-force during the reporting period that provided Personal Injury Protection coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-10</td>
<td>Was the Company still actively writing policies in the state at year end?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-11</td>
<td>Does the Company write in the non-standard market?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-12</td>
<td>If yes, what percentage of your business is non-</td>
<td>Percentage</td>
</tr>
</tbody>
</table>
### Property & Casualty Market Conduct Annual Statement

**Private Passenger Auto Data Call & Definitions**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>standard?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1-13</strong></td>
<td>If yes, how is non-standard defined?</td>
</tr>
<tr>
<td><strong>1-14</strong></td>
<td>Has the company had a significant event/business strategy that would affect data for this reporting period?</td>
</tr>
<tr>
<td><strong>1-15</strong></td>
<td>If yes, add additional comments</td>
</tr>
<tr>
<td><strong>1-16</strong></td>
<td>Has this block of business or part of this block of business been sold, closed or moved to another company during the reporting period?</td>
</tr>
<tr>
<td><strong>1-17</strong></td>
<td>If yes, add additional comments</td>
</tr>
<tr>
<td><strong>1-18</strong></td>
<td>How does company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? Re-open original claim/open new claim</td>
</tr>
<tr>
<td><strong>1-19</strong></td>
<td>Does the company use Managing General Agents (MGAs)?</td>
</tr>
<tr>
<td><strong>1-20</strong></td>
<td>If yes, list the names of the MGAs.</td>
</tr>
<tr>
<td><strong>1-21</strong></td>
<td>Does the company use Third Party Administrators (TPAs)?</td>
</tr>
<tr>
<td><strong>1-22</strong></td>
<td>If yes, list the names of the TPAs.</td>
</tr>
<tr>
<td><strong>1-23</strong></td>
<td>Does the company use telematics or usage-based data?</td>
</tr>
<tr>
<td><strong>1-24</strong></td>
<td>Does the company use digital claim settlement?</td>
</tr>
<tr>
<td><strong>1-25</strong></td>
<td>If yes, list the vendors providing third-party data and algorithms used in the digital claim settlement process, and for each vendor identify the vendor’s role in the digital claims process.</td>
</tr>
<tr>
<td><strong>1-26</strong></td>
<td>Claims Comments</td>
</tr>
<tr>
<td><strong>1-27</strong></td>
<td>Underwriting Comments</td>
</tr>
</tbody>
</table>
Property & Casualty Market Conduct Annual Statement
Private Passenger Auto Data Call & Definitions

<table>
<thead>
<tr>
<th>Coverages</th>
<th>Reported also at the Digital Claim Handling Process Level of Detail *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collision</td>
<td>X</td>
</tr>
<tr>
<td>Comprehensive/Other Than Collision</td>
<td>X</td>
</tr>
<tr>
<td>Bodily Injury</td>
<td></td>
</tr>
<tr>
<td>Property Damage</td>
<td>X</td>
</tr>
<tr>
<td>Uninsured Motorists and Underinsured Motorists (UMBI)</td>
<td></td>
</tr>
<tr>
<td>Uninsured Motorists and Underinsured Motorists (UMPD)</td>
<td>X</td>
</tr>
<tr>
<td>Medical Payments</td>
<td></td>
</tr>
<tr>
<td>Combined Single Limits</td>
<td></td>
</tr>
<tr>
<td>Personal Injury Protection</td>
<td></td>
</tr>
</tbody>
</table>

* Includes Digital Claims, Hybrid Claims and Non-Digital Claims (Applies only to claims related data elements)

Additionally, an “All” breakout will be included for the reporting of Median Days to Final Payment.

Schedule 2—Private Passenger Auto Claims Activity, Counts Reported by Claimant, by Coverage
Report the number of reserves/lines/features opened for each coverage part per claim. For example, if one claim results in a reserve/line/feature opened for two bodily injury claimants (one property damage claimant, one collision claim for the insured, and one medical payment claim for the insured), it would be reported as follows: Collision – 1, Bodily Injury – 2; Property Damage – 1; and Medical Payments – 1. The number of days to final payment (if payment is made) would be calculated separately for each claimant.

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-28</td>
<td>Number of claims open at the beginning of the period</td>
</tr>
<tr>
<td>2-29</td>
<td>Number of claims opened during the period</td>
</tr>
<tr>
<td>2-30</td>
<td>Number of claims closed during the period, with payment</td>
</tr>
<tr>
<td>2-31</td>
<td>Number of claims closed during the period, without payment.</td>
</tr>
<tr>
<td>2-32</td>
<td>Number of claims closed during the period, without payment, because the amount claimed is below the insured’s deductible.</td>
</tr>
</tbody>
</table>
## Property & Casualty Market Conduct Annual Statement

### Private Passenger Auto Data Call & Definitions

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-33</td>
<td>Number of claims remaining open at the end of the period</td>
</tr>
<tr>
<td>2-34</td>
<td>Median days to final payment</td>
</tr>
<tr>
<td>2-35</td>
<td>Number of claims closed with payment within 0-30 days</td>
</tr>
<tr>
<td>2-36</td>
<td>Number of claims closed with payment within 31-60 days</td>
</tr>
<tr>
<td>2-37</td>
<td>Number of claims closed with payment within 61-90 days</td>
</tr>
<tr>
<td>2-38</td>
<td>Number of claims closed with payment within 91-180 days</td>
</tr>
<tr>
<td>2-39</td>
<td>Number of claims closed with payment within 181-365 days</td>
</tr>
<tr>
<td>2-40</td>
<td>Number of claims closed with payment beyond 365 days</td>
</tr>
<tr>
<td>2-41</td>
<td>Number of claims closed without payment within 0-30 days</td>
</tr>
<tr>
<td>2-42</td>
<td>Number of claims closed without payment within 31-60 days</td>
</tr>
<tr>
<td>2-43</td>
<td>Number of claims closed without payment within 61-90 days</td>
</tr>
<tr>
<td>2-44</td>
<td>Number of claims closed without payment within 91-180 days</td>
</tr>
<tr>
<td>2-45</td>
<td>Number of claims closed without payment within 181-365 days</td>
</tr>
<tr>
<td>2-46</td>
<td>Number of claims closed without payment beyond 365 days</td>
</tr>
<tr>
<td>2-47</td>
<td>Number of lawsuits open at beginning of the period</td>
</tr>
<tr>
<td>2-48</td>
<td>Number of lawsuits opened during the period</td>
</tr>
<tr>
<td>2-49</td>
<td>Number of lawsuits closed during the period</td>
</tr>
<tr>
<td>2-50</td>
<td>Number of lawsuits open at end of period</td>
</tr>
<tr>
<td>2-51</td>
<td>Number of lawsuits closed with consideration for the consumer.</td>
</tr>
</tbody>
</table>

### Schedule 3—Private Passenger Auto Underwriting

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-52</td>
<td>Number of autos which have policies in-force at the end of the period</td>
</tr>
<tr>
<td>3-53</td>
<td>Number of policies in-force at the end of the period</td>
</tr>
<tr>
<td>3-54</td>
<td>Number of new business policies written during the period</td>
</tr>
<tr>
<td>3-55</td>
<td>Dollar amount of direct premium written during the period</td>
</tr>
<tr>
<td>3-56</td>
<td>Number of Company-Initiated non-renewals during the period</td>
</tr>
<tr>
<td>3-57</td>
<td>Number of cancellations for non-pay or non-sufficient funds</td>
</tr>
<tr>
<td>3-58</td>
<td>Number of cancellations at the insured’s request</td>
</tr>
<tr>
<td>3-59</td>
<td>Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated company</td>
</tr>
</tbody>
</table>


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<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-60</td>
<td>Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to an affiliated company</td>
</tr>
<tr>
<td>3-61</td>
<td>Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to an affiliated company</td>
</tr>
<tr>
<td>3-62</td>
<td>Number of complaints received directly from any person or entity other than the DOI</td>
</tr>
</tbody>
</table>

Definitions:

In determining what business to report for a particular state, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages. Exclude lender-placed or creditor-placed policies.

Data should be reported for both private passenger automobiles and motorcycles. Exclude antique vehicles and primarily off-road vehicles such as dune buggies or three-wheel ATVs.

Cancellations – Includes all cancellations of the policies where the cancellation effective date is during the reporting year. The number of cancellations should be reported on a policy basis regardless of the number of automobiles insured under the policy.

Report cancellations separately for:
- Policies cancelled for non-payment of premium or non-sufficient funds
  - These should be reported every time a policy cancels for the above reasons (i.e., if a policy cancels for non-pay three times in a policy period, and is reinstated each time; each cancellation should be counted).
- Policies cancelled at the insured’s request
- Policies cancelled for underwriting reasons.

Exclude:
- Policies cancelled for ‘re-write’ purposes where there is no lapse in coverage.

Cancellations within the first 59 days – Company-initiated cancellations for new business where the notice of cancellation was issued within the first 59 days after the original effective date of the policy.
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- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the ‘underwriting’ period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Cancellations from 60 to 90 days – Company-initiated cancellations where the notice of cancellation was issued 60 to 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the ‘underwriting’ period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Cancellations greater than 90 days – Company-initiated cancellations where the notice of cancellation was issued more than 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the ‘underwriting’ period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Claim - A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy. Each claimant/insured reporting a loss is counted separately.

Include:

- Both first- and third-party claims.

Exclude:

- An event reported for “information only”.
- An inquiry of coverage if a claim has not actually been presented (opened) for payment.
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- A potential claimant if that individual has not made a claim nor had a claim made on his or her behalf.

Claims Closed With Payment – Claims closed with payment where the claim was closed during the reporting period regardless of the date of loss or when the claim was received. The number of days to closure, however, should be measured as the difference between the date of the final payment and the date the claim was reported or between the date of the final payment and the date the request for supplemental payment was received. See also “Date of Final Payment”.

Exclude:
- Claims where payment was made for company loss adjustment expenses if no payment was made to an insured/claimant.
- Claims that are closed because the amount claimed is below the insured’s deductible.

Clarifications:
- If a claim is reopened for the sole purpose of refunding the insured’s deductible, do not count it as a paid claim.
- For claims where the net payment is $0 due to subrogation recoveries, report the number of claims in which any amount was paid to the insured; do not net the payment with subrogation recoveries when counting the number of paid claims.

Calculation Clarification:
- For each coverage identifier, the sum of the claims settled with payment across each closing time interval should equal the total number of claims closed with payment during the reporting period.

Handling Additional Payment on Previously Reported Claim/Subsequent Supplemental Payment for claims closed with payment during the reporting period:
- If a claim is reopened for a subsequent supplemental payment, count thereopened claim as a new claim. Calculate a separate aging on the supplemental payment from the time the request for supplemental payment was received to the date the final payment was made.

Claims Closed Without Payment – Claims closed with no payment made to an insured or third party. The number of days to closure is the difference between the date
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the claim was closed and the date the claim was reported and/or reopened. See also “Date of Final Payment”.

Include:

- All claims that were closed during the reporting period regardless of the date of loss or when the claim was received.
- Claims where no payment was made to an insured/claimant even though payment was made for company loss adjustment expenses.
- A demand for payment for which it was determined that no relevant policy was in-force at the time of the loss if a claim file was set up and the loss was investigated.
- Claims that are closed because the amount claimed is below the insured’s deductible.

Complaint — any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose.

Include:

- Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.)
- Complaints received from third parties.

Coverage - Collision Insurance – Coverage to provide protection against physical contact of an automobile with another inanimate object resulting in damage to the insured automobile.

Clarification:

- Rental/transportation/tow expenses which are paid as a result or part of a collision claim should not be counted as separate claims.

Coverage - Comprehensive/Other than Collision Insurance – Coverage providing protection in the event of physical damage (other than collision), including theft of the insured automobile.

Clarification:

- Rental/transportation/tow expenses which are paid as a result or part of a comprehensive/other than collision claim should not be counted as separate claims.
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**Coverage - Bodily Injury** – Physical damage to one’s person. The purpose of liability (casualty) insurance is to cover bodily injury to a third party resulting from the negligent acts and omissions of an insured.

**Coverage - Property Damage Liability Insurance** – Coverage in the event that the negligent acts or omissions of an insured result in damage or destruction to another’s property.

Include:
- ‘Property Damage Rental’ coverage (i.e. amounts paid for a third party claimant’s rental car).

**Coverage - UMBI** – Includes both Uninsured Motorist Coverage and Underinsured Motorists Coverage for bodily injury claims.
- **Underinsured Motorist Coverage (UIM)** – Provides coverage for bodily injury sustained by an insured who is involved in an accident caused by an at-fault driver who does not have sufficient liability insurance to pay for the damages.
- **Uninsured Motorist Coverage (UM)** – Provides coverage for bodily injury sustained by an insured involved in an accident caused by an at-fault driver who does not have liability insurance.

**Coverage - UMPD** – Includes both Uninsured Motorist Property Damage Coverage and Underinsured Motorist Property Damage Coverage.
- **Underinsured Motorist Property Damage Coverage** – Provides coverage for property damage to covered property caused by an at-fault driver who does not have sufficient liability insurance to pay for the damages.
- **Uninsured Motorist Property Damage Coverage** – Provides coverage for property damage to covered property caused by an at-fault driver who does not have liability insurance.

**Coverage - Medical Payments Coverage** – First party coverage for injuries incurred in a motor vehicle accident.

**Coverage - Combined Single Limit** – Bodily injury liability and property damage liability expressed as a single sum of coverage.
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Coverage - Personal Injury Protection (PIP) – A first party benefit. coverage to pay basic expenses for an insured and his/her family in states with no fault automobile insurance laws. No-fault laws generally require drivers to carry personal injury protection coverage to pay for basic medical needs of the insured, such as medical expenses, in the event of an accident. For the purposes of this project, all PIP coverages (wage, funeral, death, medical, etc) that would correspond to first party coverages in the applicable participating states should be included.

Date of Final Payment – The date final payment was issued to the insured/claimant.

Calculation Clarification:
• If partial payments were made on the claim, the claim would be considered closed with payment if the final payment was made during the reporting period regardless of the date of loss or when the claims was received.
• Report a claim as “closed with payment” or “closed without payment” if it is closed in the company’s claims system during the reporting period (even if the final payment was issued in a prior reporting period.)
• If a claim remains open at the end of the reporting period (even though a final payment has been issued) it should be reported as open. Only when the claim is closed in the company’s claims system, would you report the days to final payment.

Example:
• A claim is open on 11/1/00 and final payment is made on 12/1/00. The claim is left open until 2/1/01 to allow time for supplemental requests.
  o The claim would be reported as open in the “00” MCAS submission and closed in the “01” MCAS submission.
  o The number of days to final payment would be calculated as 30 days and reported in the “01” MCAS submission.

Date the Claim was Reported – The date an insured or claimant first reported his or her loss to either the company or insurance agent.

Digital Claim Handling Process Level of Detail Breakdown:

Digital Claim – A claim involving a claim settlement determination which was accepted by the insured/claimant without adjustment whereby the entire claim was handled without human intervention on the part of the insurance company.
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in the loss appraisal process, settlement determination, and/or in the production of the initial loss settlement offer. Digital claims utilize only digital information to establish the extent of damage and to produce a loss settlement determination through the application of one or more automated loss algorithms applied to digital information. No human inspection or appraisal of the damaged property is conducted by the insurance company, independent adjuster, or other person relied upon by the insurance company during the life cycle of the claim.

Examples of digital claim information include, but are not limited to, photos taken by a claimant or insured, photos taken by a plane or drone, and/or data provided by in-vehicle or in-property sensors.

**Hybrid Claim** – A claim whereby the initial loss settlement determination began as a digital claim, however, at some point in the claim life cycle required the use of human resources in the loss appraisal process, settlement determination, and/or in the production of the initial or subsequent loss settlement offer.

**Non-Digital Claim** – means any claim other than a Digital Claim or Hybrid Claim.

**Direct Written Premium** - The total amount of direct written premium for all policies covered by the market conduct annual statement (new and renewal) written during the reporting period.

Calculation Clarification:

- Premium amounts should be determined in the same manner as used for the financial annual statement.
- If premium is refunded or additional premium is written during the reporting period (regardless of the applicable policy effective date), the net effect should be reported.
- If there is a difference of 20% or more between the Direct Written Premium reported for market conduct annual statement and the Direct Written Premium reported on the financial annual statement, provide an explanation for the difference when filing the market conduct annual statement in order to avoid inquiries from the regulator receiving the market conduct annual statement filing.
- Reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier, nor, shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded.
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Note: Revisions to the 2021 data year Lawsuits definitions were adopted by the Market Regulation and Consumer Affairs (D) Committee and NAIC EX/ Plenary during the 2020 NAIC Fall National Meeting.

Lawsuit – A court proceeding to recover a right to a claim, including lawsuits for arbitration cases.

Exclude:
- Subrogation claims where lawsuit is filed by the company against the tortfeasor.
- Non-lawsuit legal activity or litigation filed by an insurer, including, but not limited to: request to compel an independent medical examination, an examination under oath, and declaratory judgment actions filed by an insurer.

Calculation Clarification:
- Lawsuits should be reported on the same basis as claims. One lawsuit should be reported for each claimant / coverage combination, regardless of the number of actual lawsuits filed.
- One lawsuit with two claimants would be reported as two lawsuits as any awards/payments made would be made to the claimants individually.
- One lawsuit filed seeking damages for multiple coverages should be reported as one lawsuit for each applicable coverage. If the lawsuit is seeking damages for bodily injury and property damage, one lawsuit should be reported for each of the two coverages.
- Lawsuits should be reported in the state in which the claim is reported on this statement.
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Lawsuits Closed During the Period with Consideration for the Consumer—A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the claimant in an amount greater than offered by the reporting insurer before the lawsuit was brought.

Median Days to Final Payment – The median value for all claims closed with payment during the period.
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Calculation for losses with one final payment date during the reporting period:
- Date the loss was reported to the company to the date of final payment.

Calculation for losses with multiple final payment dates during the reporting period:
- Date the request for supplemental payment received to the date of final payment (for each different final payment date.)

Exclude:
- Subrogation payments should not be included.

Calculation Clarification / Example:
- To determine the Median Days to Final Payment you must first determine the number of days it took to settle each claim. This is the difference between the date the loss was reported to the company, or the date the request for supplemental payment was received, to the date of final payment. The Median Days to Final Payment is the median value of the number of days it took to settle all claims closed with payment during the period.

Median - A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.

Consider the following simple example of the number of days it took to settle each of the following seven claims:

<table>
<thead>
<tr>
<th>Claim</th>
<th>Nbr 1</th>
<th>Nbr 2</th>
<th>Nbr 3</th>
<th>Nbr 4</th>
<th>Nbr 5</th>
<th>Nbr 6</th>
<th>Nbr 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days to Settle</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>20</td>
</tr>
</tbody>
</table>

In this situation, the Median Days to Final Payment would be 5 because it is the middle value. There are exactly 3 values below the median (2, 4, & 4) and 3 values above the median (6, 8, & 20). If the data set had included an even number of values, then the median would be the average of the two middle values as demonstrated below.
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<table>
<thead>
<tr>
<th>Days to Settle</th>
<th>Nbr 1</th>
<th>Nbr 2</th>
<th>Nbr 3</th>
<th>Nbr 4</th>
<th>Nbr 5</th>
<th>Nbr 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days to Settle</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>20</td>
</tr>
</tbody>
</table>

Median Days to Final Payment = \( \frac{5 + 6}{2} = 5.5 \)

The median should be consistent with the paid claim counts reported in the closing time intervals.

Example: A carrier reports the following closing times for paid claims.

<table>
<thead>
<tr>
<th>Closing Time</th>
<th># of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30</td>
<td>22</td>
</tr>
<tr>
<td>31-60</td>
<td>13</td>
</tr>
<tr>
<td>61-90</td>
<td>18</td>
</tr>
<tr>
<td>91-180</td>
<td>11</td>
</tr>
<tr>
<td>181-365</td>
<td>12</td>
</tr>
<tr>
<td>&gt;365</td>
<td>15</td>
</tr>
</tbody>
</table>

The sum of the claims reported across each closing time interval is 91, so that the median is the 46th claim. This claim falls into the closing time interval “61-90 days.” Any reported median that falls outside of this range (i.e., less than 61 or greater than 90) will indicate a data error.

**NAIC Company Code** – The five-digit code assigned by the NAIC to all U.S. domiciled companies which filed a Financial Annual Statement with the NAIC.

**NAIC Group Code** – The code assigned by the NAIC to identify those companies that are a part of a given holding company structure. A zero indicates that the company is not part of a holding company.

**New Business Policy Written** – A newly written agreement that puts insurance coverage into effect during the reporting period.

Exclude:
- Renewals or ‘re-written’ policies unless there was a lapse in coverage.

**Non-Renewals** – A policy for which the insurer elected not to renew the coverage for circumstances allowed under the “non-renewal” clause of the policy.
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Include:

- All company-initiated non-renewals of the policies where the non-renewal effective date is during the reporting period.

Exclude:

- Policies where a renewal offer was made and the policyholder did not accept the offer.
- Instances where the policyholder requested that the policy not be renewed.

Calculation Clarification:

- The number of non-renewals should be reported on a policy basis regardless of the number of autos insured under the policy.

Policy In-force – A policy in which the coverage is in effect as of the end of the reporting period.

Private Passenger Auto Insurance – Those policies issued on automobiles owned or leased by an individual or by husband and wife resident in the same household that are reported on lines 19.1, 19.2, and 21.1 of the state page of the financial annual statement.

Include:

- This covers four-wheel vehicles including station wagons, vans, or pick-up trucks with a gross vehicle weight up to 10,000 pounds or less and not customarily used in the occupation, profession, or business of the insured.
- Vehicles as defined above that are reported on Lines 19.1, 19.2, and 21.1 of the state page of the financial annual statement which meet the definition of private passenger automobiles.
- Motorcycles
- Policies where the insured’s vehicle is titled privately to the insured but is used by the insured for work should be included, unless the coverage is written on a commercial auto form.
- Policies written on a volunteer basis and those written through a residual market mechanism such as assigned risk pools should be included.
- Policies written on RV’s and motor homes are included as they are licensed vehicles that fall under the various states’ Motor Vehicle Responsibility laws.
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Exclude:
- Policies written on antiques, collectibles, all-terrain vehicles, snowmobiles, trailers, dune buggies.
- Miscellaneous vehicles written on Inland Marine policies.
- Other vehicles classified by ISO as miscellaneous that do not fall under the various states’ Motor Vehicle Responsibility laws.
- ‘Fleet’ policies are generally considered to be a commercial policy and would not be included unless the premium for these policies is being reported as ‘private passenger auto’ insurance on lines 19.1, 19.2 or 21.1 of the state page of the financial annual statement.
- Non-owned vehicle insurance policies.
- Lender-placed or creditor-placed policies.
- Mobile/Manufactured homes intended for use as a dwelling regardless of where [or what line] on the Statutory Annual Statement state page associated premium is reported.

Telematics and Usage-Based Data – Data which is collected through devices installed in a vehicle, through mobile applications, or other method. These devices then transmit the data in real time back to insurers. Examples of usage-based data collected via telematics includes - but is not limited to - miles driven, time of day, where the vehicle is driven (Global Positioning System or GPS), rapid acceleration, hard braking, hard cornering and air bag deployment.
Regulatory Information Retrieval System (RIRS)  
Proposed Coding Structure Changes  

Overview  
Outlined below are the Market Information Systems Research and Development (D) Working Group proposed revisions to the Regulatory Information Retrieval System (RIRS) coding structure. These revisions address the serious deficiencies of the current coding structure. They are designed to render greater coherency to the data structure and make the system more compatible with other market information systems.  
In brief, this proposal consists of:
1) New Record Type field to distinguish routine administrative actions from actions that are a result of an infraction or financial impairment. This distinction is important for market analysis purposes.
2) New Modification Indicator field to link related RIRS records. Some RIRS records represent a termination, modification, or extension of a previous RIRS record. This new field can be used to eliminate duplicate records when counting unique actions.
3) New Line of Business field to reflect infractions that arise out of activity specific to a line of business.
4) Significant Revisions to the Origin of Action, Reason for Action, and Disposition for Action codes to provide a more logical overall data structure.

<table>
<thead>
<tr>
<th>Record Type (New)</th>
<th>Code</th>
<th>Code Name</th>
<th>Definition</th>
<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXX</td>
<td>Financial Impairment</td>
<td>Action was taken by the state regulatory authority with respect to the financial condition of an insurer or other regulated entity.</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Violation</td>
<td>Action was taken regarding a violation of statute or regulation. Excludes routine or administrative actions that do not involve such a violation.</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Administrative Action Only (no violation)</td>
<td>A formal action taken by the state regulatory authority in which no violation of statute or regulation has occurred related to the action. Could include such actions as rate filing review or transfer from a state’s wind pool.</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Other</td>
<td>Any formal action that is not adequately described by any of the above three record types.</td>
<td>New</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Modification Indicator (New)</th>
<th>Code</th>
<th>Code Name</th>
<th>Definition</th>
<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Yes</td>
<td>Action is a Modification to Existing RIRS Record</td>
<td>New</td>
<td>If Yes, provide previous RIRS identifier in new field</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>No</td>
<td>Action is Not a Modification to Existing RIRS Record</td>
<td>New</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Line of Business (New)</th>
<th>Code</th>
<th>Code Name</th>
<th>Definition</th>
<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXX</td>
<td>Accident and Health - Group</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Code Name</td>
<td>Definition</td>
<td>Code Status</td>
<td>Notes</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>---------------------------------</td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Accident and Health - Individual</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Annuity – Group</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Annuity – Individual</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Auto – Commercial</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Auto – Private Passenger</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Bail Bonds</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Commercial Liability</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Commercial Property</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Credit</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Fidelity and Surety</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Homeowner</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Life - Group</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Life - Individual</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Long Term Care</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Medical Malpractice</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Medicare Supplement</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Title</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Workers Compensation</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>None</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Other</td>
<td>Corresponds to financial annual statement</td>
<td>New</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Origin of Action (Revised)**

The Origin of Action field is meant to provide information about the origin (source) of the regulatory action. The code(s) used should be reflective of the source of information or activity that resulted in the regulatory action. Information about the reason (allegations) and/or disposition (outcome) of the action should be reported in those respective fields. (max 4)

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
<th>Definition</th>
<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1002</td>
<td>FINRA</td>
<td>Reporting by a state insurance department of an action taken by FINRA associated with a domicile or resident entity or individual subject to the jurisdiction of said state insurance department.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1003</td>
<td>Market Analysis</td>
<td>Action resulting from market analysis, including but not limited to actions resulting from Baseline, Level 1, or Level 2 market analysis reviews.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1005</td>
<td>Complaint Investigation</td>
<td>Action resulting from an investigation of one or more complaints against the entity or individual.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1007</td>
<td>Field Investigation</td>
<td>Action resulting from a regulatory investigation and verification of circumstances through direct communication with an entity or individual. These investigations often involve on-site work and would include investigations completed by those in fraud and/or investigation units of the department.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1008</td>
<td>Public Inquiry</td>
<td>Concern resulting from close examination of a matter to determine information or truth provided by an outside party (other than the Insurance Department, insurer, or producer).</td>
<td>Delete</td>
<td>Used by 12 states, 17 times. Proposed alternative: (1055) “Third Party Information”</td>
</tr>
<tr>
<td>1010</td>
<td>Routine Dept. Action</td>
<td>Action resulting from recurring insurance departmental activity not triggered by a regulatory issue contemplated in other origin codes. Examples of actions included in this code</td>
<td>Keep</td>
<td>May also consider Code 1020</td>
</tr>
</tbody>
</table>

As of 8/24/2021

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1013</td>
<td>Financial</td>
<td>Action resulting from activity associated with or related to financial aspects of the entity, including, but not be limited to, actions taken as result of financial filings (e.g., Risk Based Capital (RBC) filings), financially hazardous conditions, suspensions, rehabilitation, liquidations, mergers, domestications, etc.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1015</td>
<td>Information/Action by Other State(s)</td>
<td>Action resulting from information or an action taken against the Entity or individual by another state’s Department of Insurance or other state agency.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Other States Action”</td>
</tr>
<tr>
<td>1016</td>
<td>Annual Statement Filing</td>
<td>Action resulting from the review of an insurers financial annual statement or market conduct annual statement.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Annual Statement”</td>
</tr>
<tr>
<td>1018</td>
<td>Information/Referral from Another State Agency</td>
<td>Action resulting from information or referral from another state agency within the entering state.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1020</td>
<td>Insurer Report</td>
<td>Action taken as the result of any type of report filed with the Department of Insurance not explicitly contemplated by another origin code. This would include, but not be limited to Statistical Filings and other state mandated filings.</td>
<td>Keep</td>
<td>May also consider Code 1010</td>
</tr>
<tr>
<td>1023</td>
<td>Statistical Filing</td>
<td>Action resulting from litigation or other legal proceeding. This would include, but not be limited to, actions resulting from class actions lawsuits and other legal proceedings.</td>
<td>Delete</td>
<td>Used by 10 states, 59 times. Proposed alternative: (1020) “Insurer Report”</td>
</tr>
<tr>
<td>1025</td>
<td>Legal</td>
<td>Action resulting from litigation or other legal proceeding. This would include, but not be limited to, actions resulting from class actions lawsuits and other legal proceedings.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1030</td>
<td>Market Conduct Exam</td>
<td>Action resulting from a market conduct examination, including but not limited actions resulting from targeted, comprehensive, or desk examinations.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1035</td>
<td>Financial Exam</td>
<td>Action resulting from a financial examination of a regulated entity, including but not limited to actions taken because of routine examinations and premium tax audits.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1040</td>
<td>Workers Comp Exam</td>
<td>Concern resulting from examination of a workers compensation insurer’s business practices and operations in order to determine its compliance with state insurance laws and regulations.</td>
<td>Delete</td>
<td>Used by 3 states, 7 times. Proposed alternatives: (1030) “Market Conduct Exam”, (1035) “Financial Exam”, or both</td>
</tr>
<tr>
<td>1050</td>
<td>Bankruptcy Notices</td>
<td>Concern resulting from a notice that an insurer or producer has filed for legal insolvency, indicating that the insurer is unable to meet financial obligations to customers and stockholders, or that a producer or agency has financial issues that may impact compliance with state insurance laws and regulations.</td>
<td>Delete</td>
<td>Used by 5 states, 6 times. Proposed alternative: (1025) “Legal”</td>
</tr>
<tr>
<td>1055</td>
<td>Third Party Information</td>
<td>Action resulting from information obtained from an outside source that is not explicitly contemplated by another origin code. This would</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Code Name</td>
<td>Definition</td>
<td>Code Status</td>
<td>Notes</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td>1060</td>
<td>Licensing / Company Administration</td>
<td>Action resulting from a regulated entity’s licensing status. This would include but not be limited to actions resulting from the submission of applications by the regulatory entity, failure of the entity to provide information in response to an application.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Licensing Administration”</td>
</tr>
<tr>
<td>1063</td>
<td>Background Check</td>
<td>Action resulting from the review of a background check of a producer or employee of a regulated entity. This would include but not be limited to actions stemming from a review of criminal, financial, or disciplinary events regardless of the source that are not explicitly contemplated by another origin code.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1065</td>
<td>Other*</td>
<td>Action taken that was prompted by information, an activity or event not contemplated by another origin code.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Other if checked you must enter description, up to 100 characters”</td>
</tr>
<tr>
<td>XXXX</td>
<td>Form/Rate/Rule Filing</td>
<td>Action taken as a result of a review/analysis of a regulated entity’s policy form, rate, and/or rule filing. This would include a review/analysis of underwriting guidelines where such filings are required to be made.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Information/Referral from Federal Agency</td>
<td>Action resulting from information or referral from a Federal agency.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Market Conduct Initiative</td>
<td>Action resulting from a market conduct initiative along the continuum of regulatory responses, including but not limited actions resulting from interrogatories, targeted information gathering (i.e. surveys, data calls, etc.), and policy &amp; procedure reviews.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Multi-state Regulatory Action/Settlement</td>
<td>Action resulting from a multi-state regulatory action and/or settlement of a regulated entity. This would include, but not be limited to, actions resulting from a multi-state examination, settlement or other coordinated activity along the continuum or regulatory responses.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Prior Dept. Action</td>
<td>An action taken as the direct result of a prior action taken against the entity or individual. This would include but not be limited to failure to comply with a previous order, lifting of prior orders, suspensions, or restrictions.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Self-reported Information</td>
<td>Action taken as the result of information voluntarily reported by the entity or individual.</td>
<td>New</td>
<td></td>
</tr>
</tbody>
</table>

*If checked, you must enter a description of up to 100 characters.

**Reason for Action (Revised)**

The Reason for Action field is meant to provide information about the reason (allegations) for the regulatory action. The code(s) used should be reflective of allegations associated with the action (i.e. the nature of the violation found). Information about the origin (source) and/or disposition (outcome) of the action should be reported in those respective fields. (max 20)
### Claims

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
<th>Definition</th>
<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>Claim Handling</td>
<td>Finding of cause resulting from the process of dealing with demands for payment of contract/policy benefits by the insured or the insured’s beneficiary or representative.</td>
<td>Delete</td>
<td>Proposed alternative: use new, more specific code(s) related to claim handling issues</td>
</tr>
<tr>
<td>XXXX</td>
<td>Claim Denials Due to Improper Rescission</td>
<td>Improper rescission of a policy subsequent to the presentation of a claim.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Failure to Pay Mandated Coverages</td>
<td>Improper denial or reduction of coverages that are mandated by statute or regulation.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Failure to Provide Appropriate Claims Materials or Other Reasonable Assistance</td>
<td>Failure to provide required claim forms, notifications of coverage, coinsurance, deductibles, or other items necessary to properly process a claim.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Failure to Resolve Timely / Prompt Pay</td>
<td>Failure to resolve and if appropriate pay claims within statutory timeframes. This would include failure to comply with ‘prompt pay’ statutes and/or regulations.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Files Not Adequately Documented</td>
<td>Inadequate documentation of claims and/or retention of claims records.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Improperly Compelling Claimant to Litigate</td>
<td>Delay or inadequate settlement offer made after claim liability has become reasonably clear, thus compelling a claimant to litigate.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Inadequate Explanations of Claims Denied / Closed Without Payment</td>
<td>Deficient correspondence with a claimant or policyholder regarding the reasons for a claim denial, including failure to explain the policy basis for a denial and appeal rights or other related issue in violation of statute or regulation.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Inadequate Loss Valuation Practices / Procedures</td>
<td>Improper damage estimates, total loss valuations or other claim valuation procedures and practices.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Inadequate / Untimely Investigation</td>
<td>Inadequate or untimely investigation to determine available coverage or liability.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Inappropriate Subrogation Practices / Procedures</td>
<td>Inappropriate recoupment of a loss from a liable third party, improper distribution of such a recoupment, and/or other inadequate subrogation practice and/or procedure.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Initial Contact Not Timely / Not Made</td>
<td>Failure to make initial contact or failure to make initial contact with an insured or claimant within timeframes established by statute and/or regulation.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Misrepresentation of Coverage</td>
<td>Available coverage was not adequately communicated to a policyholder or claimant.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Other Claims Handling Issue*</td>
<td>Any other claims handling issue not described by any other reason code and/or combination of reason codes.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Other Improper Claims Settlement Practice*</td>
<td>All other improper claim handling procedures or practices not described by any other reason code and/or combination of reason codes.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Other Improper Denial of Claim*</td>
<td>All claim denial violations not included in an above category not described by any other reason code and/or combination of reason codes.</td>
<td>New</td>
<td></td>
</tr>
</tbody>
</table>

### Complaint Handling

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
<th>Definition</th>
<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXXX</td>
<td>Failure to Maintain Complaint Log</td>
<td>Improper documentation of consumer complaints, both those received directly from a consumer and via insurance departments.</td>
<td>New</td>
<td></td>
</tr>
</tbody>
</table>
### Escrow/Settlement, Closing or Security Deposit Funds

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
<th>Definition</th>
<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXXX</td>
<td>Funds Submitted for Collection / Deposited in Non-qualified Institution</td>
<td>Failure to collect and deposit funds in an appropriate institution, such as an institution insured by the FDIC.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Inappropriate Disbursement Procedures / Practices</td>
<td>Failure to disburse funds in conformity with all applicable statutes and regulations. This would include, but not be limited to escrow funds that are applied in a way that is not in accordance with statutes and/or regulations regarding the handling of funds, escrow shortages, failure to provide good funds, or Improper or Inadequate Escrow Accounting Procedures or Controls.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Inappropriate Interest Paid</td>
<td>Failure to pay appropriate interest in accordance with statute or regulation.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Other Escrow / Settlement, Closing or Security Deposit Funds Issue*</td>
<td>Any other issue not described by any other reason code and/or combination of reason codes.</td>
<td>New</td>
<td></td>
</tr>
</tbody>
</table>

### Marketing & Sales

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
<th>Definition</th>
<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>Marketing &amp; Sales</td>
<td>Finding of cause resulting from an entity’s activities involving the marketing, advertising and sales of products that are regulated by the Department of Insurance.</td>
<td>Delete</td>
<td>Proposed alternative: use new, more specific code(s) related to marketing and sales.</td>
</tr>
<tr>
<td>2012</td>
<td>Unsuitable / Inappropriate Replacement</td>
<td>Failure to comply with mandated replacement and/or suitability statutes and/or regulations.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Life Insurance Replacement Violation” Typically related to life insurance or annuities</td>
</tr>
<tr>
<td>2014</td>
<td>Misrepresentation of Insurance Produce / Policy</td>
<td>Deceptive representations regarding the nature of an insurance product.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td>Misleading Advertising</td>
<td>Use of advertising that does not comply with applicable state statutes and/or regulations, including but not limited to false and/or misleading advertising.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Advertising”</td>
</tr>
<tr>
<td>2045</td>
<td>Rebating</td>
<td>Improperly providing monetary inducements to purchase coverage.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2111</td>
<td>Inappropriate Sales or Solicitation to a Military Service Member</td>
<td>Inappropriate sales and/or solicitation of insurance products to military service member, including but not limited to violations of the Military Sales Practices Model Regulation or law.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Code Name</td>
<td>Definition</td>
<td>Code Status</td>
<td>Notes</td>
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</tr>
<tr>
<td>2112</td>
<td>Inappropriate Sales or Solicitation on a Military Installation**</td>
<td>Inappropriate sales or solicitation of insurance products on a military installation, including but not limited to violations of the Military Sales Practices Model Regulation or similar state statute and/or regulation.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Disclosure / Outline of Coverage Inadequate / Not Timely / Not Provided</td>
<td>Inadequate procedures to provide full disclosure or appropriate outline of coverage to consumers in connection with the sale of an insurance product.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Failure to Provide Adequate Producer Training, Education, Compliance Oversight</td>
<td>Training materials and communications with producers fail to comply with statute or regulation.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Illustrations Inadequate / Not Timely / Not Provided</td>
<td>Sales materials and exhibits fail to contain all required information, disclaimers, or are otherwise misleading.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Other Marketing &amp; Sales Issue*</td>
<td>Any of marketing and sales violation not described by any other reason code and/or combination of reason codes.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Other Unfair Marketing &amp; Sales Practice*</td>
<td>Any other unfair marketing and sales practice not described by any other reason code and/or combination of reason codes.</td>
<td>New</td>
<td></td>
</tr>
</tbody>
</table>

### Operations & Management

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
<th>Definition</th>
<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2028</td>
<td>TPA Violation</td>
<td>Finding of cause resulting from non-compliance with a state’s Third Party Administrator (TPA) laws and regulations.</td>
<td>Delete</td>
<td>Proposed alternative: (XXXX) “Failure to Adequately Supervise MGAs, TPAs, or Other 3rd Party Contractor”</td>
</tr>
<tr>
<td>2039</td>
<td>Failure to Maintain Adequate Books &amp; Records</td>
<td>Records are incomplete, inaccessible, inconsistent, or disordered, or fail to conform to state record retention laws.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Failure to Maintain Books &amp; Records”</td>
</tr>
<tr>
<td>2065</td>
<td>Notice of Financial Impairment from Another State</td>
<td>Notification from another state of financial impairment.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2070</td>
<td>Financial Impairment</td>
<td>Finding of cause resulting from an insurer having insufficient assets, capital, policyholder surplus, or reserves to meet financial obligations to customers and stockholders and is therefore ineligible to transact insurance business in the state.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2072</td>
<td>Cure of Financial Impairment</td>
<td>Used when Financial Impairment was reported, where an insurer was found to be ineligible to transact insurance business, has remedied the problem; is now considered solvent and eligible to transact insurance business.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2080</td>
<td>Dissolution</td>
<td>Finding of cause resulting from notification that a producer firm or insurer has been dissolved, disbanded, or liquidated as a corporation.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2100</td>
<td>No Certificate of Authority</td>
<td>Finding of cause resulting from an insurer engaging in the business of insurance in a state without authorization from the Department of Insurance.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2101</td>
<td>Exceeded Certificate of Authority</td>
<td>Engaging in activities not contemplated within the scope of authority of an existing certificate of authority. This could include, but not be limited to, writing lines of business not covered by the existing certificate of authority and/or exceeding</td>
<td>Code Name Change</td>
<td>Previous Code Name “Certification Violation”</td>
</tr>
<tr>
<td>Code</td>
<td>Code Name</td>
<td>Definition</td>
<td>Code Status</td>
<td>Notes</td>
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</tr>
<tr>
<td>2102</td>
<td>Unauthorized Insurance Business</td>
<td>Finding of cause resulting from an entity engaging in actions that are regulated as the business of insurance without authorization from the Department of Insurance in the state.</td>
<td>Delete</td>
<td>Proposed alternative: (2100) “No Certificate of Authority” and/or (2101) “Exceeded Certificate of Authority”</td>
</tr>
<tr>
<td>XXXX</td>
<td>Failure to Adequately Supervise MGAs, TPAs, or Other 3rd Party Contractor</td>
<td>Failure to exercise an appropriate level of oversight of third parties that assume a business function and act on behalf of an insurer. Example: An MGA that is not operating in accordance with statutes and/or regulations regarding the supervisory responsibility for the local and field operations of an insurer.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Inadequate Appeals Practices / Procedures</td>
<td>Improper or inadequate procedures to appeal unsatisfactory claim outcomes. Examples: First-level appeals are reviewed by a qualified medical practitioner. Second-level review processes conform to applicable statute and/or regulation.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Inadequate External / Independent Review Practices / Procedures</td>
<td>Failure to provide appropriate cost-free access to an independent external body to review medical determinations in relation to the terms of a policy or applicable statute and/or regulation.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Inadequate Grievance Practices / Procedures</td>
<td>Failure to adhere to policy provisions regarding the handling of complaints or appeals by consumers or health care providers.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Inadequate Internal / External Audit Practices / Procedures</td>
<td>Company failed to implement proper surveillance procedures to ensure the absence of significant structural or systemic problems with core functions.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Inadequate Network</td>
<td>Failure to provide timely and local access to healthcare providers in accordance with policy provisions or state and/or federal requirements. Example: A health plan network that is not in accordance with requirements mandated by statute and/or regulation related to a network adequacy.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Inadequate Provider Credentialing / Monitoring</td>
<td>Failure to ensure that contracted providers are properly licensed and practicing within the scope of their license and at the contracted location.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Inadequate Safeguards for Security of Data &amp; Information</td>
<td>Failure to adequately preserve the privacy of confidential or sensitive information. This would include but not be limited to, improper disclosure within a regulated entity, failure of procedures to maintain the integrity of company information stored in electronic or other media, failure to provide appropriate privacy disclosures to consumers, or to notify consumers of security breaches. Example: Failure to maintain adequate information controls, data backup and recovery systems, or to restrict access to sensitive information.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Inadequate Utilization Review Practices / Procedures</td>
<td>Improper procedures or practices associated with monitoring the use, delivery, or efficiency of medical services by insureds.</td>
<td>New</td>
<td></td>
</tr>
</tbody>
</table>
### Code Name

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
<th>Definition</th>
<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXXX</td>
<td>Quality Assurance Violation</td>
<td>Inappropriate or inadequate procedures or practices associated with conducting quality assessments and improving health outcomes, including adequately communicating such procedures to health care providers.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Other Operations &amp; Management Issue*</td>
<td>Any other management and operations issue not described by any other reason code and/or combination of reason codes.</td>
<td>New</td>
<td></td>
</tr>
</tbody>
</table>

#### Policyholder Service

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
<th>Definition</th>
<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>Policyholder Service</td>
<td>Finding of cause resulting from a company’s service to owners of insurance policies, including complaints, customer service, claims or any other service.</td>
<td>Delete</td>
<td>Proposed alternative: use new, more specific code(s) related to policyholder service</td>
</tr>
<tr>
<td>XXXX</td>
<td>COBRA Non-compliance</td>
<td>Improper documentation of eligibility for group health insurance coverage.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>HIPPA Non-compliance</td>
<td>Improper handling of private electronic claims records or other patient information.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Improper Processing of Free Looks</td>
<td>Failure to remit a full refund if a policy is returned with required timeframes; or to adhere to any other free-look provisions prescribed by the policy or by statute or regulation.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Improper Processing of Nonforfeitures</td>
<td>Failure to secure a policyholder’s interest in a policy in the event the policy lapses, in accordance with policy provisions or statute and/or regulation.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Improper Processing of Reinstatements</td>
<td>Differential treatment of similarly situated individuals with respect to reinstatement rights provided under the policy or as required by state law or regulation.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Premium / Billing Notices Inadequate / Not Timely / Not Provided</td>
<td>Failure to provide billing notices and/or notify consumers of premiums due within timeframes established by statute and/or regulation. This would include instances where billing notices are inadequate and/or did not contain information required by statutes and/or regulations.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Other Required Notification / Correspondence Inadequate / Not Timely / Not Provided</td>
<td>Failure to make any other required notification and/or made the notification in a timely manner. This would include instances where notices are inadequate and/or did not contain information required by statutes and/or regulations.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Reasonable Attempts to Locate Policyholder Not Made</td>
<td>No reasonable attempt was made to locate policyholders or beneficiaries.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Other Policy Holder Service Issue*</td>
<td>Any other policyholder service issue not described by any other reason code and/or combination of reason codes, including but not limited to a failure to provide notification of changes in customer service telephone numbers or locations, failure to promptly answer telephone calls or electronic inquiries, or failure to clearly identify the name of the underwriter on correspondence.</td>
<td>New</td>
<td></td>
</tr>
</tbody>
</table>

### Producer Licensing

As of 8/24/2021

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<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
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</tr>
</thead>
<tbody>
<tr>
<td>2026</td>
<td>Premium Finance Act Violation</td>
<td>Finding of cause resulting from non-compliance with the premium finance act, including but not limited to licensing, record-keeping, policy notices and contractual charges.</td>
<td>Delete</td>
<td>Used by 4 states, 5 times. Proposed alternative: use appropriate “other” code</td>
</tr>
<tr>
<td>2027</td>
<td>Surplus Lines Violation</td>
<td>A producer committed a violation of statutes and/or regulations related to surplus lines business.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2030</td>
<td>Failure to Meet Continuing Education Requirements</td>
<td>A producer failed to meet the mandatory continuing education requirements. This would also include instances where the producer failed to maintain one or more qualifications to hold a license.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2032</td>
<td>Continuing Education Requirements Met</td>
<td>A producer deficient in respects to meeting mandated continuing education requirements is now compliant. This would also include instances where the failure to maintain a qualification required to hold a license has been rectified.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2037</td>
<td>Failure to Notify Department of Address Change</td>
<td>A producer failed to notify the department of a change in address in accordance with statutes and/or regulations. This would include instances where the producer failed to notify the department in a timely manner.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2042</td>
<td>Failure to Pay Child Support / Student Loans</td>
<td>A producer license was denied, suspended, or revoked due to the producer failing to pay child support and/or student loans.</td>
<td>Code Name Change</td>
<td>Previous Code Name &quot;Failure to Pay Child Support&quot;</td>
</tr>
<tr>
<td>2055</td>
<td>Producer / Adjuster / Other Not Properly Licensed</td>
<td>A producer is not properly licensed to transact business for a given line of insurance; or adjuster not properly licensed according to statute or regulation.</td>
<td>Code Name Change</td>
<td>Previous Code Name &quot;No License&quot;</td>
</tr>
<tr>
<td>2056</td>
<td>Demonstrated Lack of Fitness or Trustworthiness</td>
<td>Action taken on a producer license due to a demonstrated lack of fitness and/or trustworthiness. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2058</td>
<td>Misstatement on Application</td>
<td>Action taken on a producer license due to a misstatement on the application. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2059</td>
<td>Failure to Make Required Disclosure on Application</td>
<td>Action taken on a producer license due to the failure to make a required disclosure on the application. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.</td>
<td>Code Name Change</td>
<td>Previous Code Name &quot;Failure to Make Required Disclosure on application&quot;</td>
</tr>
<tr>
<td>2060</td>
<td>Producer / Adjuster / Other Not Properly Appointed</td>
<td>A producer or adjuster is not properly appointed to an insurer as required by statute or regulation.</td>
<td>Code Name Change</td>
<td>Previous Code Name &quot;Not Appointed&quot;</td>
</tr>
<tr>
<td>2061</td>
<td>Selling for Unlicensed Insurer</td>
<td>A producer solicited on behalf of an unlicensed insurer.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2062</td>
<td>Allowed Business from Agent Not Appointed / Licensed</td>
<td>Finding of cause resulting from an insurer accepting policy applications from producers at a time when they were not licensed or under appointment with that insurer as required by the state’s laws and the company’s requirements.</td>
<td>Delete</td>
<td>Proposed alternative: (2055) &quot;Producer / Adjuster / Other Not Properly Licensed&quot; and/or (2060) &quot;Producer / Adjuster / Other Not Properly Appointed&quot;</td>
</tr>
<tr>
<td>2063</td>
<td>Employed Unlicensed Individuals</td>
<td>Finding of cause resulting from employees of a producer or insurer conducting the business of insurance without required authorization or license from the Department of Insurance.</td>
<td>Delete</td>
<td>Proposed alternative: (2055) &quot;Producer / Adjuster / Other Not Properly Licensed&quot;</td>
</tr>
<tr>
<td>2064</td>
<td>Paid Commission to Un-appointed Agents</td>
<td>Finding of cause resulting from an insurer or producer providing payment or sharing of commissions to producers who are not licensed.</td>
<td>Delete</td>
<td>Proposed alternative: (2060) &quot;Producer / Adjuster / Other Not Properly Appointed&quot;</td>
</tr>
<tr>
<td>Code</td>
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<td>Definition</td>
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<td>Notes</td>
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</tr>
<tr>
<td>2097</td>
<td>Bail Bond Forfeiture Judgment</td>
<td>Action taken on a producer license was due to a bail bond forfeiture judgment. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2075</td>
<td>Failure to Report Other State Action</td>
<td>Action was taken on a producer license due to the failure to report an action taken by another state. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2104</td>
<td>Failure to Remit Premiums to Insurer</td>
<td>A producer failed to remit premiums to an insurer.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2105</td>
<td>Misappropriation of Premium</td>
<td>A producer misappropriated premium.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2106</td>
<td>Forgery / Fraud</td>
<td>A producer committed forgery and/or fraud. This would include, but not be limited to, forgery of an insurance application, providing false evidence insurance, misrepresentation to insurer to obtain policy benefits and/or commission, and other acts of dishonest or fraud. Example: Misrepresentation to insurer to obtain a life insurance policy with the intent to sell interests in the proceeds.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Forgery”</td>
</tr>
<tr>
<td>2107</td>
<td>Criminal Record / History</td>
<td>Action taken on a producer license due a criminal record and/or history. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2108</td>
<td>Criminal Proceedings</td>
<td>Action taken on a producer license due to criminal proceedings. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Producer / Adjuster Not Properly Terminated</td>
<td>Failure to adhere to all statutes and regulations regarding the termination of a producer, such as notification requirements to both the producer and the relevant regulation bodies.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Other Producer / Adjuster Licensing Issue*</td>
<td>Any other violation with respect to licensure and appointment of producers or adjusters not described by any other reason code and/or combination of reason codes.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Failure to Account for Premium Funds</td>
<td>Failure to maintain records showing the deposit, handling, and proper remittance premium funds.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Failure to Maintain Separate Fiduciary Account</td>
<td>Failure to create a fiduciary account for the deposit and remittance of premiums separate from agency operating funds.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Commingling of Premiums with Personal Funds</td>
<td>Failure to keep premium funds separate from personal funds.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Other Fiduciary/Accounting Violation*</td>
<td>A fiduciary violation not included in an above category, not described by any other reason code, or combination of reason codes</td>
<td>New</td>
<td></td>
</tr>
</tbody>
</table>

**Underwriting & Rating**

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
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<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>Underwriting</td>
<td>Finding of cause resulting from the process of selecting, classifying, and rejecting risks in order to assign appropriate rates to insureds.</td>
<td>Delete</td>
<td>Proposed alternative: use new, more specific code(s) related to underwriting</td>
</tr>
<tr>
<td>2050</td>
<td>Rate Violation</td>
<td>Finding of cause resulting from use of premium rates not filed with the Department of Insurance,</td>
<td>Delete</td>
<td>Proposed alternative: use new, more specific code(s) related to underwriting</td>
</tr>
<tr>
<td>Code</td>
<td>Code Name</td>
<td>Definition</td>
<td>Code Status</td>
<td>Notes</td>
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</tr>
<tr>
<td>XXXX</td>
<td>Inadequate or Excessive Rate</td>
<td>Rates are either excessive or inadequate in relation to expected exposure presented by the risk and/or expected losses, as defined by statute and/or regulation.</td>
<td>New</td>
<td>more specific code(s) related to rating violations</td>
</tr>
<tr>
<td>XXXX</td>
<td>Incorrect Application of Rate</td>
<td>Actual rates charged deviate from the insurer’s established rates or rating plan. This would include, but not be limited to, instances where rates charged are not in accordance with state mandates, filed, do not adhere to filings, and/or improper documentation of modifications exists. Example: Inconsistent application of scheduled rating plan across eligible risks.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Rates Not Filed / Approved</td>
<td>The use of rates that have not been filed or approved by the state insurance department as required by statute or regulation.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Rates Unfairly Discriminatory</td>
<td>Like risks are charged different rates in a way not justified by expected loss costs.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Use of Prohibited Rating Factors</td>
<td>Use of factors for rating prohibited by statute or regulation.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Other Rating Issue*</td>
<td>Any improper rating practice not described by any other reason code and/or combination of reason codes.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>2053</td>
<td>Forms Not Filed &amp;/or Approved</td>
<td>The use of insurance forms that have not been properly filed or approved by the appropriate regulatory authority.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Use of Unapproved Forms”</td>
</tr>
<tr>
<td>XXXX</td>
<td>Improper Question on Application</td>
<td>Insurance application contains improper questions or otherwise not in accordance with applicable statutes and/or regulations.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Mandated Coverages / Offerings Not Provided</td>
<td>Failure to provide coverage for benefits required by statute or regulation. This would include, but not be limited to, forms that do not comply with statutes and/or regulations regarding mandated and/or required coverages.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Other Forms Issue*</td>
<td>Any other form violation not described by any other reason code and/or combination of reason codes.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Cancellation / Non-Renewal Notice Inadequate / Not Timely / Not Provided</td>
<td>Notice of the termination of coverage was not issued, was not issued within timeframes prescribed by statute or policy provisions. This would include instances where notices are inadequate and/or did not contain information required by statutes and/or regulations.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Failure to Send Required Cancellation / Non-Renewal Notice”</td>
</tr>
<tr>
<td>XXXX</td>
<td>Mandatory Disclosures / Notifications Inadequate / Not Timely / Not Provided</td>
<td>Improper issuance of disclosures or notifications, in violation of policy provisions, statute, or regulation. This would include notices of mandated coverage, disclosure of preexisting condition exclusions, or disclosure that credit insurance is optional and not a condition for loan approval. It does not include cancellation or nonrenewal notices, which have a separate code.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Unfairly Discriminatory Underwriting Practices / Procedures</td>
<td>Underwriting practices that treat like risks differently and violate statutes and/or regulations regarding the fair treatment of risks.</td>
<td>New</td>
<td></td>
</tr>
</tbody>
</table>
## Code Name

### Definition

**Other Cancellation / Nonrenewal / Recession Issue***

Any other improper termination of coverage not described by any other reason code and/or combination of reason codes. Example: Rescissions made for non-material misrepresentations.

**Declination Notice – Inadequate / Not Timely / Not Provided**

Failure to issue notify an applicant or failure to timely notify an applicant that coverage is rejected as required by statute and/or regulation. This would include instance where notices where inadequate and/or did not contain information required by statutes and/or regulations.

**Other Declination Issue***

Other inappropriate declination not described by any other reason code and/or combination of reason codes. Example: Failure to adhere to internal underwriting guidelines.

**Other Underwriting Issue***

Any other violation related to the determination of eligibility for coverage, not described by any other reason code and/or combination of reason codes.

## Miscellaneous

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
<th>Definition</th>
<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>Market Conduct Examination</td>
<td>Finding of cause resulting from examination of the business practices and operations of an entity in order to determine its compliance with state insurance laws and regulations.</td>
<td>Delete</td>
<td>Describes origin of action Proposed alternative: (1030) “Market Conduct Exam” Origin of Action code and select the appropriate Reason Code(s) that apply to underlying reason for the action.</td>
</tr>
<tr>
<td>2074</td>
<td>Other States Action</td>
<td>Finding of cause resulting from another state’s Department of Insurance activity about an issue which also affects the entering state.</td>
<td>Delete</td>
<td>Describes origin of action Proposed alternative: (1015) “Other States Action” Origin of Action code and select the appropriate Reason Code(s) that apply to underlying reason for the action.</td>
</tr>
<tr>
<td>2029</td>
<td>Unfair Insurance Practices Act Violation</td>
<td>Finding of cause resulting from unfair methods of competition or deceptive acts being used, from this Act or the Unfair Trade Practices Act as applied to the business of insurance.</td>
<td>Delete</td>
<td>Proposed alternative: use new, more specific code(s) related to unfair insurance practices</td>
</tr>
<tr>
<td>2035</td>
<td>Failure to Cooperate with Examination / Investigation / Inquiry</td>
<td>Other failure to cooperate with an examination or investigation. This would include, but not be limited to, failure to respond to appropriate requests for information and/or providing inaccurate or misleading information.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Failure to Respond” If the issue is late or incomplete response, then use 2036.</td>
</tr>
<tr>
<td>2036</td>
<td>Late or Incomplete Response</td>
<td>Failure to respond timely and/or failure to provide a complete response in response to a request for information. This would include, but not be limited to failure to submit timely and complete mandated filings such as statistical reports and annual reports.</td>
<td>Keep</td>
<td></td>
</tr>
</tbody>
</table>

As of 8/24/2021

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## Disposition for Action (Revised)

The Disposition field is meant to provide information about the disposition (outcome) of the regulatory action. The code(s) used should be reflective of the outcome of the action. In other words what happened as a result of the action. Information about the reason (allegations) and/or origin (source) of the action should be reported in those respective fields. (max 4)

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
<th>Definition</th>
<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3001</td>
<td>License, Denied</td>
<td>The entity or individual applied for a new license or attempted to renew a license and it was denied</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3003</td>
<td>License, Suspended</td>
<td>The entity or individual’s license was suspended. The entity or individual is temporarily prohibited from engaging in the business of insurance.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3004</td>
<td>License, Cancelled</td>
<td>The entity or individual’s license was cancelled.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3006</td>
<td>License, Revoked</td>
<td>The entity or individual’s license was revoked; The entity or individual is prohibited from engaging in the business of insurance.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3009</td>
<td>License, Probation</td>
<td>The entity or individual’s license is subject to a probationary period during which the entity or individual is obligated to comply with certain standards and/or conditions specified by the issuing authority or the license can be cancelled, revoked or suspended.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3010</td>
<td>License, Conditional</td>
<td>The entity or individual’s license is issued on a conditional basis under which the entity or individual must meet certain standards and/or conditions specified by the issuing authority before an unrestricted license can be issued. Failure to meet the conditions may result in license being cancelled, revoked, or suspended by the issuing authority.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3011</td>
<td>License, Supervision</td>
<td>The entity or individual’s license is under supervision of the issuing authority and the</td>
<td>Keep</td>
<td></td>
</tr>
</tbody>
</table>

*If checked, you must enter a description of up to 100 characters.

**If code (2112) is checked, please enter the name of the Military Base in the "(xxxx) Other Marketing & Sales Issue*" box.
<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
<th>Definition</th>
<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3012</td>
<td>License, Reinstatement</td>
<td>The license of an entity or individual was reinstated.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3013</td>
<td>License, Granted</td>
<td>A license was granted to an entity or individual as a result of an administrative process regarding a prior action to deny, cancel or revoke a license.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3014</td>
<td>License, Surrendered</td>
<td>The entity or individual's license was ordered to surrender the license.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3015</td>
<td>License, Voluntarily Surrendered</td>
<td>The entity or individual's license was voluntarily surrendered by the entity or individual. This disposition is typically associated with situations where the entity or individual agreed to voluntarily surrender the license in lieu of the issuing authority pursuing additional administrative action.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3016</td>
<td>License, Other*</td>
<td>Any other disposition related to an entity or individual license not described by any other disposition code or combination of codes.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3021</td>
<td>Certificate of Authority, Denied</td>
<td>The entity's application for a certificate of authority or an expansion of an existing certificate of authority was denied by the issuing authority.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3023</td>
<td>Certificate of Authority, Suspended</td>
<td>The regulated entity's certificate of authority was suspended for a specific time period. During this time period, the entity is prohibited from engaging in the business of insurance in the affected jurisdiction.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3025</td>
<td>Certificate of Authority, Suspension Extended</td>
<td>The suspension of regulated entity's certificate of authority was extended beyond the initial suspension period. The temporary prohibition from engaging in the business of insurance in the affected jurisdiction is continued.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3026</td>
<td>Certificate of Authority, Revoked</td>
<td>The regulated entity's certificate of authority was revoked. The entity prohibited from engaging in the business of insurance in the affected jurisdiction.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3028</td>
<td>Certificate of Authority, Expired</td>
<td>The entity failed to take the appropriate action to renew or continue its certificate of authority.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3029</td>
<td>Certificate of Authority, Probation</td>
<td>The regulated entity's certification of authority is subject to a probationary period during which the entity is obligated to comply with certain standards and/or conditions specified by the issuing authority or the certificate of authority can be cancelled, revoked or suspended.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3031</td>
<td>Certificate of Authority, Reinstated</td>
<td>The regulated entity's certificate of authority was reinstated.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3034</td>
<td>Certificate of Authority, Surrendered</td>
<td>The entity surrendered its certificate of authority.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3036</td>
<td>Certificate of Authority, Other*</td>
<td>Any other disposition related to a certificate of authority not described by any other disposition code or combination of codes.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3042</td>
<td>Cease and Desist from Violations</td>
<td>The entity was ordered to cease and desist.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Code Name</td>
<td>Definition</td>
<td>Code Status</td>
<td>Notes</td>
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<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>3043</td>
<td>Cease and Desist from all Insurance Activity</td>
<td>The entity or individual was ordered to cease and desist from engaging in the business of insurance.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3044</td>
<td>Remedial Measures Ordered</td>
<td>The entity or individual was ordered to take specific action in order to remediate a situation which caused harm to one or more persons as a result of one or more acts taken by the entity or individual.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3045</td>
<td>Consent Order</td>
<td>The entity or individual entered into a voluntary agreement in order to resolve the issue regulatory issue that is the subject of the action.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3046</td>
<td>Stipulated Agreement/Order from a commissioner</td>
<td>The entity or individual entered into a stipulated agreement which was approved via a formal process (i.e. approved by an administrative law judge or hearing examiner) in order to resolve the issue regulatory issue that is the subject of the action.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3047</td>
<td>Previous Order Vacated / Stayed / Set Aside</td>
<td>A previous order under which the entity or individual was subject has been set aside, nullified, cancelled, or rescinded. Or an order that postpones or suspends a previous order.</td>
<td>Code Name Change Previous Code Name “Previous Order Vacated”</td>
<td></td>
</tr>
<tr>
<td>3048</td>
<td>Ordered to Provide Requested Information</td>
<td>The entity or individual has been ordered to produce information requested by the jurisdiction under its statutory authority.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3049</td>
<td>Stayed Order</td>
<td>The Department of Insurance stops a previously issued order from being put into effect.</td>
<td>Delete</td>
<td>Used by 3 states, 10 times. Proposed alternative: (3047) “Previous Order Vacated / Stayed / Set Aside”</td>
</tr>
<tr>
<td>3051</td>
<td>Final Agency Order</td>
<td>The final agency order was issued against the entity or individual.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3052</td>
<td>Ordered to Comply with Specific Statute or Regulation</td>
<td>The entity or individual was ordered comply with a specific insurance statute, rule, and/or regulation.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3055</td>
<td>Reprimanded / Censured</td>
<td>The entity or individual was formally reprimanded or censured.</td>
<td>Code Name Change Previous Code Name “Reprimanded”</td>
<td></td>
</tr>
<tr>
<td>3060</td>
<td>Hearing Waiver</td>
<td>The entity or individual waived their right to a hearing.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3065</td>
<td>Show Cause</td>
<td>An order directing the entity or individual to appear before the reporting jurisdiction to explain why they took or failed to act or why the reporting jurisdiction should or should not grant some relief.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3070</td>
<td>Re-exam</td>
<td>The Department of Insurance orders a follow-up examination of an entity to ensure compliance with state laws and regulations.</td>
<td>Delete</td>
<td>Used by 4 states, 11 times. Proposed alternative: (3105) “Other”</td>
</tr>
<tr>
<td>3075</td>
<td>Rescission of</td>
<td>The Department of Insurance retracts a previous action or order. An additional Disposition code must be selected to identify what was rescinded. If Other is selected, text explanation must be entered into the Other action disposition field.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3076</td>
<td>Involuntary Forfeiture</td>
<td>The Department of Insurance requires the surrender of the authority of an individual or firm to engage in the business of insurance in the state because of a crime, offense, or</td>
<td>Delete</td>
<td>Used by 0 states, 0 times. Proposed alternatives: (3102) “Monetary Penalty” or (3103)</td>
</tr>
</tbody>
</table>

As of 8/24/2021
code | code name | definition | code status | notes |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3078</td>
<td>restitution</td>
<td>The entity or individual was ordered to pay restitution in order to compensate one or more persons or entities harmed by actions of the regulated or unauthorized entity or individual.</td>
<td>keep</td>
<td>&quot;aggregated monetary penalty&quot;</td>
</tr>
<tr>
<td>3079</td>
<td>suspended from writing new business; renewals ok</td>
<td>The entity is prohibited from writing new business. However, it is still permitted to service current policyholders.</td>
<td>keep</td>
<td></td>
</tr>
<tr>
<td>3080</td>
<td>supervision</td>
<td>The financial condition of the entity was placed under supervision and being closely monitored by the jurisdiction.</td>
<td>keep</td>
<td></td>
</tr>
<tr>
<td>3085</td>
<td>rehabilitation</td>
<td>The entity was found to be financially impaired or insolvent. Action is being taken to restore the impaired or insolvent entity to sound financial standing.</td>
<td>keep</td>
<td></td>
</tr>
<tr>
<td>3090</td>
<td>liquidation</td>
<td>The entity was found to be insolvent and unable to become viable. Action is being taken to liquidate the entity.</td>
<td>keep</td>
<td></td>
</tr>
<tr>
<td>3095</td>
<td>conservatorship</td>
<td>The entity and its financial condition are being evaluated to determine whether the policyholders and creditors will be best served by liquidation, rehabilitation, or returning the entity to private management.</td>
<td>keep</td>
<td></td>
</tr>
<tr>
<td>3097</td>
<td>hearing</td>
<td>A hearing was brought about as a result of the action against the entity or individual.</td>
<td>keep</td>
<td></td>
</tr>
<tr>
<td>3100</td>
<td>receivership</td>
<td>The entity was placed into receivership by jurisdiction in which the entity is legally domiciled.</td>
<td>keep</td>
<td></td>
</tr>
<tr>
<td>3101</td>
<td>ancillary receivership</td>
<td>The entity was placed into receivership by a jurisdiction other than the jurisdiction in which the entity is legally domiciled.</td>
<td>keep</td>
<td></td>
</tr>
<tr>
<td>3102</td>
<td>monetary penalty</td>
<td>Monetary fine or penalty imposed on a single entity or individual in a single action for one or more violations of insurance statutes, rules, and/or regulations.</td>
<td>keep</td>
<td></td>
</tr>
<tr>
<td>3103</td>
<td>aggregate monetary penalty</td>
<td>Monetary fine or penalty imposed on one or more entities or individuals in a single action for one or more violations of insurance statutes, rules, and/or regulations.</td>
<td>keep</td>
<td></td>
</tr>
<tr>
<td>3104</td>
<td>settlement</td>
<td>The Department of Insurance negotiates an agreement with an entity without legal action or litigation being undertaken.</td>
<td>keep</td>
<td></td>
</tr>
<tr>
<td>3105</td>
<td>other*</td>
<td>Any other disposition not described by any other disposition code or combination of codes.</td>
<td>keep</td>
<td></td>
</tr>
</tbody>
</table>

* If checked, you must enter a description of up to 100 characters.
The Market Conduct Examination Guidelines (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met June 10, 2021. The following Working Group members participated: Damion Hughes, Chair, and Dennis Newman (CO); Erica Weyhenmeyer, Vice Chair (IL); Mel Heaps, Teri Ann Mecca and Crystal Phelps (AR); Sarah Borunda and Catherine O’Neil (AZ); Kurt Swan (CT); Susan Jennette and Frank Pyle (DE); Sarah Crittenden (GA); Lindsay Bates and Daniel Mathis (IA); Lori Cunningham and Ron Kreiter (KY); Mary Lou Moran (MA); Isaac Kane (MI); Paul Hanson (MN); Cynthia Amann, Jo LeDuc and Win Nickens (MO); Laura Arp, Martin Swanson and Reva Vandevoorde (NE); Tracy Biehn (NC); Ralph Boeckman (NJ); Jennifer Catechis and Myra Morris (NM); Hermoliva Abejar and Barbara D. Richardson (NV); Sylvia Lawson, Sharon Ma, Mark McLeod and Elvis Soto (NY); Rodney Beech (OH); Landon Hubbard and Shelly Scott (OK); Alex Cheng, Brian Fordham and Tashia Sizemore (OR); Gary Jones and Chris Monahan (PA); Stacie Parker and Matthew Tarpley (TX); Julie Fairbanks, Joy Morton and Bryan Wachter (VA); Christopher Antoine and Mary Block (VT); Jeanette Plitt (WA); Barbara Belling, Diane Dambach, Darcy Paskey, Rebecca Rebholz, MaryKay Rodriguez and Jody Ullman (WI); and Desiree Mauller (WV). Also participating was: Matt Gendron (RI).

1. **Heard Opening Remarks**

   Mr. Hughes introduced himself as the new chair of the Working Group, and he also introduced Ms. Weyhenmeyer as the new vice chair of the Working Group. Mr. Hughes reminded all attendees that this Working Group is the successor Working Group to the 2020 Market Conduct Examination Standards (D) Working Group.

2. **Discussed New Draft Title Standardized Data Requests (SDRs) for Inclusion in the Reference Documents of the Market Regulation Handbook**

   Mr. Hughes said that comments were received on the new Title In Force and the Title Claims SDRs from Rhode Island, Nebraska, Colorado, the Center for Economic Justice—CEJ and the American Land Title Association—ALTA. Mr. Gendron presented his comments, indicating that since most states use the NPN field, the field should not be removed from the SDRs, as suggested by interested parties during the last call. Ms. Vandevoorde presented her comments, agreeing with Mr. Gendron that the NPN field should remain in the SDRs. Mr. Gendron reminded the Working Group that the purpose of the SDRs is that they are designed to be modified, and therefore, the SDRs are a listing of fields that might be requested, but not every single field may be requested by a state market conduct examiner. She said that states that do not need a NPN can remove it from the standardized data request. Mr. Hughes agreed, saying that SDRs are designed to be flexible to meet examiners’ needs.

   Mr. Newman presented his comments, indicating that he had no changes to the Title In Force SDR. He recommended reordering the fields in the Title Claims SDR as outlined in his comment letter, so that it has a more logical flow, with regard regarding date-related fields.

   Birny Birnbaum (CEJ) said that his written comments were fairly self-explanatory, and the highlights of those include the following. In the Title In Force SDR: 1) the field PolTyp should include the policy form identifier that the company is using, as it may provide valuable information about the type of policy and type of coverage issued (he suggested that the policy form identifier also be added to the Title Claims SDR); 2) in the description of the PolTyp2 field – “reissue” is a rate, not a type of a policy form; 3) in the description of the field “PropTyp” – “residential” typically means 1-4 family residential, but it is unclear if this field is needed if an examiner has requested a policy form identifier, which will indicate whether the policy is residential or commercial; 4) the fields “Closing Protection Letter,” “Closing Protection Letter Fee,” “Arbitration,” and “Base Premium” should be added; 5) the field “Endorse” should identify endorsements used, not just that there were endorsements; and a field “Endorsement Premium” should be added to reflect premium charges associated with each endorsement; and 6) Mr. Birnbaum suggested using codes “Purchase,” “Refinance,” and “Other” instead of yes/no fields.

   Mr. Birnbaum suggested that in the Title Claims SDR: the following fields be added: 1) a field “Arbitration” similar to the “Litigation” fields found in the SDR; 2) a field “Reason Codes for Claim Denials;” 3) the fields “Outcome of Litigation,” “Claim Settlement Expense,” and the fields “Litigation Expense” and “Arbitration Expense” (a subset of settlement expense). Mr. Birnbaum suggested changing yes/no in fields like “Is Claim Currently in Litigation” to data fields like “Date Litigation Initiated.” “Status of Litigation” (where in the description field he suggested the language “ongoing, settled, court verdict,
Steve Gottheim (ALTA) said the instructions that examiners provide to a regulated entity with these SDRs should allow for “Blank If None” on most fields, if not all fields, because the type of information requested on the Title In Force and Title Claims SDRs is above and beyond what title insurers routinely collect in their policy databases. Mr. Gottheim said since a title agent is not the insurer’s agent for the purpose of closing a loan, information such as “closing file number,” “address of subject property,” etc. are not available to the title insurer, and the insurer would therefore need to obtain the information from multiple sources, which has a significant associated cost, and additional time would be needed. Mr. Gottheim said that title insurers only have access to data that is on the face of the policy. Additionally, Mr. Gottheim said that a significant portion of the information requested in the Title SDRs which is accessible to title insurers, is not in a single consolidated system; thus to provide the information requested in the SDRs, the title insurer would need to utilize significant manual efforts. Mr. Gottheim said that in both SDRs, clarification is needed for several fields, regarding what type of information examiners are requesting the title insurer provide, and he said that some fields may be repetitive or ask for information not related to title insurance. Mr. Gottheim asked what timeline would be provided by examiners to an insurer who has to obtain information from external sources, and he asked if such information could be requested by examiners in a follow up inquiry, instead of up front. Mr. Gottheim added that information requested in an SDR may not be held in one database and would therefore not be easily condensed into a report.

Mr. Gendron said that Rhode Island market conduct examiners would have concerns regarding blank items appearing in a regulated entity’s response to an SDR. He said that the Rhode Island Division of Insurance requests that a regulated entity respond to a SDR with a signed Certificate of Completeness which indicates that their answer is complete. Mr. Gendron said when there is a blank in a response, when accompanied by a Certificate of Completeness, it indicates that the regulated entity either does not have the information or it does not have access to the information; it does not signify that the regulated entity will provide the information to RI at a later time. Mr. Gottheim said regarding blanks in regulated entity responses to SDRs, if the title insurer does not have the information to respond to a particular field in an SDR, they will leave it blank, and he suggested that it be acceptable to examiners if such missing information could be provided by a regulated entity at a later date.

Mr. Gottheim said with regard to endorsements, sometimes a title insurer may obtain from a title agent a total premium, but not its components (the base premium, a list of endorsements and their associated premiums). Mr. Birnbaum said that regarding endorsements and associated premium, which are not shown on the face of a title policy, it is reasonable for examiners to ask a title insurer regarding the endorsements and the premium for each, since it is a logical expectation that a title insurer would be able to provide information to examiners regarding how a total title insurance premium was derived and calculated. Mr. Birnbaum said that the data available to a title insurer would be dependent on what type of agent is being used, examiners would have a reasonable expectation that the title insurer would more readily be able to obtain data examiners are asking for, from a direct or affiliated agent, versus from an independent agent. Mr. Birnbaum said that given that the title industry is very much data driven, title insurers should be able to provide examiners with data on title transactions, since such data is the basis for the analytics that title insurers are using for automated underwriting purposes.

Peter Kochenburger (University of Connecticut School of Law) said that examiners should be collecting information in the SDRs from title insurers on arbitration and on litigation. Mr. Gottheim said that it was his understanding that the term “litigation” in the SDRs refers to the litigation regarding the defense of claims and not litigation between the insurer and the insured.

The Working Group asked the Title SDR regulator-only subject matter experts (SMEs) to reconvene, review all title insurance comments received, make revisions where needed to the SDRs, and submit the SDRs to the Working Group as revised exposure drafts for discussion at the next scheduled call.

3. Reviewed its Charges and Prioritized its Potential 2021 Tasks

Mr. Hughes said the charges of this Working Group, as adopted by the Market Regulation and Consumer Affairs (D) Committee, are to:

1. Develop market conduct examination standards, as necessary, for inclusion in the Market Regulation Handbook (Handbook).
Mr. Hughes said that he believes that charges 2, 5, and 6 are interrelated and that there is overlap between charges 1 and 3 and charges 4 and 7. Mr. Hughes said that at the last Working Group call, the following were identified as areas of possible revision to the Handbook: 1) the Suitability in Annuity Transactions Model Regulation (#275); 2) the Insurance Holding Company System Regulatory Act (#440); 3) the Health Maintenance Organization Model Act (#430); 4) the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651); and 5) the Standard Nonforfeiture Law for Individual Deferred Annuities (#805).

Mr. Hughes said additional Working Groups and areas the Working Group should monitor on a going forward basis regarding potential updates to the Handbook are the Mental Health Parity (B) Working Group, the Accelerated Underwriting (A) Working Group, the Big Data and Artificial Intelligence (EX) Working Group, the Long-Term Care Insurance Model Update (B) Subgroup, the Innovation and Technology (EX) Task Force (referenced in charge 5), and the yet to be adopted Pharmacy Benefit Manager Licensure and Regulation Model Act.

Mr. Hughes reminded the Working Group that the Group would not draft any guidance, exam standards, regulatory guidance, etc. based upon models or guidance that is yet to be adopted by the NAIC, but the Working Group is charged with monitoring developments in other NAIC groups and task forces for future development/inclusion in the Handbook.

Mr. Hughes asked for state insurance regulators to volunteer to: 1) review any of the models on the list of recently adopted models—i.e., Model #275, Model #430, Model #440, Model #651 and Model #805; 2) review any of the other identified areas of revision to the Handbook (such as Model #275, Model #880, etc.); 2) report to the Working Group regarding whether the Handbook should be updated in these subject areas; and 3) if revisions are deemed necessary, to work together as regulator-only subject matter expert (SME) volunteer groups to prepare an initial exposure draft for review and discussion by the Working Group. Mr. Hughes asked if any volunteers arose out of the March 30 Working Group call. Petra Wallace (NAIC) said that an individual from Kentucky had volunteered to review the Insurance Holding Company System Regulatory Act (#440).

Mr. Gendron asked that a standardized data request be developed to correspond to the Travel Insurance Model Act (#632). Mr. Gendron said that the revisions to the Suitability in Annuity Transactions Model Regulation would be a higher priority than a Travel insurance-related SDR, and, with regard to the Insurance Holding Company System Regulatory Act (#440) and the Standard Nonforfeiture Law for Individual Deferred Annuities (#805)—these two models may not impact the Handbook, however, the models should be reviewed to see if any corresponding revisions need to be made to the Handbook.

Ms. Rodriguez volunteered to review the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651). Ms. Amann said that if Kentucky does not wish to volunteer for the Insurance Holding Company System Regulatory Act (#440), Missouri can volunteer to review the model, and she said that Missouri would also volunteer to undertake Charge 7 regarding the discussion of the role of market conduct examiners in reviewing insurers’ corporate governance, as outlined in corporate governance models Corporate Governance Annual Disclosure Model Act (#305) and the
Corporate Governance Annual Disclosure Model Regulation (#306). Ms. Amann suggested, regarding charge 5, that the Working Group ask for a liaison (an individual member of the Working Group associated with charge 5) who can provide a 5–10-minute update or report at this Working Group’s future calls.

Mr. Hughes said that regarding other identified models for which there were no volunteers during the call, he will be reaching out to regulators to ask for assistance in the review of the models, to determine if corresponding changes to the Handbook should be made, and to form SME groups, as needed, to develop initial exposure drafts for review and discussion by the Working Group.

4. Discussed Other Matters

Mr. Hughes asked the Working Group members to participate in as many Working Group conference calls as possible this year so the Working Group can accomplish the tasks that are planned in 2021.

Having no further business, the Market Conduct Examination Guidelines (D) Working Group adjourned.
The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met July 1, 2021. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Teri Ann Mecca (AR); Maria Ailor (AZ); Don McKinley (CA); Susan Kurtz (CO); Kurt Swan (CT); Frank Pyle (DE); Scott Woods (FL); Erica Weyhenmeyer (IL); Tate Flott (KS); Ron Kreiter and Sandra Stumbo (KY); Mary Lou Moran (MA); Mariel Kaufman (MD); Timothy Schott (ME); Jill Huisken (MI); Teresa Kroll (MO); Paul Hanson (MN); Troy Smith (MT); Reva Vandevoorde (NE); Karen McAllister and Edwin Pugsley (NH); Ralph Boeckman (NJ); Leatrice Geckler (NM); Hermoliva Abejar (NV); Larry Wertel (NY); Guy Self (OH); Landon Hubbart (OK); Jeffrey Arnold (PA); Glynda Daniels and Rachel Moore (SC); Shelley Wiseman (UT); Will Felvey (VA); Christina Rouleau (VT); and Theresa Miller (WV). Also participating was: Jo LeDuc (MO).

1. Adopted its March 19 Minutes

Mr. Haworth said the Working Group met March 19 and took the following action: 1) adopted its Feb. 25 minutes; 2) adopted revisions to the MCAS Best Practices Guide; 3) adopted a 14-day limitation for Market Conduct Annual Statement (MCAS) extension requests; 4) adopted a requirement that companies identify their MCAS attestors by line of business and by jurisdiction; and 5) adopted revisions to the NAIC Market Regulation Handbook training opportunities for market regulation analysts.

Ms. Weyhenmeyer made a motion, seconded by Ms. Rebholz, to adopt the Working Group’s March 19 minutes (see NAIC Proceedings – Spring 2021, Market Regulation and Consumer Affairs (D) Committee, Attachment Three). The motion passed unanimously.

2. Discussed Market Analysis Training

Mr. Haworth said he would like the Working Group to have one more opportunity to discuss market analyst training needs, and he encouraged additional written suggestions be sent to Randy Helder (NAIC) by July 16. He said the suggestions will be compiled in time for the Working Group’s meeting at the Summer National Meeting. He said at that time, the Working Group will consider ways to meet the training needs of market analysts.

Mr. Haworth noted that some ideas for training may include additions to the Market Analysis Techniques online course offered by the NAIC Education and Training Department; the creation of manuals with descriptions and screenshots; or more in-person Zoom walk-through trainings like he recently led for the Market Actions (D) Working Group National Analysis project.

Ms. Daniels asked if there could be training on TeamMate. Mr. Haworth said not all states use TeamMate.

Ms. Abejar said it would be good to have training on common market risks for different lines of business. The training could be provided by line of business.

3. Discussed the Next Line of Business for the MCAS

Mr. Haworth said the Working Group does not have any written suggestions for adding a new line business, but he invited the Working Group and interested parties to submit any suggestions for the next line of business to be added to the MCAS.

Mr. Haworth said the process for suggesting a new line of business is located on the Working Group’s web page. He said the process says a written suggestion should include: 1) a description of how the collection of data for this line of business will assist market regulation and benefit the consumer, as well as why the MCAS is the best choice for collecting this data; 2) supporting data on the size of the market, such as the number of carriers, policyholders, and premium volume; and 3) whether data is collected on a periodic basis in any other jurisdiction or manner.

Mr. Haworth asked that any suggestions be sent to Mr. Helder.
4. **Discussed the Initial Aggregate Analysis of MCAS Data**

Mr. Haworth said he would like to give the Working Group an opportunity to consider any first impressions of the 2020 MCAS data that was reported in April. He said the scorecards were posted on the NAIC’s MCAS web page on July 1. He cautioned that the MCAS data is confidential, and the Working Group would not discuss specific companies. As an example, he said he has noticed that some insurers are reporting far fewer complaints in the MCAS than what the department of insurance (DOI) has for the company. He said the complaints reported in the MCAS exclude complaints received by the company from the DOI. He said the expectation is that a company would receive more complaints directly from consumers than they receive from the DOI. He said he is gathering additional data on this.

Ms. Ailor said there are still validations of the MCAS data ongoing, and she suggested that the discussion should wait for another month until the validation of the data is complete. She said the Arizona DOI is currently focused on non-filers and attempting to get all filings in.

5. **Discussed Residency/Issuance Reporting in the MCAS**

Mr. Haworth asked whether the Working Group wishes to provide any guidance in the MCAS Data Call and Definitions for each line of business to guide insurers on which data to report to which state. He said the Working Group has discussed this in the past, but it has not made any changes to the definitions. He said this issue has most relevance for life, annuity and long-term care (LTC) lines of business due to the much longer policy terms, which create a greater potential for insureds to move from the state where they originally purchased these policies.

Mr. Haworth said this year, carriers submitted waiver requests to a number of states citing that they did not have approval to write a specific line of business in the state but had reported premium in the state based on the current residency of the insureds. He said the company asked for a waiver based on not being authorized to write the specific product in the state. The waiver requests were approved, but perhaps they should not have been. Mr. Haworth also noted that at least one carrier incorrectly reported risk corridor payments as premiums in Washington but had no business written in Washington.

Ms. LeDuc said the original intention was to require the companies to report in the MCAS just as they reported in the Financial Annual Statement (FAS) so there would be a correspondence of reporting between the MCAS and the FAS. Therefore, the companies were told to report by residency, but only by how they reported in the FAS. Ms. LeDuc said even if a policy is not issued in Missouri, she would still want the company to report an MCAS if there is premium reported in the FAS due to residents in Missouri. She said she does not think the waiver should have been approved.

Ms. Ailor asked how this topic is related to the way complaints are handled if, for example, a policy is issued to an association group in one state, but the certificate holder is a different state. Mr. Haworth said complaints tracking is more situational and could include third parties to an insurance contract and not the insured. Ms. Ailor said she understands how the tracking of complaints can be situational, but she said there can be instances where the certificate holder lives outside of a state where a policy was issued. The certificate holder could file a complaint with the state where the policy was issued, but no premium would have been reported to the state if the premium is reported by residency. She said in that case, there could be no comparison premium to complaints. Mr. Haworth agreed and noted that complaint analysis is not an exact science.

Mr. Haworth said this is an issue that could benefit from some additional training.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met July 28, 2021. The following Working Group members participated: Rebecca Rebholz, Chair (WI); Tate Flott, Vice Chair (KS); Sarah Borunda (AZ); Scott Woods (FL); Sarah Crittenden (GA); October Nickel (ID); Erica Weyhenmeyer (IL); Lori Cunningham (KY); Mary Lou Moran (MA); Dawna Kokosinski (MD); Jill Huisken (MI); Teresa Kroll (MO); Reva Vandevoorde (NE); Hermoliva Abejar (NV); Guy Self (OH); Gary Jones (PA); Maggie Dell (SD); Shelli Isiminger (TN); Shelley Wiseman (UT); and Letha Tate (WV).

1. Adopted its June 30 Minutes

The Working Group met June 30 and took the following action: 1) received an update on the life Market Conduct Annual Statement (MCAS) draft edits for accelerated underwriting (AU); 2) adopted edits to the draft homeowners and private passenger auto (PPA) MCAS on digital claims, and then adopted the amended digital claims MCAS; and 3) considered the lawsuit definitions and placement of the lawsuit data elements for the homeowners and PPA MCAS.

Ms. Nickel made a motion, seconded by Mr. Flott, to adopt the Working Group’s June 30 minutes (Attachment Five-A). The motion passed unanimously.

2. Received an Update on the Life MCAS Draft Edits for AU

Ms. Rebholz stated the Accelerated Underwriting (A) Working Group plans to meet on July 29 to review the latest draft of the educational paper that is currently out for comment. She stated the Working Group will take oral comments, and all written comments on the latest draft will be due by July 30. She stated the MCAS Blanks Accelerated Underwriting subject-matter expert (SME) group continues to wait for adoption of a definition of “accelerated underwriting” by the Accelerated Underwriting (A) Working Group, and that once that definition is adopted, the SME group will reconvene for further discussions.

3. Received an Update on the Other Health Drafting Group

Mr. Helder stated the Other Health Drafting Group is finishing up the work on the other types of health blanks and will be getting a date set up and sending notification to everyone who was involved in the short-term, limited-duration insurance (STLDI) blank discussions. He stated that anyone wanting to get involved in these discussions should let him know so they can be added to that distribution list.

4. Discussed the Lawsuit Definitions and Placement of the Lawsuit Data Elements for the Homeowners and PPA MCAS

Ms. Rebholz stated there are many details that go along with decisions that the Working Group needs to make related to the lawsuit reporting for the home and auto MCAS lines of business. She stated that as a result, she would like to form an SME group for these discussions so a proposal can be brought back to the Working Group for consideration. She stated there is a distribution list that was used for the Digital Claims proposal that should include property/casualty (P/C) representatives, which will be used to start the group. Ms. Rebholz stated that those who did not previously participate in the Digital Claims SME discussions and would like to participate in the lawsuit discussions should contact Teresa Cooper (NAIC) to be added to the distribution list. She stated anyone who wants to be removed from that distribution list should also let Ms. Cooper know. Ms. Rebholz asked for a state insurance regulator to lead the lawsuit discussions, and Ms. Nickel volunteered to do so.

5. Requested Submission of Suggested Edits to Existing MCAS Blanks and Data Call and Definitions

Ms. Rebholz stated there is a form to be used for the submission of suggested edits to existing MCAS blanks and data call and definitions, which is located on the Working Group’s web page. She stated any questions or issues with the form can be sent to Ms. Cooper. Ms. Rebholz stated the Working Group charges include reviewing existing MCAS lines of business, and this
will be a good way to make improvements where needed. She stated proposals for changes can be made by state insurance regulators or interested parties.

6. Discussed Other Matters

Ms. Rebholz stated that while adopting the Digital Claims edits in June, it was decided that the reporting structure for the added interrogatory would be discussed further. She asked that the SME group working on the lawsuit information for the homeowners and PPA MCAS also work on this during their discussions on the lawsuit information. She stated the data to be collected has already been determined, and that it is just the structure for reporting that needs to be discussed. There was no opposition to this approach.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met June 30, 2021. The following Working Group members participated: Rebecca Rebholz, Chair (WI); Tate Flott, Vice Chair (KS); Teri Ann Mecca (AR); Maria Ailor and Sarah Borunda (AZ); Scott Woods (FL); Sarah Crittenden (GA); October Nickel (ID); Erica Weyhenmeyner (IL); Mary Lou Moran (MA); Mariel Kaufman (MD); Jo LeDuc and Teresa Kroll (MO); Martin Swanson (NE); Gary Jones (PA); Glynda Daniels (SC); Tony Dorschner (SD); Shelli Isiminger (TN); Shelley Wiseman (UT); John Haworth and Ned Gaines (WA); and Letha Tate (WV).

1. **Adopted its May 27 and May 26 Minutes**

The Working Group met May 27 and May 26 and took the following action: 1) adopted its April 28 minutes; 2) adopted the Travel Market Conduct Annual Statement (MCAS); 3) considered the Other Health MCAS and adopted the draft as the Short-Term Limited-Duration (STLD) Insurance MCAS blank; 4) discussed digital claims MCAS edits to the Homeowners and Private Passenger Auto (PPA) MCAS lines of business; 5) discussed the draft edits to the Life MCAS to include reporting for accelerated underwriting; and 6) adopted the definition of “lawsuit.”

Mr. Flott made a motion, seconded by Mr. Haworth, to adopt the Working Group’s May 27 (Attachment Five-A1) and May 26 minutes (Attachment Five-A2). The motion passed unanimously.

2. **Received an Update on the Life MCAS Draft Edits for Accelerated Underwriting**

Ms. Rebholz stated that the subject matter expert (SME) group has not met since before the May Working Group meetings, but the drafting group under the Accelerated Underwriting (A) Working Group has been meeting weekly in June to review comments received for its released “Part 1” draft. She stated that the definition it is working on is for purposes of its paper only, and since it is still releasing drafts and receiving comments, it is likely to be some time before it is ready to adopt the paper, which will include the definition. She asked if there is any interest in bringing the drafting group back together to review definition options that were discussed during the May Working Group meetings, or if the Working Group should continue to wait for the Accelerated Underwriting (A) Working Group’s final adopted definition of “accelerated underwriting.” She stated that the definition the Accelerated Underwriting (A) Working Group adopts may not be appropriate for an MCAS in defining data to be submitted. Mr. Swanson stated that he is waiting for the Accelerated Underwriting (A) Working Group to get done with its work. Mr. Haworth stated that waiting for the Accelerated Underwriting (A) Working Group to complete its definition may be best; then, the Market Conduct Annual Statement Blanks (D) Working Group can determine how to adjust and edit it for MCAS purposes.

Birny Birnbaum (Center for Economic Justice—CEJ) stated that the definition being worked on by the Accelerated Underwriting (A) Working Group is for the purposes of an educational paper and not for MCAS reporting purposes. He believes waiting for the Accelerated Underwriting (A) Working Group to adopt its definition of “accelerated underwriting” will delay the process. Ms. Rebholz stated that based on feedback from the Market Conduct Annual Statement Blanks (D) Working Group members, this topic will be discussed at future meetings and progress from the Accelerated Underwriting (A) Working Group on the “accelerated underwriting” definition will continue to be monitored and discussed.

3. **Adopted Edits to the Draft Homeowners and PPA MCAS on Digital Claims and Adopted the Amended Digital Claims MCAS**

Ms. Rebholz stated that the drafts for Homeowners and PPA MCAS edits on digital claims were included in attachments within the meeting materials. She stated that since the May Working Group meetings, comments related to the digital claim drafts were submitted by Missouri, which include a few additional areas for discussion.

Ms. Le Duc stated that Missouri has trouble with the interrogatory question for the listing of third-party vendors because it does not see where this information will add value or provide actionable information. She stated that Missouri’s preference would be not to include this information, as it would just be a list that provides a partial picture, and it leaves out algorithms or data sources that the company might be producing or using on an internal basis, not through a third-party vendor. She stated
that if there were indicators of problems with a company’s digital claims, they would have a conversation with them and get additional information at that point as opposed to collecting it up front as part of the MCAS.

Ms. Nickel stated that she believes the purpose of asking for the listing of third-party vendors is to avoid doing additional outreach to carriers, and if a company is using third-party vendors, state insurance regulators would then be aware of that initially.

Peter Kochenburger (University of Connecticut School of Law) stated that one of the problems he sees is that there is no question for determining whether third-party vendors are being used appropriately, and the most important aspect is that insurance carriers pay the full value of the claim up to the limits. He stated that it is difficult to easily determine if there is a predictive algorithm being used that limits the policyholder’s or claimant’s ability or willingness to negotiate or consistently undervalues claim values whether it is by accident or not. He believes without asking a carrier how they arrived at the settlement amount each time, it would be difficult to examine the issue without having the basic information up front.

Mr. Birnbaum stated that listing the third-party vendors in the interrogatories is similar to listing third-party administrators (TPAs) and managing general agents (MGAs), which state insurance regulators have deemed useful. He stated that if the concern is that third-party vendors are not tied to uses on the digital claims process, a possible solution would be editing the interrogatory to add at the end of the sentence, “and for each vendor, identify the vendor’s specific role in the digital claims process” to get the name of the vendor and their role. He stated that the fact that one interrogatory cannot address every possible concern is not a reason to eliminate it, as it can address a significant portion of regulatory and consumer concern, and he believes this interrogatory does that and should be included, with the addition of, “and for each vendor, identify the vendor’s specific role in the digital claims process” at the end of the sentence.

Ms. Ailor stated that she has referred to the Financial Annual Statement in the past when wanting to know what MGAs and TPAs a company is using, and she asked if Ms. Nickel has found that helpful in the past. Ms. Nickel stated that she believes this interrogatory goes beyond what is provided in the Financial Annual Statement, and it would be more efficient to have this information provided in the MCAS.

Ms. Moran made a motion, seconded by Ms. Nickel, to keep the interrogatory as it stands and add, “and for each vendor, identify the vendor’s specific role in the digital claims process” at the end of the sentence. Ms. LeDuc stated that she would then recommend that the question be restructured differently so that there would be one line per vendor rather than one large amount of information all together. Teresa Cooper (NAIC) asked for clarification on how the Working Group would like that to look. Ms. Nickel stated that including each vendor line by line would be helpful and she would support that. Ms. LeDuc stated that having each vendor on a separate line in the database with the vendor’s name and additional information would be helpful. Ms. Cooper stated that there is not a way to continue to add a line if there are more vendors to add, but it would be possible to add five lines for each vendor to be added on a separate line, but there is not a way to have a variable record count. Ms. Nickel suggested adding 20 lines and an additional line for carriers to write in if the 20 lines were insufficient so that it could be revised for the following data year. Ms. Moran stated that she would be willing to amend her motion to include adding 20 lines for vendor information to be entered separately. Ms. Cooper stated that if that many lines were needed, it may be better to add a separate schedule for the list of vendors. Mr. Birnbaum stated that the motion could still be voted on regarding the information to be reported, and then the NAIC could determine the details of how that would look. Ms. Cooper stated that this would work if the motion reflected that. Ms. Moran restated the motion, seconded by Ms. Nickel, to keep the interrogatory as it stands; add, “and for each vendor, identify the vendor’s specific role in the digital claims process” at the end of the sentence; and discuss how the details of the data will be reported at a later date. The motion passed unanimously.

Ms. LeDuc stated that she had a suggestion that was related more to appearance. She stated that the paragraph that listed what should or should not be reported regarding digital claims appeared cumbersome, and a table format seems like it would be clearer. Mr. Birnbaum stated that the suggestion makes it appear that only certain coverages are to be reported at the digital claims handling process level of detail, which could be confusing. He stated that he believes the current language is clearer. Ms. LeDuc stated that her understanding is that only dwelling and personal property coverages would be reported at the digital claims level, and perhaps there needs to be a rewording to reflect that those coverages would also need to be reported at the digital claims level. Ms. Nickel asked if the hybrid and traditional claims would still be broken out separately regarding dwelling and personal property. Ms. LeDuc stated that she has no intention of changing the level of detail being collected, and she is just trying to make it easier to read, as she found the description of other breakouts confusing. She asked whether it would be clearer if the phrase above the Xs was removed and replaced with “other breakouts” and what constitutes a digital claim was defined elsewhere. She stated that she does not see the need to report it in the portion of other breakouts.
Ms. LeDuc made a motion, seconded by Ms. Nickel, to implement the suggestion for a table format and add the word “also” so the table description reads, “reported also at the Digital Claim Handling Process Level of Detail.” The motion passed unanimously.

Ms. Rebholz stated that the next item to review relates to the reporting of the Median Days data element. She stated that this edit was discussed and already adopted during the May Working Group meetings. The suggested solution to the concerns raised is to add the sentence, “Additionally, an ‘All’ breakout will be included for the reporting of Median Days to Final Payment.” Ms. Nickel stated that she believes there was already a median day’s breakout for those particular lines. Ms. LeDuc stated that unlike when a claim is reported and you can add all the claims reported in each of the breakout buckets, with median days, you cannot add the median days and get an overall median day because mathematically it does not work. She stated that she is looking for the overall median days for all three digital buckets together. There were no concerns raised with this sentence being added.

Ms. Rebholz stated that the final suggestion to discuss is edits to the digital claims-related definitions submitted for review. Ms. LeDuc stated that she is just trying to simplify the definition based on previous discussions, so the definition stood on its own and was easily understood. Ms. Nickel stated that she would not be opposed to removing the examples and placing them in a separate clarifying document to be used as a guidance tool. Ms. Ailor stated that rather than create another document, maybe it could be worked into the frequently asked questions (FAQ) document that already exists. Mr. Birnbaum suggested that this type of editing and discussion take place in the SME group as opposed to on a Working Group call. He stated that the reason examples were provided was to address issues raised by industry stakeholders that participated in the Digital Claims MCAS SME group discussions. Lisa Brown (American Property Casualty Insurance Association—APCIA) stated that she gets frequent questions for clarification on specific scenarios from members, and she suggests keeping the information in the one Data Call and Definitions document, as she believes it is the best way to ensure the MCAS blanks are completed properly, as opposed to having people refer to more than one document when questions arise. Ms. Nickel stated that she believes examples would be better in an FAQ document, and questions that are not addressed in the Data Call and Definitions and FAQ documents will be handled by the NAIC.

Ms. Nickel made a motion, seconded by Ms. LeDuc, to accept the digital claims edits for the Data Call and Definitions document suggested by Ms. LeDuc and create an FAQ document for digital claims. The motion passed unanimously.

Ms. Nickel made a motion, seconded by Mr. Gaines, to adopt the Digital Claims MCAS with the amendments adopted during this Working Group call. Ms. Brown asked if the adoption of the Digital Claims MCAS would be for the collection of 2023 data to be reported in 2024 since it was not passed by the June 1 deadline. Ms. Rebholz stated that this would be moved to the Market Regulation and Consumer Affairs (D) Committee for approval and determining the data year for reporting. Ms. Cooper stated that the Committee would be made aware that it was not adopted by the June 1 deadline when this information is presented, and the data year was removed from the template and exposed draft, so it would be passed on for its consideration without a data year indicated. The motion passed unanimously.

4. Considered the Lawsuit Definitions and Placement of the Lawsuit Data Elements for the Homeowner and PPA MCAS

Ms. Rebholz stated that there is a situation with the Home and Auto lawsuit definitions and placement, and during the April Working Group meeting, the Working Group approved the expansion of MCAS lawsuit reporting for Home and Auto to include non-claims-related lawsuits. However, the Working Group did not have time to discuss the actual placement and definitions for this expanded reporting prior to the June 1 deadline, and it now needs to determine if there is a way to provide guidance for the already approved expanded reporting for the 2022 data year to be reported in 2023. She stated that an attachment within the meeting materials shows a proposed draft that was distributed for review on June 3, and the intent of the exposed draft was only to accommodate for the already approved, expanded reporting. Comments were received related to the draft from the APCIA, the CEJ, and Missouri.

Ms. Brown stated that based on the written procedures for the MCAS data element revision process, she does not believe the updates are just clarifying and providing guidance to industry. She believes the updates are new data elements, and based on NAIC procedures, they would have needed to be approved by June 1 to be effective for the next data reporting year for collection in 2023. She stated that she has concerns with how arbitrations are addressed in the definition of “lawsuit.” She stated that she believes they are not actions brought before a court of law and therefore should not be included, but if they are to be included, she suggests that the calculation clarification specifically exclude intercompany arbitrations, mutually agreed upon arbitrations, appraisals, and mediations. Mr. Birnbaum stated that arbitrations are not an action brought in a court of law, which is what the definition of “lawsuit” says. He stated that there are different types of arbitrations, and most of them are
mutually agreed upon, which is qualitatively different from a what a lawsuit is. He suggested that the reference to arbitrations either be deleted, or if it is included, that language be added stating, “include arbitrations demanded by the insurer or claimant pursuant to pre-dispute mandatory arbitration provisions in the insurance contract. Do not include mutually-agreed upon arbitrations, appraisals or mediations.” He stated that he believes the model bulletin adopted by the Market Regulation and Consumer Affairs (D) Committee in August 2018, specifically related to arbitration clauses, supports the CEJ and APCIA’s positions on this matter. Ms. Rebholz stated that one of the options available is to hold the approval of expanding the lawsuit reporting to non-claims-related suits until the 2023 data year reported in 2024, without updating the claims-related lawsuit definition for the 2022 data year. Ms. LeDuc stated that the proposal she suggested is more of a layout proposal to create a separate schedule so all the information would be contained in a single space and not in two different sections. She stated that it would be easier to work with and provide the whole picture related to all lawsuits in a single location, as opposed to splitting it across the underwriting and the claims schedule. She stated that it would just be the lawsuit data elements with the six buckets, five for the claims-related lawsuits and one for the non-claims-related lawsuits. Mr. Birnbaum stated that the CEJ made this suggestion a few months back, and it was rejected by the Working Group. He also asked the Working Group to consider whether it wants to collect the lawsuit data broken out by coverage as opposed to just claims-related and non-claims-related data. He stated that it is unclear how an insurer reports lawsuits if it involves multiple coverages and how that data would be interpreted. Ms. LeDuc stated that lawsuit data is currently collected by line of business for the claims. She stated that she looked at suggesting claims versus non-claims-related lawsuit buckets, and that would have been acceptable for Missouri; but in looking at the volume of lawsuits in other jurisdictions, she recognized that other states may continue to find value in the lawsuits broken down by coverage type, so it was kept in the proposal. Ms. Nickel stated that she believes having arbitration data would be valuable to have, whether it is separate of lawsuits or not. Ms. Cooper stated that another option is to discuss this further and then adopt for the following data year if the Working Group does not want to expand the definition, as was previously voted on for the 2022 data year.

Ms. Nickel made a motion, seconded by Ms. LeDuc, to hold on the approval of expanding the lawsuit reporting to non-claims-related lawsuits until the 2023 data year reported in 2024, without updating the claims-related lawsuit definition for 2022, and revert to the prior lawsuit definitions and continue this discussion further. The motion passed unanimously.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
Market Conduct Annual Statement Blanks (D) Working Group  
Virtual Meeting  
May 27, 2021

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met May 27, 2021. The following Working Group members participated: Rebecca Rebholz, Chair (WI); Tate Flott, Vice Chair (KS); Crystal Phelps (AR); Maria Ailor (AZ); Scott Woods (FL); Sarah Crittenden (GA); October Nickel (ID); Erica Weyhenmeyer (IL); Lori Cunningham (KY); Mary Lou Moran (MA); Dawn Kokosinski (MD); Jill Huiskens and Randall Gregg (MI); Paul Hanson (MN); Cynthia Amann, Jo LeDuc and Teresa Kroll (MO); Laura Arp (NE); Hermoliva Abejar (NV); Todd Oberholtzer (OH); Gary Jones and Katie Dzurec (PA); Michael Bailes and Rachel Moore (SC); Maggie Dell (SD); Bill Huddleston and Shelli Isiminger (TN); Tanji J. Northrup and Tracy Klausmeier (UT); and John Haworth and Ned Gaines (WA). Also participating was: Kim Cross (IA).

1. Discussed Digital Claims Edits to the Homeowners and Private Passenger Auto MCAS Lines of Business

Ms. Rebholz stated that the meeting materials include the pages of the data call and definitions that contain edits for review. She stated that questions were received from Missouri state insurance regulators, and those questions and answers were posted for review on the Working Group’s web page. She asked if there were any follow up questions.

Ms. LeDuc asked for clarification on how the median days to pay would be calculated. She stated that the response was that they could estimate what the calculation is for median days to pay so there could be consistency in looking at how that played out from prior years, or they could request that the aggregate median be reported. Birny Birnbaum (Center for Economic Justice—CEJ) stated that companies could be directed to report the median days not only for the individual breakouts, but also for the total. Ms. LeDuc stated that this would mean a change to the proposal would need to be made. Mr. Birnbaum stated that this is correct, and he explained that a proposal could be made to amend the blank to include reporting for the median days not only for the breakouts by digital, but also for the total. Mr. Hanson asked how important it is to have the three categories for digital claims plus a separate column for the total, other than for transitional purposes. Ms. Abejar stated that she believes there would be value in having all four columns to identify trends for analysis purposes. Ms. Rebholz stated that one of the solutions would be to have columns for the three separate digital claims categories and then a fourth column for the total. Mr. Birnbaum stated that there was previous discussion about using the term “total” or the term “all,” and the term “all” was settled on because in some cases, the total is not needed, but rather the aggregate, so the term “all” for that fourth column would be recommended. Mr. Haworth clarified that his understanding of the four categories being discussed here are: digital claims, digital/traditional hybrid claims, traditional/other than digital claims, and all.

Ms. Ailor made a motion, seconded by Mr. Hanson, to add a total column for median days. The motion passed unanimously.

Ms. LeDuc asked for clarification on why the time frames were chosen of 0–30 days, 31–60 days and 61–90 days for claims closed with payment. Mr. Birnbaum stated that the primary reason for the time frames is consistency that companies are familiar with, and it would not require a new data element that would require programming change. He also explained that settling within 0–30 days is acceptable. He then stated that by breaking out the digital claims time frames this way, the data is more relevant and useful for the hybrid and traditional claims because they are going to be populating the other date ranges in a more accurate fashion, and the aggregate would not be skewed by digital claims.

Ms. LeDuc stated that she asked if digital claims applied to both first- and third-party claims, and the answer was yes. She asked if references to the term “insured” used in the Digital Claims MCAS example language should be changed to “insured/claimant” to be consistent with other MCAS lines of business.

Mr. Haworth made a motion, seconded by Ms. Nickel, to add “insured/claimant” in the Digital Claims MCAS example language. The motion passed unanimously.

Ms. LeDuc stated that the way the digital claims definition is currently written does not outline the requirement to have an algorithm applied for it to qualify as a digital claim. She believes the definition needs to stand on its own without having to provide examples. Ms. Abejar and Mr. Haworth agreed with this. Ms. Rebholz suggested adding “run through an algorithm” to the definition after “utilizing digital information.” Mr. Birnbaum suggested adding “through an algorithm” after “utilizing digital information only.”
Mr. Haworth made a motion, seconded by Mr. Flott, to add “through an algorithm” after “utilizing digital information only” to the digital claim settlement definition, which is also to be added to the definition of digital/traditional hybrid claim settlement. The motion passed unanimously.

Ms. Le Duc asked for clarification on a digital/traditional hybrid claim. She stated that her understanding is that the hybrid claim would be something that started off as a digital claim, then if human intervention later happened in the claim, it would be a hybrid claim. Ms. Rebholz confirmed that this was correct. Ms. Le Duc stated that she believes some clarity needs to be provided in this definition because an adjuster may look at a file without doing an in-person inspection or in-person appraisal; it does not sound like human intervention would be restricted to inspection or appraisal, but it becomes human intervention in the adjudication of the claim. Mr. Hanson stated that where it says the insurer then performs a visual inspection of the vehicle, it is unclear if that could mean a review done electronically by looking at photos or if it means in-person inspection needs to be completed. After some additional discussion among the Working Group about the three categories of digital claims, digital/traditional hybrid claims, and traditional/other than digital claims settlements, Ms. LeDuc stated that she believes more time is needed for everyone to review the draft and provide any additional comments, especially given that some revisions were made today. Mr. Birnbaum stated that the CEJ would strongly object to that, as it would mean the Digital Claims MCAS blank would not be implemented for 2022 reporting and would be pushed off for another year. He stated that these definitions were distributed two weeks ago or more for review and for people to raise any questions. Several state insurance regulators expressed interest in having more time to review the Digital Claims MCAS blank, including Ms. Cross, Ms. Moran, Ms. Arp, Ms. Abejar, Ms. Dell and Mr. Gregg; as such, the Digital Claims MCAS blank was not adopted at this time.

2. Discussed the Draft Edits to the Life MCAS to Include Reporting for Accelerated Underwriting

Ms. Rebholz stated that the draft for edits to the Life MCAS to include reporting for accelerated underwriting is included in the meeting materials. She stated that the accelerated underwriting draft is being brought before the Working Group with objection from industry to the definition of accelerated underwriting. She provided background that last year, the CEJ proposed that accelerated underwriting breakout reporting be added to the Life MCAS, and in September of last year, the Working Group voted to move forward with reviewing the proposed definitions with the intent to implement accelerated underwriting reporting. This was done to provide state insurance regulators with data related to life insurers’ use of non-traditional data sources, such as facial analytics, credit scores and social media for underwriting purposes, along with algorithms for faster underwriting turnaround. Ms. Rebholz stated that this data was intended to assist state insurance regulators with understanding the use of accelerated underwriting and monitoring the growth of the use of accelerated underwriting.

Ms. Rebholz stated that the Life Insurance and Annuities (A) Committee has a working group devoted to accelerated underwriting. This Accelerated Underwriting (A) Working Group is working on a definition of accelerated underwriting for the purposes of its white paper, but it is still in draft form. The subject matter expert (SME) group tried to wait for a definition of accelerated underwriting from the Accelerated Underwriting (A) Working Group; however, the SME group was unable to adopt a definition in time for the Market Conduct Annual Statement Blanks (D) Working Group to consider it prior to the June 1 deadline. Ms. Rebholz stated that with guidance from commissioners, it was agreed that the Accelerate Underwriting (A) Working Group would move forward with a definition, and a note was added to the definition stating the following, “[t]his definition is for MCAS reporting. In an ongoing effort to collaborate two workstreams at the NAIC, the definition will be reviewed and may be amended, as needed, upon the Accelerated Underwriting (A) Working Group’s adoption of a definition of Accelerated Underwriting.” She stated that if the accelerated underwriting edits and definitions are adopted today, that definition is subject to edits upon receipt of the Accelerated Underwriting (A) Working Group’s final definition. She stated that the SME group did not reach consensus on a definition, and the edits and most recent definition posted has been moved to the Accelerated Underwriting (A) Working Group for further discussion.

Ms. Rebholz noted that since posting the final SME group draft, proposed draft definitions were received from the American Council of Life Insurers (ACLI) and Nevada. She stated that the Accelerated Underwriting (A) Working Group also has a draft definition that they are working on, and a document was posted showing all four of the draft definitions in one document for easier review.

Ms. Rebholz stated that new interrogatories were added to indicate that whether accelerated underwriting is used by the company, and if so, to provide a listing of data categories and sources used for accelerated underwriting. She stated that no new data elements are added to the draft; instead, in addition to the existing breakouts for cash value and non-cash value products, breakouts were added for accelerated underwriting and other than accelerated underwriting for those data elements where it was deemed appropriate. The data elements that include an accelerated underwriting breakout are: 1) total number of new policies issued by the company during the period; 2) number of policies applied for during the period; 3) number of free looks.
Mr. Birnbaum stated that when the proposals for digital claims and accelerated underwriting were made, the motivation was consumer concerns and the work being done by the NAIC on big data and artificial intelligence (AI), specifically related to insurers’ use of new data sources and algorithms to speed up or replace traditional methods of pricing, claim settlement and antifraud. He stated that the industry term for the application of big data and AI for auto and home insurance claims is digital accelerated underwriting from the perspective of insurers marketing their practices to state insurance regulators and the public on the key consumer protection aspects of any big data and AI application and the consumer outcomes resulting from the use of new data sources and the new AI technology, not the benefits the insurer hopes to achieve. He stated that for those reasons, he does not believe the other definitions proposed are suitable for the purpose of MCAS reporting, as they seek to explain accelerated underwriting from the perspective of insurers marketing their practices to state insurance regulators and the public as something new the life insurance industry has invented. He stated that the reasons insurers use accelerated underwriting is not relevant, and the definition from the SME group provides very clear guidance on which criteria determine whether something is an accelerated underwriting transaction.

Ms. Abejar stated that the definition should support solving issues regarding the consumer risk that is associated with accelerated underwriting. She asked why data sets were not included for the use of medical data provided by an applicant, and the use of non-medical data provided by an applicant, and the use of medical data that is not provided by an applicant. She stated that these data sets can still be misused when there is an algorithm that is faulty or problematic. She stated that not including those data sets limits the definition. She stated that the second concern is that there is no question asking what methods, tools or systems companies are using to accelerate underwriting, because each step of the process carries a different consumer risk and probably a different regulatory approach. Mr. Birnbaum stated that the thrust of the accelerated underwriting is to focus on new data types used by insurers, and they are using those new types of data, not simply algorithms that speed up the analysis of traditional data. He provided an analogy of a property/casualty (P/C) insurance company that previously accepted accident records from a consumer in an application, now using a third-party data provider to get those reports and accident history, which speeds up a traditional underwriting process but is not introducing new types of data. He stated that regarding the second concern, the interrogatory asks for a list of vendors that provide the data or the algorithms that addresses the tools and methods used.

Ms. Rebholz stated that the SME group did not reach consensus on the definition for accelerated underwriting, and if the Market Conduct Annual Statement Blanks (D) Working Group feels there needs to be more time devoted to this with input from more state insurance regulators, it can be pushed back another year if needed. Mr. Flott stated that he believes the SME group should reconvene on this with more representatives from industry and state insurance regulators. Mr. Hanson stated his agreement with Ms. Abejar, and he believes additional time should be spent on the definition because there is a lot of information that can be obtained from the consumer and used in a manner that leads to accelerated underwriting. Mr. Huddleston, Ms. Crittenden, Ms. LeDuc, Ms. Weyhemeyer, Mr. Gregg, Ms. Huiskan, Mr. Bailes, Ms. Moran and Ms. Cross agreed that more time is needed. Ms. Cross stated that the Market Conduct Annual Statement Blanks (D) Working Group should refer to the Accelerated Underwriting (A) Working Group for a definition and not make this determination. Ms. Moran stated that she believes the Accelerated Underwriting (A) Working Group would seem to be the more appropriate working group to develop the definition.

Brendan Bridgeland (Center for Insurance Research—CIR) stated that he strongly supports Mr. Birnbaum’s recommendation, and he urged adoption of the proposed accelerated underwriting definition.

3. **Adopted the Definition of Lawsuit**

Ms. Rebholz stated that the decision was made by the Market Conduct Annual Statement Blanks (D) Working Group in April to expand the definition of lawsuits for home and auto to include non-claim related lawsuits. She stated that there are three options to consider in determining the level of granularity for reporting. She stated that the first option is to report all lawsuits at the coverage level, and it has been noted that this could be problematic since non-claims related lawsuits do not fit well into the separate coverage types. She stated that the data elements could be left in the claims reporting section, or they could be moved to a new section with reporting at that coverage level. The second option is to report lawsuits in total, either in the
underwriting section or in a new section. The third option is to report claims related lawsuits in the claims section and all other lawsuits in the underwriting section.

Ms. Rebholz asked if it would be an issue for the lawsuit language to go back to what it had been. Teresa Cooper (NAIC) stated that since the Working Group voted to expand the reporting to include non-claims related lawsuits, waiting could be an issue. She stated that it is critical to determine a lawsuit definition for the Travel and Short-Term Limited-Duration (STLD) lines of business that were recently adopted to move forward. Mr. Birnbaum suggested using the current definitions that were most recently developed for the other MCAS lines of business (Life and Annuity, Disability Income, Private Flood, Lender-Placed, Home and Auto, and Long-Term Care [LTC]), as they were vetted and straightforward. Ms. Cooper asked if Mr. Birnbaum is referring to the lawsuit definition on page 45 of the meeting materials. Mr. Birnbaum confirmed that he is and stated that the difference between agent or producer is editorial in nature, and clarification changes could be made if needed, since they would not be substantive between now and when the Market Regulation and Consumer Affairs (D) Committee considers this. Ms. Rebholz stated that if the current language is accepted, making an edit where it was previously suggested for “claimant/beneficiary” may be warranted. Ms. Crittenden asked if this is regarding option two. Ms. Cooper explained that the conversation switched from discussing Home and Auto to discussing Travel and STLD, and the question now is whether the lawsuit definition outlined on page 45 of the meeting materials, with the minor edit for “claimant/beneficiary,” should be accepted for the Travel and STLD MCAS lines of business.

Ms. Crittenden made a motion, seconded by Ms. Phelps, to adopt the definition for lawsuit as outlined on page 45 of the meeting materials, with the “claimant/beneficiary” language to be added. The motion passed unanimously.

Ms. Rebholz stated that this adopted definition of lawsuit will apply to the recently adopted Travel and STLD MCAS blanks.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
May 26, 2021

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met May 26, 2021. The following Working Group members participated: Rebecca Rebholz, Chair (WI); Tate Flott, Vice Chair (KS); Crystal Phelps (AR); Cheryl Hawley and Maria Ailor (AZ); Scott Woods (FL); Sarah Crittenden (GA); October Nickel (ID); Erica Weyhenmeyer (IL); Lori Cunningham (KY); Mary Lou Moran (MA); Dawna Kokosinski (MD); Chris Gleason (MI); Cynthia Amann, Jo LeDuc and Teresa Kroll (MO); Martin Swanson (NE); Leatrice Geckler (NM); Hermoliva Abejar (NV); Guy Self and Todd Oberholtzer (OH); Jeffrey Arnold (PA); Glynda Daniels (SC); Maggie Dell (SD); Shelli Isiminger (TN); Tanji J. Northrup (UT); John Haworth and Ned Gaines (WA). Also participating was: Kim Cross (IA).

1. **Adopted its April 28 Minutes**

The Working Group met April 28 and took the following action: 1) adopted its March 23 minutes; 2) heard an update on the Travel Market Conduct Annual Statement (MCAS); 3) heard an update on the Other Health MCAS; 4) heard an update on the Accelerated Underwriting and Digital Claims MCAS; 5) discussed the placement of complaint and lawsuit data elements within the Home and Auto MCAS reporting blanks; 6) and discussed the MCAS lawsuit definitions.

Mr. Flott made a motion, seconded by Mr. Gaines, to adopt the Working Group’s April 28 minutes (Attachment Five-A2a). The motion passed unanimously.

2. **Adopted the Travel MCAS Draft**

Ms. Rebholz stated that the Travel MCAS draft was provided for review in the meeting materials. She noted that the Travel MCAS subject matter expert (SME) group has identified Trip Cancellation, Trip Interruption, Trip Delay, Baggage Loss or Delay, Emergency Medical and Dental, Emergency Transportation and Repatriation, and Other as the coverage breakouts, with additional breakouts for Domestic versus International coverages. In addition, Emergency Medical is broken out by Primary versus Excess coverage. Ms. Rebholz stated that the Claims, Underwriting, Lawsuit and Complaint data elements are similar to other MCAS lines of business; and where possible, definitions from the *Travel Insurance Model Act* (#632) were used for consistency purposes. Since travel insurance is represented by a small number of companies and the policies are generally small in amount, it was decided by the SME group to require reporting for all companies licensed and reporting for any travel insurance within any of the participating MCAS jurisdictions. Ms. Rebholz stated that the SME group requested input from the Working Group regarding the definition of “lawsuit” for the Travel MCAS. She stated that lawsuit definitions will be discussed later in the meeting, the Travel MCAS draft could be adopted now, and the definition of “suits” could be amended, as needed.

Birny Birnbaum (Center for Economic Justice—CEJ) provided two proposed additions to the Travel MCAS draft. He stated that the first suggestion is to add a coverage breakout for cancel for any reason (CFAR) coverage, and the second is to add a data element for free-look cancellations. He stated that as a result of the pandemic, travel insurers have significantly increased the inclusion of CFAR coverage, and this breakout could provide relevant information about this new and growing benefit. He explained that CFAR coverage increases the cost dramatically for a travel insurance policy, and there are a number of features associated with it that could be confusing to a consumer. He stated that the CEJ is asking that CFAR coverage be broken out for Domestic versus International, but not by Primary versus Excess. Ms. Ailor asked if the definition for “cancel by the consumer” would need to be modified to exclude those CFAR if an addition were made for CFAR coverage. Mr. Birnbaum explained that cancel for any benefit is a coverage that allows the cancellation of a trip, but it is not the same as canceling a policy; it is using your policy to get a benefit. He explained that CFAR coverage is a different coverage that allows the cancellation of the policy for any reason, and the data element in the underwriting section is about cancelling a policy.

Mr. Birnbaum stated that the second suggestion is to add a data element in the underwriting table for free-look cancellations. This suggestion is made because the current data element does not break free-look cancellations out from other consumer-initiated cancellations and free-looks are included in travel insurance policies. He stated that this greatly limits the analytic value of the cancellation data since that element would likely include many free-look cancellations, and it is important to break them out not only to track free-look outcomes, but also to improve the value of the general cancellation data element. He pointed out that other MCAS lines of business that feature free-look periods include a free-look cancellation data element, including life insurance and long-term care insurance (LTCI) lines. The CEJ suggestion includes adding the data element for free-look cancellations during the period and the definition for “free-look” as used in the other MCAS blanks. Ms. Nickel stated that she supports the addition of the free-look cancellation data element. Michael Byrne (US Travel Insurance Association—
USTiA) stated that he believes there was a vote in the SME group on this, and he asked what the result of that vote was. Ms. Rebholz stated that it was a very close vote, and she believes there was only a one vote difference that tipped the vote toward not including this data element, with three for adding it and four for not adding it.

Ms. LeDuc stated that since this is a new blank, she believes now would be a good time to consider changing the word “states” to “jurisdictions” to be more inclusive of U.S. territories that may want to participate. She also noticed that the Travel MCAS blank has three schedules related to providing data—schedules two through four—and schedule one for interrogatories does not provide a specific line option for lawsuits and complaints where the insurance company reporting could provide additional comments related to the numbers they are reporting. She believes it would be helpful since the lawsuits and complaints are not attached to something else, and not having that separate line might not spur companies to provide information that could be helpful to analysts. She also asked why the number of complaints received directly from the department of insurance (DOI) was being asked for when that data is already available elsewhere. Ms. Nickel stated that the complaints reported by the carrier and the ones received by the DOI never seem to match up, so she believes it is helpful to have this data to be able to review and compare their information. Mr. Gaines agreed and said he sees discrepancies in this area as well, and it can be a red flag regarding data integrity.

Mr. Byrne stated that the USTiA objects to adding any new items, and it supports the template as presented by the SME group. He also stated that if additional elements are going to be added, the industry would like the opportunity to comment on them. Mr. Birnbaum stated that these issues were discussed in the SME group, and there was not consensus, which is why the request to make these additions is being asked of the Working Group. Lisa Brown (American Property Casualty Insurance Association—APCIA) stated that she would like more time to get feedback from companies, and she does not support adding the free look period, which her vote reflected in the SME group. Mr. Oberholtzer stated that Mr. Birnbaum has indicated that the majority of all cancellations are during free-look periods, so that information is already known. He stated if there were a high number of cancellations that state insurance regulators were curious about, they could ask the companies to provide additional information, as needed. Mr. Oberholtzer stated that Ohio does not support breaking out additional cancellation information. He stated that he supports the Travel MCAS blank as it was presented by the SME group, and that he wants to voice the position of state insurance regulators that voted not to add the additional data element. Ms. Nickel stated that while she believes it is important to have the additional data element, and a full premium return is important to differentiate in analysis, she would defer to Mr. Oberholtzer and his recommendation given his knowledge and expertise on this subject matter. Ms. Rebholz asked for a motion regarding Ms. LeDuc’s recommendations to change the term in the Travel MCAS draft from “states” to “jurisdictions” and to add the two interrogatory lines for any comments that companies might choose to add about lawsuits or complaints for the schedules to align.

Ms. Nickel made a motion, seconded by Ms. Isiminger, to edit the Travel MCAS draft to change the term from “states” to “jurisdictions” and to add the interrogatory lines for any comments that companies might choose to add about lawsuits or complaints. The motion passed unanimously. Ms. Rebholz then asked if there was a motion to adopt the Travel MCAS blank, and she explained that the motion could also include whether it includes adoption of the CEJ proposals.

Mr. Oberholtzer made a motion, seconded by Ms. Kroll, to adopt the Travel MCAS draft without adding the CEJ proposals. The motion passed with Idaho abstaining.

### 3. Considered the Other Health MCAS Draft

Randy Helder (NAIC) stated that the Other Health SME group has been meeting regularly and has focused on short-term limited-duration (STLD). The final draft of the Other Health STLD MCAS blank was provided in the meeting materials. This is the product of a large group of state insurance regulators, industry, and consumer representatives who put in many hours of work. He stated that when work on the Other Health MCAS blank began, the drafting group’s intention was to develop a blank to cover all the other health products that were not currently part of the Health MCAS blank. It was quickly realized that to meet the June 1 deadline for adoption, the group would have to concentrate on only one product, which was STLD insurance. If this blank is adopted by the Working Group, work on the remaining other health products will take place.

Mr. Helder stated the 2019 STLD insurance data call was used as the jumping off point, but it was significantly expanded. The blank is divided into six sections: 1) interrogatories; 2) policy/certificate administration; 3) prior authorizations; 4) claims administration; 5) consumer complaints and lawsuits, and 6) marketing and sales. Mr. Helder stated that the data will be reported in nine categories: STLD insurance products sold through associations used in the state; STLD insurance products sold through associations not used in the state; and STLD insurance products not sold through an association. Each of these categories are divided into products with a term of less than or equal to 90 days, less than or equal to 180 days, and 181–364 days. In the interrogatories, information is requested on where the products are filed and marketed; waiting periods; triggers
for pre-existing exclusions; renewals/reissues and re-underwriting upon renewal; associations and fees; the use of third-party administrators (TPAs); and other distribution channels, such as independent and captive agents or employees. The policy, claims, prior authorization, and complaints sections ask the typical questions found in the other MCAS blanks, such as: policies in-force; policies/certificates issued and renewed; covered lives and member months; cancellations by reason; claims received; claims paid; days to claims decisions; and claim denials or rejections by reason. The marketing and sales section asks for information on: applications received, approved and pending; the number of new applications denied by reason and renewal apps denied by reason; and how the applications were initiated and completed (whether by phone, face-to-face, mail or online); and information requested about commissions paid, unearned commissions returned to the company, and other fees charged to applicants and policyholders that the company collected. It is specified in the instructions that the threshold is $50,000 in premium within the jurisdiction, and the STLD insurance products should be reported by the residency of the individual insured. Mr. Helder stated that the drafting group left the definition of “lawsuit” unfinished. He stated that the intention is to have a definition of “lawsuit”, since this blank does ask for lawsuit information. It was determined that it would be best to allow the Working Group to finish its work on the definitions first and to proceed with adoption of this blank, as the data elements for lawsuits will not change regardless of the definition. The drafting group believes the Other Health STLD Insurance MCAS blank is ready for adoption.

Mr. Birnbaum stated the data element of 2-20 is for the number of policies/certificates cancelled during the free-look period, and he asked why the SME group felt this was an important data element. Mr. Helder stated that he did not recall the exact discussion, but he believes it was kept in the blank, as it was not something they wanted to exclude from the data collection.

Ms. Nickel stated that when the SME group was initially meeting, the idea was that this blank would encompass other health products, but then the focus changed to just STLD insurance. She suggested just calling this blank the STLD Insurance MCAS blank, and when work begins for the other health products, calling that the Other Health MCAS blank.

Ms. Nickel made motion, seconded by Mr. Oberholtzer, to adopt the draft as the STLD Insurance MCAS blank. Ms. Crittenden advised that in line 1-07 there is an extra “to” that needs to be deleted, in line 1-09 a period needs to be added after the parentheses, and there is a typo in line 2-26 that should be 2-28. Ms. Rebholz confirmed that those corrections would be made. Ms. Amann asked if there is a comment period after today if the blank is adopted. Mr. Helder stated that comments can be made between June 1 and Aug. 1, prior to the Market Regulation and Consumer Affairs (D) Committee reviewing this. The motion passed unanimously.

4. Considered the Digital Claims Edits to the Homeowners and PPA MCAS Lines of Business

Ms. Rebholz stated that Digital Claims edits to the Homeowners and Private Passenger Auto (PPA) lines of business need to be considered. She stated that two interrogatories related to Digital Claims were added for each line of business. For PPA, claims-related data elements for the Collision, Comprehensive/Other Than Collision, Property Damage and Uninsured Motorists and Underinsured Motorists (UMPD) coverages are broken out to identify Digital Claims, Digital/Traditional Hybrid Claims, and Traditional/Other than Digital Claims. For Homeowners reporting, the Digital claims breakouts apply to the Dwelling and Personal Property coverages. Definitions were also added for Digital Claim Settlement, Digital/Traditional Hybrid claim settlement, and Traditional/Other than Digital claim settlement.

Ms. Kroll stated that Ms. LeDuc had to step away, but she had some questions on this agenda item. The first question was why a list of vendors was being asked for in the interrogatories section. Ms. Nickel stated that digital claims are sometimes processed through drone companies; and at times, carriers just use a vendor to inspect vehicles or homes and make an analysis, so this question would provide more information on who the carrier is using to process their claims. Ms. Rebholz stated that there was some conversation in the SME group that there could be a possible correlation to specific vendors listed and high complaint numbers, which could be an indicator for state insurance regulators to take a closer look at the data. The next question asked was regarding the other breakout section and which lines are to be broken out; 2-26 through 2-46 for PPA and 2-23 through 2-39 for Homeowners. Mr. Birnbaum stated that the breakout applies to the claims-related data elements and only applies to those coverages that provide property damage benefits, so it does not apply to liability coverages. The additional questions on this agenda item will be discussed on the May 27 Working Group call.

Ms. Cross asked if the comments that are due by Aug. 1 for any proposals adopted will be reviewed by the Working Group or directly by the Market Regulation and Consumer Affairs (D) Committee. Ms. Rebholz confirmed that the comments would be reviewed by the Committee after adoption by the Working Group.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met April 28, 2021. The following Working Group members participated: Rebecca Rebholz, Chair (WI); Tate Flott, Vice Chair (KS); Crystal Phelps (AR); Cheryl Hawley (AZ); Scott Woods (FL); Sarah Crittenden (GA); October Nickel (ID); Erica Weyhenmeyer (IL); Dawna Kokosinski (MD); Jill Huisken (MI); Teresa Kroll (MO); Martin Swanson (NE); Leatrice Geckler (NM); Hermoliva Abejar (NV); Guy Self (OH); Katie Dzurec (PA); Rachel Moore (SC); Maggie Dell (SD); Shelli Isiminger (TN); Shelley Wiseman (UT); Ned Gaines (WA); and Letha Tate (WV).

1. **Adopted its March 23 Minutes**

The Working Group met March 23 and took the following action: 1) adopted its Feb. 24 minutes; 2) heard an update on the Travel Market Conduct Annual Statement (MCAS); 3) heard an update on the Other Health MCAS; 4) heard an update on the Accelerated Underwriting and Digital Claims MCAS; 5) discussed the placement of complaint and lawsuit data elements within the Home and Auto MCAS reporting blanks; 6) discussed the MCAS lawsuit definitions; and 7) adopted a motion to add a note in the Disability Income blank clarifying that Schedule 3 is designed to only collect claims information about claims that have payment.

Mr. Flott made a motion, seconded by Ms. Kroll to adopt the Working Group’s March 23 minutes (see NAIC Proceedings – Spring 2021, Market Regulation and Consumer Affairs (D) Committee, Attachment Four). The motion passed unanimously.

2. **Heard an Update on the Travel MCAS**

Ms. Rebholz noted that the Travel MCAS subject matter expert (SME) group met March 29, April 19, and April 27. She stated that the most recent draft of the data call and definitions has been sent to the SME group for a final review, with any comments to be provided by the end of this week. Depending on comments received, the draft will be approved to pass along to the Working Group, or additional discussion will take place if needed to finalize the draft.

3. **Heard an Update on the Other Health MCAS**

Ms. Dzurec stated that the Other Health SME group is meeting regularly, and it is close to having a draft for the Working Group to review. Currently, definitions are being finalized to ensure that they support the questions and interrogatories, then ratios will be reviewed. Ms. Dzurec stated that one of the ongoing discussions related to short-term limited-duration (STLD) is the relationship between insurers and associations. The SME group is trying to ensure that the data that will be requested is data the companies will have, since associations are their own incorporated entities. Currently, the group is on iteration 5.6, which is posted on the Working Group’s web page in the “Current MCAS Blanks Discussions” if anyone wishes to review it. Ms. Dzurec stated that unlike the Health MCAS blank, cost sharing will not be in the Other Health blank.

4. **Heard an Update on the Accelerated Underwriting and Digital Claims Discussions**

Ms. Rebholz stated that the Accelerated Underwriting SME group met April 2, April 15, and April 20. Concerns with the definition of Accelerated Underwriting have been voiced by industry, and the SME group has had difficulty moving forward with the definition. Ms. Rebholz stated that to ensure coordination amongst committees and working groups, she met yesterday with the chair of the Market Regulation and Consumer Affairs (D) Committee and the chair of the Life Insurance and Annuities (A) Committee’s Accelerated Underwriting (A) Working Group. They discussed the Working Group’s need for a definition of Accelerated Underwriting for MCAS reporting purposes and also noted the June 1 deadline. Additional communication with the Accelerated Underwriting (A) Working Group will take place, and Ms. Rebholz hopes to have a definition available to review in time for the Market Conduct Annual Statement Blanks (D) Working Group to approve by the June 1 deadline.

Ms. Rebholz stated that the Digital Claims SME group met April 1, April 15, and April 21. Final drafts of the Home and Auto data call and definitions with the addition of the Digital Claims data element and definitions have been distributed to the SME group. Ms. Rebholz stated that some input was received, so the SME group is working to finalize the drafts and provide them to the Working Group for its approval in May.

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5. Discussed the Placement of Complaint and Lawsuit Data Elements within the Home and Auto MCAS Reporting Blanks

Ms. Rebholz noted that attachment two in the meeting materials outlines the information for this agenda item. She stated that during its March meeting, the Working Group discussed the reporting of complaints within the Home and Auto MCAS submissions. Currently, complaints are reported within the Underwriting section of the blank, and they are reported in total only. No Working Group members have voiced interest in changing the complaint reporting for Home and Auto to report at the coverage level. Ms. Rebholz stated that the question for the Working Group is whether state insurance regulators need complaint data by coverage type to perform market analysis or are total complaint counts sufficient for analysis purposes. She stated that the options are: 1) no change, which means total Home and Auto complaint counts are sufficient for market analysis, and the complaints will continue to be reported in total within the Underwriting section of the blank; or 2) ask that Home and Auto complaints be reported by coverage, which means state insurance regulators need coverage level complaint data to perform market analysis. If option two is chosen, then the Home and Auto complaints data element will need to be moved to another section of the blank. Ms. Rebholz asked for input from Working Group members, other state insurance regulators, and interested parties, and there was no discussion. Teresa Cooper (NAIC) stated that if there was no discussion or motion on this topic, it is assumed that no change is needed. Ms. Rebholz confirmed that would be appropriate, and no change was made.

Ms. Rebholz stated that the next matter to discuss is lawsuit reporting for Home and Auto. Attachment two in the meeting materials outlined this discussion topic. Ms. Rebholz stated that the question to the Working Group is whether state insurance regulators need lawsuit counts that include non-claims-related lawsuits to perform market analysis for the Home and Auto lines of business or is it sufficient to collect only lawsuit counts that are claims-related. She outlined the options as: 1) no change, which means only claims-related lawsuit counts are needed for market analysis purposes, and Home and Auto lawsuits will continue to be reported by coverage type within the Claims section of the blank and capture lawsuit data for claims-related suits only; or 2) include non-claims-related suits, which means lawsuit counts would include non-claims-related lawsuits for market analysis purposes. She stated that option two aligns with reporting used in other MCAS lines.

Mr. Gaines made a motion, seconded by Ms. Crittenden, to include non-claims-related lawsuit data in the Home and Auto MCAS blanks reporting. The motion passed unanimously.

6. Discussed the MCAS Lawsuit Definitions

Ms. Rebholz stated that there are comments in attachment three of the meeting materials for the Working Group to discuss. Each bullet under the lawsuit definition for the lines of business of Life and Annuity, Disability Income, Private Flood, Lender-Placed Home and Auto, and Long-Term Care (LTC) was reviewed. The issue raised for the first bullet was whether producers should be excluded, or clarification be added for the term “agent” and whether the term “agent” refers to a conservator or power of attorney. Ms. Rebholz stated that concern was raised that some companies may not track lawsuits against agents, so asking for that kind of reporting may not be helpful. Ms. Crittenden asked if the term “representative” would be a better term instead of “agent.” Mr. Gaines stated that “representative” may be a better term. Mr. Birnbaum stated that he has concern with using the term “representative” since it is an undefined term and changing “agent” to “producer” might be better since “producer” is the broader term. He stated that if a lawsuit was filed against a company’s employee, then it would be a lawsuit against the company also, so capturing that information is covered. Ms. Rebholz noted that there were comments received suggesting that another option would be to keep the definition and just add clarification to the terms in the definition. She stated that a decision on this will be considered at a later date.

Ms. Rebholz stated that the next item to review is whether the second bullet should be removed, because comments were received stating that it becomes unclear when it is combined with the first bullet. A decision on this will be reviewed at a later date, as there was no discussion suggesting the need for a change here. Ms. Rebholz stated that the third bullet question to consider is whether there should be separate reporting for arbitrations. A decision on this will be reviewed at a later date, as there was no discussion suggesting the need for a change here. Ms. Rebholz clarified that absent feedback on these bullet points, the wording will stay the same. She encouraged anyone that feels changes need to be made to share their thoughts verbally, in the chat or even after the call, if preferred.

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The next bullet discussed was regarding the use of the term “complainant.” The question is whether the intent was for this to refer to plaintiffs in a lawsuit rather than complainants. Mr. Gaines stated that he believes “plaintiff” would be clearer than “complainant.” Ms. Kroll stated that she agrees that “plaintiff” is clearer than “complainant” regarding lawsuits. The last bullet discussed was regarding whether clarification needed to be added for what a general cause of action is. Mr. Bates stated that he has concerns with this bullet because having to basically restate a claim in an explanatory note regarding class action lawsuits could be problematic. Ms. Rebholz stated that this is the current definition, and she was not aware of any concerns or issues companies were having in listing a general cause of action; but she noted her interest in hearing from industry representatives if there have been issues with earlier reporting in providing this information. She stated that a decision does not need to be made right now, and comments will be included for future discussion as to whether state insurance regulators find this information useful.

Ms. Cooper stated that she reviewed previous call minutes, and the comment raised on the issue regarding the first bullet was that it states, “include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant.” The second bullet states, “include all lawsuits whether or not a hearing a proceeding before the court occurred.” The comment stated that these bullets together seem unclear. Ms. Weyhenmeyer suggested removing “or its agent” from the first bullet and then making bullet two a sub-bullet to the first as a clarification. Mr. Birnbaum suggested removing the second bullet and leaving the first bullet as it currently reads. Mr. Bates stated that when a producer that acts on behalf of a company is sued, the company is also named in the lawsuit. He also stated that the lawsuit could be a human resources (HR) action against the producer and have nothing to do with the company, or it could be that the producer did not explain the policy terms as well as were needed, and the company may or may not be included on lawsuits like that. Ms. Nickel stated that she believes it is important to focus on what the company is involved in rather than the agent, since that could encompass a broad range of different relationships. Mr. Birnbaum stated that he believes the HR example is misplaced since an applicant for insurance, policyholder or beneficiary is unlikely to bring an action against an HR policy of an agent. He stated that if a lawsuit is brought against an agent, the company is going to know since it would have to be reported to the company. Michael Byrne (McDermott Will & Emery LLP) stated that he does not believe that was always the case under every contract of an agent to report all lawsuits against the agent if it has nothing to do with the product being sold on behalf of the insurer. Ms. Rebholz stated that after hearing the comments on this topic, some proposed draft language options will be created to review and consider on a future call. She asked that Working Group members think about what data they would like to capture here and whether or not capturing lawsuits naming agents as a defendant is necessary in the context of this reporting.

Ms. Rebholz stated that the next topic to discuss is the Lender-Placed Home and Auto MCAS lawsuit definition and reporting. The question is whether the Lender-Placed insurance should use the same reporting approved in the last agenda for Home and Auto. The issue with Lender-Placed insurance is that the approved definition aligns with the Life, Annuity, Disability Income, Private Flood and LTC definition instead of aligning with the Home and Auto definition. Ms. Rebholz stated that this does not need to be decided on today, and she asked that this question be given some thought so a decision can be made in May.

7. **Discussed Other Matters**

Ms. Rebholz stated that in May, the Working Group will have two meetings to allow for ample time to consider all proposals before the June 1 deadline. She stated that drafts will be posted and/or distributed for review prior to the May meetings.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
Privacy Protections (D) Working Group
Virtual Meeting
July 12, 2021

The Privacy Protections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met July 12, 2021. The following Working Group members participated: Cynthia Amann, Chair (MO); Ron Kreiter, Vice Chair (KY); Erica Weyhenmeyer (IL); LeAnn Crow (KS); Chris Aufenthie (ND); Teresa Green (OK); Raven Collins (OR); and Don Beatty and Katie Johnson (VA). Also participating was: Hermoliva Abejar (NV).

1. ** Adopted its June 14 Minutes **

The Working Group met July 12 and took the following action: 1) adopted its June 14 minutes; 2) discussed the draft of the initial privacy policy statement; and 3) requested comments in the form of parameters and examples on the initial privacy policy statement by June 7 for discussion during the next Working Group meeting scheduled for June 14.

Mr. Beatty made a motion, seconded by Ms. Collins, to adopt the Working Group’s June 14 minutes (Attachment Six-A). The motion passed unanimously.

2. ** Discussed Comments Received on the Initial Privacy Policy Statement **

Ms. Amann said the Working Group will continue to discuss its latest draft of the privacy policy statement with separate outline sections for each of the six consumer categories on the minimum consumer data privacy protections that are appropriate for the business of insurance was distributed prior to this meeting.

In accordance with its November 2019 work plan, Ms. Amann said the Working Group is currently focused on consumer data privacy protections other than those already in the *NAIC Insurance Information and Privacy Protection Model Act* (#670), the *Privacy of Consumer Financial and Health Information Regulation* (#672), and the *Insurance Data Security Model Law* (#668). She said following a delay due the COVID-19 pandemic, the Working Group identified six consumer data privacy protections as gaps per the analysis in this work plan, posted them, and discussed them during its meetings in November 2020, as well as in March, May, and June 2021. Ms. Amann said sections in the NAIC models concerning federal acts like the federal Gramm-Leach-Bliley Act (GLBA) and the federal Health Insurance Portability and Accountability Act (HIPAA) will be considered, if necessary, after the six consumer categories identified by the gap analysis and NAIC leadership have been addressed.

As a reminder, she said the six consumer categories identifying corresponding consumer rights that attach to notice requirements and how insurers may be subject to these requirements are: 1) the right to opt-out of data sharing; 2) the right to opt-in of data sharing; 3) the right to correct information; 4) the right to delete information; 5) the right of data portability; and 6) the right to restrict the use of data.

Ms. Amann said that while the titles of these categories are listed as rights, they are not to be interpreted as guarantees. She said the Working Group will not focus on changing the titles of the six consumer protection categories as they were given to the Working Group by NAIC members. However, it will provide recommendations and examples for additional clarification. For example, the right to delete data would not include the deletion of factual data such as that contained in court documents.

Ms. Amann said the Working Group will discuss today comments received since its June 14 meeting. She said the Working Group will not focus on changing the titles of the six consumer protection categories as they were given to the Working Group by NAIC members. However, it will provide recommendations and examples for additional clarification. For example, the right to delete data would not include the deletion of factual data such as that contained in court documents.

Ms. Amann said the Working Group will discuss today comments received since its June 14 meeting. She said the Working Group will not focus on changing the titles of the six consumer protection categories as they were given to the Working Group by NAIC members. However, it will provide recommendations and examples for additional clarification. For example, the right to delete data would not include the deletion of factual data such as that contained in court documents.
3. **Heard a Presentation on Consumer Data Privacy from the University of Texas at Austin and the University of Georgia**

Ms. Amann said the Working Group will hear a presentation from NAIC consumer representatives Karrol Kitt (University of Texas at Austin) Brenda J. Cude (University of Georgia) on data privacy from a consumer’s perspective.

Ms. Kitt said her comments stem from a micro perspective that state insurance regulators and the insurance industry have primary responsibility for the privacy of insurance consumers’ data. She said consumers typically underestimate the range and extent of data being collected on them. She also said that studies have shown the average consumer has 27 online accounts and that there is a relentless pursuit of consumers through social media advertising. Ms. Kitt said there is no easy way for consumers to track the use of their data and that consumers simply do not understand. She said what consumers need is an easy way to track and control their own data. Ms. Kitt said a DataGrail Inc. study indicated that four out of five consumers surveyed expect to have control over their data and that two out of three expect to be able to opt out of data sharing. She asked how much money the average company makes from selling third-party information. Ms. Kitt said she prefers to opt in like HIPAA requires as she is comfortable with where and how her medical data is used or shared. She also said something this important should be easy to use, especially with the demands of regular life. Ms. Kitt said consumers tend to have knowledge deficiencies and they lack motivation because there is an informational imbalance between industry and consumers. She said industry lives on the daily consumption of data and uses its own jargon to earn profit, but this is not the case for consumers who feel they are at a disadvantage, so they simply do not bother to learn or investigate the accuracy or use of their data. Ms. Kitt said in 2020, DataGrail’s survey found that 80% of consumers want to control their own data; that 82% reported concerns over protections that do not work; and that 62% said unsubscribe links do not work. She also said that consumers have a right to be forgotten after their relationship with an insurance company ends.

Ms. Cude said there are common themes (not just for insurance, in the U.S., or globally) of data. She said: 1) consumers do not distinguish insurance data from other business data; 2) consumers want rights, but they do not have the technical expertise to use them effectively; 3) getting consumers’ attention is difficult, as is getting them to learn and understand privacy issues; 4) greater transparency is needed in the language they do get; and 5) consumers have no opportunity to understand if privacy terms are written in legalese. Ms. Cude said consumers need to understand what personal data is and how it is used in all the devices in our homes, via the Internet of Things (IoT) data, shopping habits, vacuums, thermostats, TVs, etc. She said consumers need to know who is monitoring their data, what type of algorithmic capability those monitoring data have, and that consumers can suffer discrimination and harm.

Ms. Amann asked if they had any recommendations for the Working Group. Ms. Cude said the Working Group needs to be aware that the common consumer does not separate insurance data from any other type of financial business data. Ms. Kitt said one example is that a consumer cannot be charged for a credit card not being accepted for a purchase as Congress made such charges opt in only. Ms. Amann asked if it made any difference whether opt in or opt out should be used when the subject was data sharing versus data receiving of information. Dr. Kitt said opt in reduces costs for notices and opt out costs more. She also said the USAA has an easy privacy notice: It does not share data, period.

With that, Ms. Amann said the next Working Group meeting is scheduled for Aug. 9.

Having no further business, the Privacy Protections (D) Working Group adjourned.
The Privacy Protections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met June 14, 2021. The following Working Group members participated: Cynthia Amann, Chair (MO); Ron Kreiter, Vice Chair (KY); Erica Weyhenmeyer (IL); LeAnn Crow (KS); T.J. Patton (MN); Chris Aufenthie (ND); Martin Swanson (NE); Teresa Green (OK); Gary Jones (PA); and Don Beatty and Katie Johnson (VA). Also participating was: Hermoliva Abejar (NV).

1. Adopted its May 10 Minutes

The Working Group met May 10 and took the following action: 1) adopted its March 29 minutes; 2) discussed the draft of the initial privacy policy statement; and 3) requested comments in the form of parameters and examples on the initial privacy policy statement by June 7 for discussion during the next Working Group meeting scheduled for June 14.

Mr. Beatty made a motion, seconded by Mr. Swanson, to adopt the Working Group’s May 10 minutes (Attachment Six-A1). The motion passed unanimously.

2. Discussed Comments Received on the Initial Privacy Policy Statement

Ms. Amann said the Working Group would continue to discuss the privacy policy statement on the minimum consumer data privacy protections that are appropriate for the business of insurance. She said the Working Group would focus on consumer data privacy protections other than those already in the NAIC Insurance Information and Privacy Protection Model Act (#670), the Privacy of Consumer Financial and Health Information Regulation (#672), and the Insurance Data Security Model Law (#668). She also said sections in these NAIC models concerning federal acts like the Gramm-Leach-Bliley Act (GLBA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will be considered, if necessary, after the six consumer categories identified by the gap analysis and NAIC leadership have been addressed.

Ms. Amann said the six consumer categories identifying corresponding consumer rights that attach to notice requirements and how insurers may be subject to these requirements are:

1. The right to opt out of data sharing.
2. The right to opt into data sharing.
3. The right to correct information.
4. The right to delete information.
5. The right of data portability.
6. The right to restrict the use of data.

Ms. Amann said the titles of these categories are listed as rights, as that is the way these categories were received from NAIC members; however, these titles are not to be interpreted as guarantees but as points of discussion. She also said the Working Group will not change the titles of the six consumer protection categories; rather, the Working Group would provide recommendations and examples for additional clarification to these categories. For example, she said the right to delete data would not include the deletion of factual data, such as that contained in court documents. She said the Working Group would discuss comments received since the May 10 call, which is when the Working Group requested comments from Working Group members, interested state insurance regulators, and interested parties in the form of parameters and examples on the initial privacy policy statement.

Ms. Amann said comments in the form of parameters and examples on the initial privacy policy statement received by June 7 would be discussed following some brief comments by the attendees who submitted them. She said the templates that she made will be coming out soon with functional definitions that would be used not to highlight potential areas of concern, but to point to areas where the Working Group could make recommendations to fix, reinterpret, reword, explain, or clarify.

Bob Ridgeway (America’s Health Insurance Plans—AHIP) said to summarize the comments submitted, he suggested that the Working Group retain the HIPAA safe harbor contained in Model #672 because it is pervasive in that it has permeated the entire health insurance world since 2002. He said companies have worked diligently on complying, and it affects more than
just insurance. He said it also affects doctors, providers, companies, third-party administrators (TPAs), as well as those who do business with them. He said other business associates follow them regarding how to submit and process electronic claims. He said HIPAA and the GLBA exempts or carves out insurance. He also said California has this as well, with the California Consumer Privacy Act (CCPA) covering other companies. He said HIPAA already addresses all six rights in that for opt-out or opt-in, companies are prohibited from sharing data except for treatment or payment, health care operations, or special needs. He said the opt-in had to be signed indicating what data would be shared and how. He said HIPAA is already extensive as to how to correct data. Much like the General Data Protection Regulation (GDPR), he said the right to delete is not in HIPAA because a patient’s medical history is very important when considering the care a patient will need in the future. He said access to one’s data is not a concern, as patients can get a copy of their own medical records and take them elsewhere whenever they like. He said portability means the right to accounting for old data and where health information can be sent, such as to an attorney, requires a HIPAA release. He said a recent U.S. Department of Health and Human Services (HHS) rule about the disclosure of health information will serve to restrict the use of data under 45 CFR 164.522.

Ms. Amann said it was helpful to have HIPAA citations that address health care insurance, but the Working Group would also want to address concerns state insurance regulators are hearing from consumers regarding the six categories identified, and she recommended that the Market Regulation and Consumer Affairs (D) Committee address these concerns. When Ms. Abejar asked how record retention was affected by HIPAA, Mr. Ridgeway said typical record retention was 3–5 years, but claim processing was required to be kept for a very long time. Chris Petersen (Arbor Strategies LLC) added that the coordination of benefits and proving continuity of coverage also required records to be kept indefinitely in some instances. Ms. Amann said state insurance regulators need data to be retained as well for market conduct exams, so the Working Group would need to include explanations for consumers as to why some of their data could not be deleted, removed, or created as well as how its use could be limited by the consumer. Ms. Abejar asked about cyber insurance and was given the same answer. She asked if health insurers notify consumers that the requested change has been made. Mr. Ridgeway and Mr. Petersen said the company would have to show the consumer where the change they requested had been made in the consumer’s records. Mr. Swanson asked that the cybersecurity question be revisited. He said the state’s Attorney General’s office may have to be notified, and other state laws may kick in for the consumers’ protection. As an example, he said he recently got a letter about a breach from a company that he had not dealt with in many years, so the system worked as it was intended. Mr. Ridgeway asked how consumers know companies are doing this as required by state bulletins. He suggested that such bulletins be cross referenced with the Information Technology (IT) Examination (E) Working Group, including the changes made to the Financial Condition Examiners Handbook to ensure that companies do it. Ms. Amann said consumer rights come with limitations.

Randi Chapman (Blue Cross Blue Shield Association—BCBSA) said HIPAA clearly exempts health insurance, which can be confusing; and she recommended a clarification that if health insurance companies are not exempt by HIPAA, wording should be added to NAIC models so they conform with HIPAA. She said the Working Group should not add more requirements to HIPAA.

Mr. Petersen, speaking on behalf of the Coalition of Health Insurers, said he concurs with everything Mr. Ridgeway and Ms. Chapman said. He said HIPAA was specific to the insurance industry and its uniqueness to the health insurance industry. He said HIPAA was concerned about doing harm to consumers by adding to the safe harbor already in the GLBA. He said it is necessary to recognize HIPAA as a leader and allow deletion only to correct inaccurate data, not to delete all data, as medical history is needed (especially in the emergency room) and required by record retention laws. He said portability had been addressed in California and the European Union (EU) because it is needed to move one’s data from one internet to another one so it is required there, but it is not required generally in the U.S. He said one can share a copy with state insurance regulators and law enforcement, but one cannot move the data permanently. Ms. Amann said consumer disclosure notices are not just about what information but how it is distributed or shared. She said maybe notices should only be required when a change is made. She said the Insurance Holding Company System Regulatory Act (#440) and the IT Examination (E) Working Group addressed the issue of third-party vendors by referring to them as Essential Services Providers. She said Insurtech is where she expects problems and where she has concerns because of third-party vendors or business associates, which have HIPAA responsibilities as well and are required by HIPAA to comply via their contractual relationships. She said there are anecdotal problems where the law needs more umph. Mr. Petersen said that is not realistic because people give away their information at the pharmacy and at Safeway all the time just for discounts. Ms. Amann said state insurance regulators can warn consumers, but they cannot stop consumers from making their own decisions about such trade-offs of data for discounts. She said this conversation affects all other lines of business trades, not just health insurance.

Mr. Swanson asked if most states had adopted HIPAA. Mr. Ridgeway said most states had a HIPAA carve-out or something like that already. Mr. Petersen said states had adopted Model #670, which amends access to HIPAA; Model #672, which
provides a safe harbor for health information; or some combination of the two models. Mr. Swanson asked if the Market Regulation Handbook had been examined for HIPAA compliance already. Mr. Petersen said after the GLBA was added, it asserted market conduct over privacy and examined 100 companies. Ms. Amann said underwriting and claims are useful because if states see something during the examination, they can do a privacy review at the same time. She said new situations require an understanding of how current requirements can be applied; i.e., how it can be better for consumers. Mr. Swanson said homeowners insurance is different than health insurance. He said if states do not enforce HIPAA, then the federal government will. Ms. Amann said she does not want to give the American Council of Life Insurers (ACLI) a heart attack, but she wants to put them on notice that the Working Group is moving forward with its current framework, and it will include suggested definitions and requirements or revisions where it is deemed necessary. She said the Working Group would love to have input from other trades and companies representing other lines of business, but it will move forward without it if necessary. She said NAIC staff would distribute the privacy policy statement (not a model and not a white paper) for comment. Mr. Beatty said he saw Sonja Larkin-Thorne (Consumer Advocate – Retired) on the participants lists, and he said any observations she might have for the Working Group would be useful. He said the Working Group had not heard from the Life and Annuity or Property/Casualty (P/C) folks, and he encouraged them to provide input in the form of comments, examples, etc. to avoid unintended consequences with what the Working Group comes up with on their own. Ms. Larkin-Thorne said she had been following this work personally and for the state of Connecticut. Ms. Amann said it would be great to have more input from consumer representatives and on other lines of business. She also asked Lois E. Alexander (NAIC) to reach out to them. Shelby Schoensee (ACLI) said she was just assigned by the ACLI to work with this Working Group recently. She also said she planned to submit comments soon. Ms. Amann said the Working Group would be moving quickly, as it truly wants to help consumers understand their privacy issues sooner rather than later.

Ms. Amann said the next Working Group call is scheduled for July 12.

Having no further business, the Privacy Protections (D) Working Group adjourned.
Privacy Protections (D) Working Group
Virtual Meeting
May 10, 2021

The Privacy Protections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met May 10, 2021. The following Working Group members participated: Cynthia Amann, Chair, (MO); Ron Kreiter, Vice Chair (KY); LeAnn Crow (KS); T.J. Patton (MN); Chris Aufenthie and Johnny Palsgraaf (ND); Martin Swanson (NE); Teresa Green (OK); Gary Jones (PA); and Don Beatty and Katie Johnson (VA).

1. **Approved its March 29 Minutes**

   The Working Group met March 29 and took the following action: 1) adopts its 2020 Fall National Meeting minutes; 2) receive status reports on federal and state privacy legislation; 3) review the 2021 NAIC Member-Adopted Strategy for Consumer Data Privacy Protections; 4) discuss comments received on the 2020 Fall National Meeting verbal gap analysis; and 5) announce the Consumer Privacy Protections Panel at the NAIC Virtual Insurance Summit.

   Mr. Beatty made a motion, seconded by Mr. Swanson, to adopt the Working Group’s March 29 minutes (see NAIC Proceedings – Spring 2021, Market Regulation and Consumer Affairs (D) Committee, Attachment Six). The motion passed unanimously.

2. **Discussed the Draft of the Initial Privacy Policy Statement**

   Ms. Amann said the Working Group completed its work plan in 2020. She said the Working Group received additional guidance through the Market Regulation and Consumer Affairs (D) Committee in the form of the following NAIC Member-Adopted Strategy for Consumer Data Privacy Protections. She said the Working Group is currently working on item C because item A and item B have already been completed.

   **NAIC Member-Adopted Strategy for Consumer Data Privacy Protections**

   1. Charge the Market Regulation and Consumer Affairs (D) Committee with:
      a. Summarizing consumer data privacy protections found in existing NAIC models—the Health Information Privacy Model Act (#55), the NAIC Insurance Information and Privacy Protection Model Act (#670), and the Privacy of Consumer Financial and Health Information Regulation (#672).
      b. Identifying notice requirements of states, the European Union’s (EU’s) General Data Protection Regulation (GDPR) and the California Consumer Privacy Act (CCPA), and how insurers may be subject to these requirements.
      c. Identifying corresponding consumer rights that attach to notice requirements, such as the right to opt-out of data sharing, the right to correct or delete information, the right of data portability and the right to restrict the use of data, and how insurers may be subject to these requirements.
      d. Setting forth a policy statement on the minimum consumer data privacy protections that are appropriate for the business of insurance.
      e. Delivering a report on items (a–d) above by the NAIC Fall National Meeting.

   2. Engage with state attorneys general (AGs), Congress and federal regulatory agencies on state and federal data privacy laws to minimize preemption provisions and maximize state insurance regulatory authority.

   3. Reappoint the Privacy Protections (D) Working Group to revise NAIC models, as necessary, to incorporate minimum consumer data privacy protections that are appropriate for the business of insurance. Complete by the NAIC Fall National Meeting.

   Ms. Amann said Minnesota, Nevada, Oregon, and Virginia submitted comments on the initial privacy policy statement drafted in accordance with item D as a framework on which to build minimum consumer data privacy protections that are appropriate for the business of insurance. She said states on the state insurance regulator subject matter expert (SME) group agreed that all six categories identified in the statement should stay. Ms. Johnson said Virginia might be including portability in its Uniform Electronic Transactions Act (UETA), as Virginia said a consumer had to opt-in, meaning that companies could post a disclosure online, but the company must mail the disclosure to the consumer if the consumer asks for a hard copy of the document. Mr. Beatty asked Brooke Stringer (NAIC) if the categories listed were sufficient to address federal issues, topics, and concerns. Ms. Stringer said preemption and private rights of action are two of the top federal issues, so she said the categories identified are within the realm of federal expectations. Mr. Patton asked how consumers could opt-in and opt-out, as these two categories seem to be opposites. Ms. Amann said the Working Group’s approach right now would be to consider both and recommend...
one following its discussions. Mr. Patton said the chart should be updated, as Minnesota did address the bill listed even though the bill did not move.

Chris Petersen (Arbor Strategies LLC), speaking on behalf of the Coalition of Health Insurers, said general statements, such as those in the Unfair Trade Practices Act (#880), require companies only to maintain records. He said if the right to delete is allowed, it would be impossible for the company to maintain those records. He said the Health Insurance Portability and Accountability Act (HIPAA) only allowed the right to request, not to delete. He also said adding examples to recommendations would be helpful as guidance. Ms. Amann said the six categories will serve as the topics to be discussed at a high level, and examples would be a good idea. She said verbiage would be drafted as a point of discussion, as well as perhaps to specify that it is for the insurance sector only. Kate Kiernan (Public Policy Consulting) said in Minnesota, opt-in and opt-out are not mutually exclusive. She said the same law can have opt-in for more sensitive information and opt-out for less sensitive information.

Angela Gleason (American Property Casualty Insurance Associations—APCIA) suggested that the Working Group not discuss already regulated issues. Ms. Amann said this general discussion is for today’s call only. She said HIPAA is so controlling that the Working Group may not be able to change or revise it, the Gramm-Leach-Bliley Act (GLBA), etc., so these are to be put aside for now to be folded in later as consumers, industry, and state insurance regulators refine the draft. Bob Ridgeway (Americas Health Insurance Plans—AHIP) asked why Section A of the draft is separate from Section B. Ms. Amann said she envisions: 1) Section A to mean why the consumer has the right to correct with policy reasons in favor of it and why; 2) Section B to mean how an insured could do this, and as a practical matter that the consumer could not correct information fraudulently—i.e., change information that is proven to be true via public records (arrest records, court documents, etc.)—and the right to correct could only be within or after 180 days; and 3) Section C to mean how state insurance regulators would enforce this. Ms. Johnson said states that had adopted Model #670 had accelerated underwriting notice; it says the consumer can correct or delete incorrect information if the company has taken an adverse action, and it has a limitation on timing of the information. Ms. Amann said existing limitations would still apply. She said new recommended revisions would not cover all carte blanche, and the policy statement would help to explain these situations. Mr. Petersen said non-insurance information should not be looked at by the Working Group, but the Working Group should only look at the insurance industry. He said HIPAA’s right to request is not absolute. Ms. Johnson said it would be helpful to have information from industry on where the rails should be, and Virginia would only look at information companies gather. Ms. Kiernan asked if the privacy policy statement would be final by the Fall National Meeting. Ms. Amann said it would be final and would recommend if a new model is needed or if revisions would be needed, as well as the parameters for the new model or changes.

Ms. Amann requested comments in the form of parameters and examples on the initial privacy policy statement by June 7 for discussion during the next Working Group meeting scheduled for June 14.

Ms. Alexander said she would attempt to schedule Working Group meetings every four to six weeks, while avoiding overlap with other groups working on interrelated issues.

Having no further business, the Privacy Protections (D) Working Group adjourned.
The Antifraud (D) Task Force met July 26, 2021. The following Task Force members participated: Trinidad Navarro, Chair (DE); Judith L. French, Vice Chair, represented by Michelle Brugh Rafeld (OH); Lori K. Wing-Heier represented by Alex Romero (AK); Alan McClain represented by Crystal Phelps and Paul Keller (AR); Evan G. Daniels represented by Kyson Johnson (AZ); Ricardo Lara represented by George Mueller (CA); Michael Conway represented by Damion Hughes (CO); Andrew N. Mais represented by Kurt Swan (CT); Doug Ommen represented by Benjamin Olejnik (IA); Dean L. Cameron represented by Kyle Cammack (ID); Vicki Schmidt represented by Tate Flott (KS); Sharon P. Clark represented by Juan Garrett (KY); James J. Donelon represented by Matthew Stewart (LA); Anita G. Fox represented by Jill Huisken (MI); Grace Arnold represented by Michael Marben and Cam Jenkins (MN); Chlora Lindley-Myers represented by Carrie Couch and Jeana Thomas (MO); Troy Downing and David Dachs (MT); Mike Causey represented by Angela Hatchell, Della Shepherd and Tracy Biehn (NC); Jon Godfread represented by Laney Herauf (ND); Eric Dunning represented by Martin Swanson (NE); Chris Nicolopoulos represented by Brendan Harris (NH); Marlene Caride represented by Richard Besser (NJ); Glen Mulready represented by Rick Wagnon (OK); Andrew R Stolfi represented by Dorothy Bean (OR); Raymond G. Farmer represented by Chuck Myers and Michael Bailes (SC); Doug Slape represented by Chris Davis (TX); Jonathan T. Pike represented by Armand Glick (UT); Scott A. White represented by Mike Beavers (VA); and James A. Dodrill represented by Greg Elam (WV).

1. **Adopted its May 25 Minutes**

The Task Force met May 25 and took the following action: 1) adopted its March 24 minutes; and 2) appointed the Improper Marketing of Health Plans (D) Working Group.

Mr. Beavers made a motion, seconded by Ms. Biehn, to adopt the Task Force’s May 25 minutes (Attachment One). The motion passed unanimously.

2. **Discussed the Improper Marketing of Health Plans**

Commissioner Navarro said the Task Force has remained vigilant throughout this time with the COVID-19 pandemic. The communication and collaboration between states, antifraud organizations, and federal and state law enforcement agencies, as well as international counterparts, have continued to be a vital piece to fighting the insurance fraud taking place during this virtual environment.

Commissioner Navarro said the Task Force has continued to meet to specifically discuss and receive updates on potential insurance fraud taking place, whether it is due to COVID-19 or any other trend taking place. Commissioner Navarro said included with these meetings is the Improper Marketing of Health Plans group.

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Commissioner Navarro said during its May 25 meeting, a motion was presented to the Task Force for the creation of the Improper Marketing of Health Plans (D) Working Group, which would report to the Antifraud (D) Task Force. Commissioner Navarro said the motion passed unanimously and has been presented to the Market Regulation and Consumer Affairs (D) Committee. He said once it has passed through the Committee, it will be presented to Executive (EX) Committee and Plenary for consideration of adoption.

3. **Received an Update from the Antifraud Education Enhancement (D) Working Group**

Ms. Rafeld said the Working Group has held two webinars this year on: 1) outside resources for state insurance fraud departments; and 2) investigator safety training. Ms. Rafeld said as Working Group chair, she worked directly with NAIC staff regarding sessions for the NAIC Insurance Summit, which took place in June. Ms. Rafeld said the fraud sessions included: 1)

Ms. Rafeld said moving forward, the Working Group will continue to monitor emerging issues for new fraud schemes and provide the necessary training to assist with education on the various types of insurance fraud.

4. Received an Update from the Antifraud Technology (D) Working Group

Mr. Glick said the Working Group has not met formally this year. However, it is continuing to work on its new charge given to it in 2020: “Review and provide recommendations for the development of an Antifraud Plan repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions.” He said the Working Group’s first step was to review and revise the 2011 Antifraud Plan Guideline (#1690). Mr. Glick said the revisions were fully adopted by the Executive (EX) Committee and Plenary during the Spring National Meeting. He said the next step was for the Working Group to create a guideline template that can be used for the creation and submission of an Antifraud Fraud Plan. He said this template will also be used for developing the repository. Mr. Glick said the Working Group publicly reached out to form a subject-matter expert (SME) team that can work on creating this template. This small group will be meeting every other week through October to complete this task.

Mr. Glick said the NAIC is currently working on the Online Fraud Reporting System (OFRS) redesign. He said once this redesign is completed, the Working Group will resume its responsibilities concerning the review and management of enhancements for the OFRS.

5. Heard a Report from the Coalition

Matthew Smith (Coalition Against Insurance Fraud—Coalition) said the Coalition had 37 states participate in its COVID-19 Impact study. Mr. Smith said the result of study is on the Coalition’s web page at Insurancefraud.org. Mr. Smith said the Coalition is referring to this study as a trend study—not a research study. He said there was a lot of useful information taken from this study. Mr. Smith said some of the more interesting information was that the amount of fraud referral numbers from previous years remained consistent with this study even with the COVID-19 pandemic. He said this pandemic has contributed to the past year being the lowest usage of automobile on the roads. However, the automobile fraud referral has remained consistent. Mr. Smith said there was also a dramatic increase in arson, while workers’ compensation remained consistent. He said it is important to note that the study was a national trend study and not broken out by specific state.

Mr. Smith said the Coalition is working with several strategic partners to update a globalization of insurance fraud study. He said there are 45 nations that are contributing to this study. He said the study will close on Aug. 30, and on Nov. 15, the Coalition will hold a webinar updating its members of the findings. Mr. Smith said the Coalition will hold its annual end of the year meeting in person Dec. 6–7 in Washington, DC.

Mr. Smith said the Coalition has its infographics program on its web page, and he encouraged states to use the Coalition’s resources as they see fit. He said the Coalition is also working with strategic international partners on the Globalization of Insurance Fraud Conference. Mr. Smith said they plan to open up the conference to in person next year, and he encouraged states to participate.

6. Heard a Report from the NICB

Alan Haskins (National Insurance Crime Bureau—NICB) said the NICB just wrapped up its Contractor Fraud Awareness Week. Mr. Haskins said the NICB issued its third publication on tips to avoid natural disasters and contract fraud. He said the NICB has been monitoring any potential increases in trends and that it has seen a 9% increase in vehicle theft across the country.

Mr. Haskins said at this time, 90% of states have wrapped up their legislative session. He said the theft of catalytic converters has been high due to the price in metal found on the catalytic converters. Mr. Haskins said the NICB is working with states to monitor this activity and assist however needed. He said the NICB tracked more than 600 bills during the 2021 legislative sessions.
7. **Received an Update on the OFRS**

Mr. Welker said in 2018, the NAIC approved the redesign of the OFRS. He said the purpose of the redesign was to modernize interfaces for state insurance regulator, public and industry users. The redesign changes would support a new functionality for the system while also providing the means to create a series of reports that would provide states with detailed data that could be used for tracking fraud trends. Mr. Welker said there is an industry and consumer side to the OFRS. NAIC staff have focused on completing the industry side first. Once completed, it can be used to mirror the changes for the consumer. Mr. Welker said they are currently going through beta testing to help finalize this process. He said it is important for states and all other users to recognize that during the redesign process, the functionality of the OFRS has not been interrupted and that states are still receiving the fraud referral data. He said NAIC staff will continue to collaborate with the Working Group through the completion of the redesign.

Having no further business, the Antifraud (D) Task Force adjourned.
The Antifraud (D) Task Force met May 25, 2021. The following Task Force members participated: Trinidad Navarro, Chair (DE); Lori K. Wing-Heier represented by Alex Romero (AK); Alan McClain represented by Crystal Phelps, Pat O’Kelly, and Teri Ann Mecca (AR); Evan G. Daniels represented by Paul Hill (AZ); Michael Conway represented by Damion Hughes (CO); Andrew N. Mais represented by Kurt Swan (CT); Doug Ommen represented by Benjamin Olejnik (IA); Dean L. Cameron represented by Kyle Cammack (ID); Vicki Schmidt represented by Ryan Morton (KS); Sharon P. Clark represented by Juan Garrett (KY); James J. Donelon represented by Matthew Stewart (LA); Anita G. Fox represented Jill Huisken (MI); Grace Arnold represented by Michael Marben (MN); Chlora Lindley-Myers represented by Carrie Couch and Marjorie Thompson (MO); Troy Downing and Jeannie Keller (MT); Mike Causey represented by Tracy Biehn (NC); Jon Godfread represented by Dale Pittman (ND); Eric Dunning represented by Martin Swanson (NE); Chris Nicolopoulos represented by Brendan Harries (NH); Marlene Caride represented by Richard Besser (NJ); Glen Mulready represented by Rick Wagnon (OK); Andrew R Stolfi represented by Stephanie Noren (OR); Raymond G. Farmer represented by Chuck Myers and Michael Bailes (SC); Doug Slape represented by Chris Davis (TX); Jonathan T. Pike represented by Armand Glick (UT); Scott A. White represented by Mike Beavers (VA); and James A. Dodrill represented by Greg Elam (WV).

1. **Adopted its Spring National Meeting Minutes**

Mr. Beavers made a motion, seconded by Ms. Biehn, to adopt the Task Force’s March 24 minutes (see NAIC Proceedings – Spring 2021, Antifraud (D) Task Force). The motion passed unanimously.

2. **Adopted a Motion to Appoint the Improper Marketing of Health Plans (D) Working Group**

Commissioner Navarro said over the past several months, state insurance departments and officials from federal agencies have been meeting to discuss the improper marketing by various entities of health plans. He said this group was originally created to bring members of the Health Insurance and Managed Care (B) Committee and the Market Regulation and Consumer Affairs (D) Committee together in effort to share information regarding entities that were improperly marketing health insurance products Commissioner Navarro said these discussions included the use of lead generators, unsolicited phone calls, internet solicitation, and other marketing methods. He said due to the importance of these discussions, the state insurance regulators on these calls have also reached out to include members from federal government groups. Commissioner Navarro said the collaboration among this group has assisted with administrative action being taken against entities and schemes that have been identified.

Commissioner Navarro said in addition, these discussions and the actions taken have identified a need to look at and possibly update or create a new model to address the aggressive and improper marketing of health plans and the oversight of lead generators. He said all participating states have agreed.

Commissioner Navarro said that there was also a white paper on internet sales that would need to be updated in order to reflect the changes not only on how internet is used in today’s society, but also how some have used this to market plans improperly in ways that was not contemplated a few years ago.

Commissioner Navarro said the next step for the Task Force is to formalize this group as a new working group reporting to the Task Force. He said the Working Group will serve two purposes. He said the first would be to continue the facilitation and engage in discussions about the marketing of health plans that are improper, with the goal to have participation from state insurance regulators both at a state and federal level. Commissioner Navarro said the participation of interested state insurance regulators would not be limited to members of the Task Force but rather state insurance regulators from all areas of expertise, including health, market conduct, fraud, and legal divisions. Commissioner Navarro said the working group would meet only in regulator-to-regulator session.

Commissioner Navarro said the second purpose would be for the Working Group to look at either modifying existing models or creating a new model that addresses the usage of lead generators for sales of insurance products and to update marketing rules to modernize the regulation of those activities.
Commissioner Navarro said the Task Force was provided an email with the draft charges for the Working Group soliciting comments. There are two charges that were submitted: 1) coordinate with regulators, both on a state and federal level, to provide assistance and guidance monitoring the improper marketing of health plans, and coordinate appropriate enforcement actions, as needed, with other NAIC committees, task forces, and working and working groups; and 2) review existing NAIC models and guidelines that addresses the usage of lead generators for sales of health insurance products, and identify models and guidelines that need to be updated or developed to address current marketplace activities. Commissioner Navarro said no comments or suggestions were received prior to today’s meeting.

Ms. Biehn made a motion, seconded by Mr. Swanson, to appoint the Improper Marketing of Health Plans (D) Working Group, which would report to the Antifraud (D) Task Force. The motion passed unanimously.

Commissioner Navarro said the next step will be to present this motion to the Market Regulation and Consumer Affairs (D) Committee. He said once adopted by the Committee, it would then be presented to the Executive (EX) Committee and Plenary for consideration of adoption. Commissioner Navarro said once the Working Group is official, it will reach out to state insurance departments in order to establish the members.

Having no further business, the Antifraud (D) Task Force adjourned.
The Market Information Systems (D) Task Force met July 28, 2021. The following Task Force members participated: Mike Kreidler, Chair (WA); Chlora Lindley-Myers, Vice Chair (MO); Evan G. Daniels represented by Cheryl Hawley (AZ); Ricardo Lara represented by Pam O’Connell (CA); Michael Conway represented by Damion Hughes (CO); Andrew N. Mais represented by Kurt Swan (CT); Trinidad Navarro represented by Frank Pyle (DE); Dana Popish Severinghaus represented by Erica Weyhenmeyer (IL); Vicki Schmidt represented by Tate Flott (KS); Grace Arnold represented by Paul Hanson (MN); Troy Downing represented by Troy Smith (MT); Marlene Caride represented by Ralph Boeckman (NJ); Russell Toal (NM); Barbara D. Richardson (NV); Judith L. French represented by Rick Campbell (OH); Doug Slape represented by Leah Gillum (TX); James A. Dodrill represented by Jeannie Tincher (WV); and Mark Afable represented by Rebecca Rebholz (WI). Also participating was: Brent Kabler (MO).

1. **Adopted its Spring National Meeting Minutes**

   Director Lindley-Myers made a motion, seconded by Ms. O’Connell, to adopt the Task Force’s March 22 minutes (see NAIC Proceedings – Spring 2021, Market Information Systems (D) Task Force). The motion passed unanimously.


   Mr. Kabler said the Working Group met July 21, July 15, and June 16. During these meetings, the Working Group reviewed the progress of the implementation of the Market Information Systems (MIS) metric report recommendations for metric updates and methods to improve metric result reporting and data quality.

   Mr. Kabler said the Working Group heard presentations from NAIC staff and the Center for Economic Justice (CEJ) regarding the use of artificial intelligence (AI) in market analysis. He said NAIC staff retained a consultant to develop both AI, as well as more traditional statistical techniques, to construct predictive models of insolvency risk. He said NAIC staff believe the methods show promise and could significantly advance financial risk surveillance. Among AI and statistical models explored were decision tree analysis, generalized linear models (GLMs), and logistic regression. Birny Birnbaum (CEJ) encouraged the Working Group to adopt a long-term perspective and develop a multiyear plan to explore AI techniques that might be beneficial to market analysis. Mr. Birnbaum also indicated state insurance regulators have failed to acquire granular transactional data that could be leveraged by AI methods to provide a much more robust surveillance system to reduce consumer harm.

   Mr. Kabler said the Working Group reviewed comments received on the proposed changes to the Regulatory Information Retrieval System (RIRS) coding structure.

   Mr. Kabler said the Working Group reviewed outstanding Uniform System Enhancement Requests (USER) and approved a request to add the complaint subject code to i-Site+ and the Consumer Insurance Search (CIS). The RIRS coding change and restructure has been the most ambitious project of the Market Information Systems Research and Development (D) Working Group. He said he has been working on it even before the Working Group was formed.

   Superintendent Toal made a motion, seconded by Director Lindley-Myers, to adopt the Market Information Systems Research and Development (D) Working Group report. The motion passed unanimously.

3. **Adopted the RIRS Coding Change Proposal**

   Commissioner Kreidler said the Market Information Systems Research and Development (D) Working Group adopted the RIRS proposal prior to the Spring National Meeting and reported on its adoption to the Task Force during the Spring National Meeting. He said that at that time, the Task Force agreed to expose the proposal on the Task Force web page, receive comments, and consider its adoption during the Summer National Meeting.

   Commissioner Kreidler said the Working Group reviewed the proposal with representatives of the Financial Analysis Solvency Tools (E) Working Group and the state producer licensing directors and their feedback were incorporated into the proposal. He said the proposal was also reviewed with the state back-office system vendors, who made a recommendation to create a user’s
guide for the new codes, and the vendors do not anticipate any additional cost to implement the necessary system changes to support the proposal.

Commissioner Kreidler said comments were received from the California Department of Insurance (DOI) and the CEJ. Mr. Birnbaum said he supports the proposed changes to RIRS coding. He said his comments were focused on prioritization of origin of action codes and disposition codes. He said multiple codes are allowed on RIRS entries and it would be useful to prioritize them when inputting to show the relative importance. Mr. Kabler said that was a good suggestion but noted that analysts will generally use their own subjective prioritization when reviewing an action with multiple codes.

Superintendent Toal made a motion, seconded by Commissioner Richardson, to adopt the RIRS coding change proposal. The motion passed unanimously.

4. Heard a Report on Outstanding USER Forms

Chris Witt (NAIC) said USER Form 10082 is the request to add a Complaints Database System (CDS) subject code for “pandemic” and a coverage code for “business interruption.” He said while completing this request, it was discovered that subject codes are not displayed. He said the USER Form 10082 is complete, and the Working Group approved a new USER Form 10083.1 to display the subject codes in i-Site+ and CIS.

Mr. Witt explained the first page of the USER Form Status Update identifies other market regulation projects that are outside the USER form process. These are projects arising from State Ahead initiatives or that are needed to maintain and update existing systems such as the Market Conduct Annual Statement (MCAS) submission tool. This information is included to assist the Task Force and the Working Group in their prioritization.

Having no further business, the Market Information Systems (D) Task Force adjourned.
The Producer Licensing (D) Task Force met Aug. 4, 2021. The following Task Force members participated: Elizabeth Kelleher Dwyer, Co-Chair (RI); Larry D. Deiter, Co-Chair (SD); Ricardo Lara represented by Charlene Ferguson and Tyler McKinney (CA); Michael Conway represented by Steven Giampaolo (CO); Trinidad Navarro represented by Ashley Webb (DE); David Altmaier represented by Matt Guy and Matt Tamplin (FL); Doug Ommen represented by Jackie Russo and Andria Seip (IA); Sharon P. Clark (KY); James J. Donelon represented by Barry Ward (LA); Mike Causey represented by Angela Hatchell (NC); Eric Dunning represented by Kevin Schlautman and Martin Swanson (NE); Chris Nicolopoulos represented by Joan Lacourse (NH); Judith L. French represented by Tynesia Dorsey (OH); Andrew R. Stolfi represented by Kirsten Anderson (OR); Jessica K. Altman represented Christopher Monahan (PA); Doug Slape represented by Chris Herrick (TX); Scott A. White represented by Richard Tozer (VA); Mike Kreidler represented by Jeff Baughman (WA); Mark Afable represented by Rebecca Rebholz and Melody Esquivel (WI); and James A. Dodrill represented by Greg Elam and Robert Grishaber (WV).

1. **Adopted its March 26 Minutes**

Commissioner Clark made a motion, seconded by Ms. Ferguson, to adopt the Task Force’s March 26 minutes (see NAIC Proceedings – Spring 2021, Producer Licensing (D) Task Force). The motion passed unanimously.

2. **Heard an Update on the State Implementation of Online Examinations**

Director Deiter said 40 jurisdictions offer online examinations. He said South Dakota implemented online examinations in April, and 28% of the exams since April have been administered online. He said the pass rate for online examinations is a little higher than in-person examinations. Mr. Tozer said Virginia implemented online examinations in June 2020, and approximately 40% of its examinations are administered online. Ms. Ferguson said California administers 35–40% of its examinations in the online format and has not seen any difference in pass rates from in-person examinations. She said the online format has provided candidates with greater access to examinations with online examinations being available seven days a week and 24 hours a day. Mr. Baughman said Washington began offering online examinations in October 2019 and has not seen any difference in pass rates from in-person examinations. He said 80% of Washington’s exams are administered online. Superintendent Dwyer said Rhode Island has had a similar experience, and she questioned if any states have had security issues.

Joel Norris (Pearson VUE) said the security of online examinations is very important, and while a camera and microphone can pick up what can be seen and heard in view of the camera, there are instances where a candidate leaves the view of the camera. He said there are also instances where a candidate does not follow the proctor’s instructions, and there is the possibility that an applicant has another person present outside the view of the camera. He said the physical management of the remote exam environment is very important, and the proctor can revoke the administration of an exam if the candidate leaves the view of the camera and does not follow the proctor’s instructions. He said proctors have escalated issues, and Pearson VUE has both an incident level response and a broader review of how to curtail certain behavior for all online exams. He said incidents are reported to the client, and the client can then share the information with other states. He said Pearson VUE supports transparency, but it also has contract obligations with clients.

In response to Commissioner Clark’s question about what percentage of candidates have their online exam revoked, Mr. Norris said Pearson VUE keeps track of specific incidents and reports, and exams may also be revoked due to technology issues. Commissioner Clark said she would like to know what percentage of all online exams are revoked because of security concerns.

3. **Discussed a Referral from the Special (EX) Committee on Race and Insurance**

Superintendent Dwyer said she anticipates the Special (EX) Committee on Race and Insurance to refer the following change to the Producer Licensing (D) Task Force: “The Producer Licensing (D) Task Force will receive a report on the availability of producer licensing exams in foreign languages, the steps exam vendors have taken to mitigate cultural bias, and the number and location of producers by company compared to demographics in the area.”

Superintendent Dwyer said the Task Force has solicited examination vendors on the processes they follow to eliminate bias in examinations. She said the Task Force does not plan to circulate information about specific vendors. She said information is being sought from continuing education (CE) providers. She said there would be more detail shared at the next Task Force
meeting. Mr. Tozer said Virginia reviews examinations for bias on an annual basis and works with their examination vendor to identify questions that should be revised.


Superintendent Dwyer suggested that the Task Force review the guidelines to create a more user-friendly resource for states to create greater consistency in how states review 1033 waiver requests. She said the Task Force should also be reviewing how criminal convictions affect producer licensing applicants, and she referenced a new pilot program implemented by the Pennsylvania Department of Insurance (DOI) for prospective insurance agents with criminal records.

Mr. Monahan said the Pennsylvania DOI allows a person with a criminal conviction to voluntarily provide criminal record information through an electronic portal. The Pennsylvania licensing and legal teams review the information and provide non-binding feedback on how the criminal activity might affect his/her ability to obtain a producer license. This helps the person determine if he/she should spend time and effort with pre-licensing education. Mr. Monahan said Pennsylvania had 10–20 people use this service in the first two weeks. He said the service is free, and nobody, to date, has had a conviction that would have prohibited the issuance of a license. Superintendent Dwyer said Rhode Island has had a similar program for 10 years, and she said the program in Pennsylvania is very nicely done.

David Leifer (American Council of Life Insurers—ACLI) said the ACLI is supportive of the NAIC looking at how criminal background checks and the 1033 waiver process affects applicants for producer licenses. He said the ACLI also supports the implementation of online examinations, and this has benefited applicants in geographic areas where there is not easy access to examinations centers. He said the ACLI supports licensing standards that ensure qualified producers, but he believes it is important to look at licensing practices that create unnecessary barriers to individuals seeking a producer license.

Mr. Tozer said Virginia has a 1033 waiver process and is working with other states that contract with Sircon to develop best practices for the review of 1033 requests. He said Virginia does not require a separate application for a 1033 waiver if the disclosure of the criminal information is part of the normal, electronic application process. He said the NAIC Uniform Producer Licensing Applications have a question relevant to 1033 waivers, and Virginia can review court records without requiring the resident applicant to submit additional information to Virginia. If needed, he said Virginia may look at a non-resident candidate if there is a 1033 waiver concern and the resident state did not issue a waiver. Superintendent Dwyer encouraged Mr. Tozer to provide additional information on the recommendations from the states that contract with Sircon.

5. **Discussed Procedures for Amending Uniform Applications**

Director Deiter said the draft procedures are being developed to ensure that the consideration of changes to the uniform applications support the NAIC members’ goal of providing stable applications and encourage the use of electronic technology for licensing. The Task Force is seeking comments on the procedures through Sept. 3.

6. **Received Reports from the Producer Licensing Uniformity (D) Working Group and the Uniform Education (D) Working Group**

Superintendent Dwyer said the chair position for the Producer Licensing Uniformity (D) Working Group remains open, and the leadership for both working groups continues to be in a state of flux. She said Director Deiter and she are working to transition to new leadership for the working groups.

Having no further business, the Producer Licensing (D) Task Force adjourned.
FINANCIAL CONDITION (E) COMMITTEE

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Financial Condition (E) Committee
Columbus, Ohio
August 14, 2021

The Financial Condition (E) Committee met Aug. 14, 2021. The following Committee members participated: Scott A. White, Chair (VA); Michael Conway, Vice Chair, (CO); Dana Popish Severinghaus (IL); Amy L. Beard represented by Roy Eft (IN); Eric A. Cioppa (ME); Chlora Lindley-Myers represented by John Rehagen (MO); Mike Chaney (MS); Russell Toal (NM); Linda A. Lacewell represented by Sud Sumit (NY); Judith L. French, Dale Bruggeman, and Tom Botsko (OH); Raymond G. Farmer (SC); Doug Slape and Jamie Walker (TX); Mark Afable (WI); and Jeff Rude (WY).

1. **Adopted its July 8 and Spring National Meeting Minutes**

Commissioner White said the Committee met July 8 and took the following action: 1) adopted changes to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) that are intended to make explicit, rather than implicit, the regulatory authority that a commissioner should have relative to the continuation of essential services of an insurance company from an affiliate during a receivership; and 2) updated the life risk-based capital (RBC) bond factors effective for the 2021 reporting period.

Director Farmer made a motion, seconded by Commissioner Rude, to adopt the Committee’s July 8 (Attachment One), and April 13 (see NAIC Proceedings – Spring 2021, Financial Condition (E) Committee) minutes. The motion passed unanimously.

2. **Adopted the Reports of its Task Forces and Working Groups**

Commissioner White stated that the Committee usually takes one motion to adopt the Committee’s task force and working group reports that are considered technical, noncontroversial, and not significant by NAIC standards—i.e., they do not include model laws, model regulations, model guidelines, or items considered to be controversial. He reminded members of the Committee that subsequent to the Committee adoption of its votes, all the technical items included within the reports adopted will be sent to the NAIC members for review shortly after the conclusion of the Summer National Meeting as part of the E-Committee Technical Changes Report. Pursuant to the Technical Changes Report process previously adopted by the NAIC Plenary, the members will have 10 days to comment, otherwise the technical changes will be considered adopted by the NAIC and effective immediately. With respect to the task force and working group reports, Commissioner White asked the Committee: 1) whether there were any items that should be discussed further before being considered for adoption and sent to the members for consideration as part of the E-Committee Technical Changes Report; and 2) whether there were other issues not up for adoption that are currently being considered by task forces or workings groups reporting to this Committee that require further discussion. The response to both questions was no.

In addition to presenting the reports for possible adoption, Commissioner White also noted that the Financial Analysis (E) Working Group met July 14, June 16, May 18–19, and April 19 in regulator-to-regulator sessions, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss letter responses and financial results. Additionally, the Valuation Analysis (E) Working Group met July 26 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss valuation items related to specific companies

Commissioner Slape made a motion, seconded by Director French, to adopt the following task force and working group reports: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Examination Oversight (E) Task Force; Financial Stability (E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Risk Retention Group (E) Task Force; Valuation of Securities (E) Task Force; Group Capital Calculation (E) Working Group (Attachment Two); Group Solvency Issues (E) Working Group (Attachment Three); Mortgage Guaranty Insurance (E) Working Group (Attachment Four and Five); Mutual Recognition of Jurisdictions (E) Working Group (Attachment Six); NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group (Attachment Seven); and National Treatment and Coordination (E) Working Group (Attachment Eight).
3. **Adopted a Referral to the Statutory Accounting Principles (E) Working Group**

Commissioner White directed the Committee to a draft memorandum, which he explained was drafted by NAIC staff at his direction, as a means to start a conversation about modifying some of the terminology within the statutory accounting maintenance process. He noted that during the course of discussing *Statement of Statutory Accounting Principles (SSAP) No. 71—Policy Acquisition Costs and Commissions*, there was confusion about the term “non-substantive.” He suggested that while everyone was aware that the SSAP No. 71 issue was debated extensively at the Statutory Accounting Principles (E) Working Group, and therefore a deliberative discussion equivalent of what occurs for a new accounting pronouncement took place, the term “non-substantive” was still confusing. He asked members of the Committee to consider where they agreed with the concept of referring the issues to the Statutory Accounting Principles (E) Working Group so that it could further develop the final language. No objections or questions were raised.

Superintendent Cioppa made a motion, seconded by Commissioner Conway, to refer the memorandum to the Statutory Accounting Principles (E) Working Group (Attachment Nine). The motion passed unanimously.

4. **Adopted Revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions**

Mr. Rehagen described that the *Process for Evaluating Qualified and Reciprocal Jurisdictions* (process document) was first adopted by the NAIC in 2013, and its purpose was to provide a documented evaluation process for creating and maintaining the NAIC List of Qualified Jurisdictions. She noted that the process document was updated to incorporate the 2019 revisions to the *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786) addressing reciprocal jurisdictions, and to make some revisions to the requirements for the re-evaluation of qualified jurisdictions. He emphasized how it was considered important to amend the process quickly in order to complete the reciprocal jurisdiction reviews for Bermuda, Japan, and Switzerland by the end of 2019. However, it was necessary to further improve the document in order to incorporate provisions for terminating the status of a qualified or reciprocal jurisdiction, and for creating a passporting process for reciprocal jurisdictions. A new draft was exposed for a 30-day public comment period on March 23, and four comment letters were received from interested parties.

Mr. Rehagen noted that the newly repurposed Mutual Recognition of Jurisdictions (E) Working Group met on May 27 and incorporated the suggested revisions from the comment letters. In addition, NAIC staff met with the Federal Insurance Office (FIO) on July 23 and incorporated some of the FIO’s suggestions, which added some clarifications to the process document. The Reinsurance (E) Task Force then adopted the revised process document on July 27.

Mr. Rehagen made a motion, seconded by Director Farmer, to adopt the revisions to the *Process for Evaluating Qualified and Reciprocal Jurisdictions* (Attachment Ten) and refer it to Plenary after this meeting for consideration of adoption. The motion passed unanimously.

5. **Adopted Revised Charges for the Renamed Macroprudential (E) Working Group**

Commissioner White described how the Financial Stability (E) Task Force was just now beginning its work on its macroprudential surveillance system, and with that there is a need to modify the charges to focus the Liquidity Stress Test Working Group on the elements of such a system, and at the same time, change the name to reflect that fact.

Mr. Rehagen made a made a motion, seconded by Mr. Eft, to adopt the revised charge for the renamed Macroprudential (E) Working Group (Attachment Eleven). The motion passed unanimously.

Having no further business, the Financial Condition (E) Committee adjourned.
The Financial Condition (E) Committee met July 8, 2021. The following Committee members participated: Scott A. White, Chair (VA); Michael Conway, Vice Chair, (CO); Dana Popish Severinghaus and Eric Moser (IL); Eric A. Cioppa (ME); Chlora Lindley-Myers represented by John Rehagen (MO); Mike Chaney represented by Mark Cooley (MS); Marlene Caride (NJ); Russell Toal represented by Leatrice Geckler (NM); Linda A. Lacewell represented by My Chi To (NY); Judith L. French and Tom Botisko (OH); Raymond G. Farmer represented by Mike O'Shual (SC); Doug Slape represented by Jamie Walker and James Kennedy (TX); and Jeff Rude (WY). Also participating were Philip Barlow (DC); and Mark Afable (WI).

1. **Adopted Changes Model #440 and Model #450**

Mr. Kennedy described how in 2020, the Receivership Law (E) Working Group of the Receivership and Insolvency (E) Task Force was given the charge to provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities. This includes nonregulated entities and specifically for agreements with affiliated entities whose sole business purpose is to provide services to the insurance company. This charge came out of prior recommendations from the Receivership and Insolvency (E) Task Force as part of the Macroprudential Initiative (MPI) that identified continuation of essential services as an area where regulatory powers are implicit rather than explicit. He said the experiences of state insurance regulators have shown that receivers continue to be challenged by this issue as current remedies may not immediately address the need to continue services in receivership. He described how the NAIC adopted a Request for NAIC Model Law Development in 2020 to open the Insurance Holding Company System Regulatory Act (Model #440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (Model #450) for this purpose and how the Working Group began meeting in 2020. He described how they first conducted a survey to identify recommendations for how to address this issue, including amendments to the models. The draft amendments to both models were exposed for public comment twice with subsequent revisions made to address comments. The amendments to Model #440 were exposed a third time following a final round of edits and in all discussions that was active participation by state insurance regulators and interested parties.

Mr. Kennedy described the specific changes to Model #440, which are within Section 5, Standards and Management of an Insurer Within an Insurance Holding Company System, and within Model #450 as found in Section 19, Transactions Subject to Prior Notice. They are specific to the provisions of affiliated cost sharing and management services agreements. He explained that includes requirements that the books and records of the insurer be updated to specifically include data of the insurer, being the property of the insurer. The data and records should be identifiable and capable of segregation—essentially, available to the receiver in the event of insolvency, including the systems necessary to access them. The data is specifically defined in Model #450. If the insurance commissioner deems the insurer to be in a statutorily defined hazardous financial condition, he or she may require a bond or deposit, limited in amount, after consideration of whether there are concerns about the affiliated party’s ability to fulfill the contract in the event of a liquidation. The premiums are the property of the insurer, with any right of offset subject to receivership law. The affiliated entity is subject to jurisdiction of receivership court, and in certain circumstances, the insurance commissioner may require the affiliate to agree to this in writing. The models include provisions relating to indemnification of the insurer in the event of gross negligence or willful misconduct by the affiliate. Finally, in the event of receivership, including supervision and conservatorship, the rights of the insurer extend to the receiver or guaranty fund. Also, the affiliate will make available essential personnel. The affiliate will continue the services for a minimum period of time as specified in the agreement with timely payment for post-receivership work. Finally, the affiliate will maintain necessary systems, programs or infrastructure and make them available to the receiver or insurance commissioner for as long as the affiliate receives timely post-receivership payment unless released by the receiver, insurance commissioner, or receivership court.

Mr. Kennedy noted that the Working Group and the Task Force adopted the amendments on May 4 and May 20, respectively.

Mr. Kennedy made a motion, seconded by Commissioner Conway, to adopt the changes to Model #440 and Model #450 as presented to the Committee. The motion passed unanimously.
2. **Adopted the Life RBC Bond Factors (2021-1L)**

Mr. Botsko described how the proposed changes to the life risk-based capital (RBC) bond factors have had a difficult road to get to this point. He noted that after years of discussion, state insurance regulators believed they have reached an acceptable set of factors that will be effective for the 2021 reporting period. He described how state insurance regulators had learned many things from this process, including to have a more inclusive discussion about what assumptions to consider in the model for the analysis. He described how the American Academy of Actuaries (Academy) and Moody’s each prepared a set of life RBC bond factors from their individual models. While each set of factors provided a similar impact to the total RBC for the companies, there were some slight differences. He said that as is the case with many models, some are informative, but most are wrong. However, in this case, state insurance regulators believed the results of each model provided a better reflection of the risks associated with bonds for RBC purposes. He described how the adopted factors by both the Life Risk-Based Capital (E) Working Group and Capital Adequacy (E) Task Force represent years of discussion and work by state insurance regulators, the Academy, and industry. He stated that state insurance regulators agree that these factors are a better reflection of bond risk for the robust set of bond categories.

Mr. Botsko repeated that state insurance regulators learned many important things from this process. One item in particular is to spend more time determining the specifics of the analysis, as well as discussing the assumptions with industry before beginning the modeling procedure (or analysis) for projects. While regulators have shared potential projects in the past, state insurance regulators learned that for projects of this nature, they need to have better discussions with all involved parties, particularly in the early stages. He stated that while the various parties involved may not agree on everything, they need to reach a consensus and move forward. He stated that as the RBC working groups continue with their current and future projects, they will provide transparent processes and analysis to all parties involved. While these groups believe they have done this in the past, they will make a better effort to achieve this. Mr. Barlow described the degree of work involved but the good product that resulted. He noted they had two viable alternatives, and while they went with the proposal submitted by Moody’s, there was overlap in the methods and the assumptions, although ultimately the one selected was based upon the assumptions and not methods.

Commissioner White provided a special thanks to Mr. Botsko; the chair of the Life Risk-Based Capital (E) Working Group, Mr. Barlow; all the members of that Working Group; members of the Academy; and members of the industry who helped to complete this project. He stated that while the project has taken some time, he appreciates the effort from the people involved.

Commissioner Caride made a motion, seconded by Commissioner Rude, to adopt the proposed changes to the life RBC bond factors as presented to the Committee. The motion passed unanimously.

Having no further business, the Financial Condition (E) Committee adjourned.
The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee met July 26, 2021. The following Working Group members participated: John Rehagen, Chair (MO); Kathy Belfi, Vice Chair (CT); Susan Bernard (CA); Philip Barlow (DC); Ray Spudeck and Virginia Christy (FL); Carrie Mears (IA); Susan Berry (IL); Roy Eft (IN); Christopher Joyce (MA); Judy Weaver and Steve Mayhew (MI); Barbara Carey (MN); Jessica Price (NC); Justin Schrader (NE); David Wolf (NJ); Bob Kasinow (NY); Dale Bruggeman (OH); Greg Lathrop (OR); Kimberly Rankin (PA); Hui Wattanaskolpant (TN); Amy Garcia (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI). Also participating was: Tom Botsko (OH).

1. **Adopted its May 27, May 17, April 27, and March 10 Minutes**

During its May 27, May 17, April 27, and March 10 meetings, the Working Group took the following action: 1) adopted a revised template for use in the 2021 group capital calculation (GCC) trial implementation, including changes to gather data on a stress scenario; 2) adopted clarifying edits to the GCC instructions that will be used for the 2021 GCC trial implementation; and 3) exposed proposed changes to the *Financial Analysis Handbook* (Handbook) for the GCC.

Mr. Eft made a motion, seconded by Mr. Schrader, to adopt the Working Group’s May 27 (Attachment Two-A), May 17 (Attachment Two-B), April 27 (Attachment Two-C), and March 10 (see NAIC Proceedings – Spring 2021, Financial Condition (E) Committee, Attachment Two) minutes. The motion passed unanimously.

2. **Exposed Draft Maintenance Documents**

Mr. Rehagen suggested that the Working Group develop certain maintenance documents related to the GCC and directed participants to draft documents that could meet such needs. He described how these documents would allow the same kind of process as used by other groups, which is to allow anyone (state insurance regulator, industry, consumer, etc.) that wants to present proposed changes to the GCC to do so by first completing a form. He noted that the specific forms developed involved NAIC staff basically taking similar forms for risk-based capital (RBC) forms and updating them for what would be needed for the GCC.

Mr. Rehagen suggested that the main purpose of these forms is to establish some rules so that everyone understands the timeline for when changes need to be adopted by the Working Group to be effective that year. He noted that initially, the forms use the same dates as used for RBC, which means that any change to the template must be adopted by April 30, and all other changes need to be adopted by June 30.

The Working Group agreed to expose GCC maintenance documents for a 60-day public comment period ending Sept. 24.

3. **Exposed a Draft Referral to the Capital Adequacy (E) Task Force**

Mr. Rehagen directed participants to a draft referral to the Capital Adequacy (E) Task Force. He described that the main purpose of the referral is to make the RBC working groups aware of differences between the GCC and RBC and whether RBC working groups believe making changes to RBC for consistency would be appropriate.

Dan Daveline (NAIC) provided more details regarding differences between the GCC and RBC as documented in the draft memorandum. He described how in developing the GCC, most of the discussions were revolved around the treatment of non-insurance and non-financial related entities to achieve consistency between the GCC and RBC. Specifically, the desire by all parties is for the same GCC treatment, whether entities are owned by an insurer or by a sister company. Mr. Daveline noted that in the end, the GCC adopted a factor that mirrored the result within the RBC post-covariance factor. He stated that because of that, there were fewer differences between the GCC and RBC than what was originally envisioned, but he noted how NAIC staff still believe it is appropriate to present a list of such items to the extent that RBC working groups want to consider changes for consistency purposes. He described how there are three types of entities for consideration, but ultimately, the question is whether the RBC working groups want to modify their formulas to be more consistent with the GCC.
Mr. Daveline described that the first item on the list deals with how the GCC treats insurance companies, most of which are foreign insurance companies. The GCC brings in the minimum capital required by the regulator for a foreign insurance company. This is to show respect for the authority of that regulator, as state insurance regulators would like to receive a reciprocal response on the U.S. basis, but also because this is the most relevant measure of capital at risk. Mr. Daveline noted that the second item on the list is similar in terms of the GCC treatment, but it pertains to other regulated entities such as banks. The last item on the list shows how the GCC treats other financial entities such as asset managers, investment advisors, and other financial entities. In the GCC, a factor is applied to their average revenues, while in RBC, a different factor is applied to the book/adjusted carrying value (BACV) for these entities. Mr. Daveline pointed out that as has been argued in the past, the RBC approach of using BACV as the base instead of average revenue may make more sense since RBC pertains to directly owned subsidiaries where the BACV may be the most relevant measure.

Mariana Gomez-Vock (American Council of Life Insurers—ACLI) noted support for a memo that summarizes the differences between the GCC and RBC. However, the ACLI expressed concern regarding whether the RBC groups should modify the RBC formulas to be more consistent with the GCC when a trial implementation of the GCC has not yet been completed. Specifically, she noted that the GCC approach for investment advisors and asset managers is new and has never been tested before. Therefore, she suggested removing the last sentence in the second paragraph of the memo so that the adoption of the GCC approach would not be proposed for considerations by the RBC working groups. Mr. Daveline stated that it is not going to be problematic to have this sentence stricken if the Working Group agreed. Mr. Eft agreed with striking this sentence, and the Working Group is not opposed; therefore, it was stricken as requested.

Mr. Botsko, chair of the Capital Adequacy (E) Task Force, stated his appreciation for the groups responsible for the GCC and RBC sharing information on a regular basis. Acknowledging many parallels between the two, he considered it extremely important to be consistent with each other as much as possible. Except for those items with different approaches where appropriate, both groups should take into consideration those items that could be changed by either the GCC or RBC and determine whether their formulas are appropriate.

Lou Felice (NAIC) recommended identifying categories in RBC that are different from the GCC and having an actual structure of formulas ready for those areas that could be changed for consistency purposes.

The Working Group agreed to expose the draft referral document for a 90-day public comment period ending Oct. 25.

4. Discussed Other Matters

The trial implementation is approaching its deadline at the end of the week. NAIC staff can be reached for questions. The draft Handbook guidance is being exposed for comment. Once comments are received, there will likely be another call. NAIC staff may make additional edits based on comments, run them by the state insurance regulators or the drafting group, and re-expose them again.

Having no further business, the Group Capital Calculation (E) Working Group adjourned.
The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee met May 27, 2021. The following Working Group members participated: John Rehagen, Chair (MO); Kathy Belfi, Vice Chair (CT); Susan Bernard (CA); Ray Spudeck (FL); Carrie Mears (IA); Susan Berry (IL); John Turchi and Christopher Joyce (MA); Judy Weaver (MI); Barbara Carey (MN); Jackie Obusek (NC); Justin Schrader (NE); Dave Wolf (NJ); Bob Kasinow (NY); Dale Bruggeman and Tim Biler (OH); Kimberly Rankin (PA); Trey Hancock (TN); Jamie Walker (TX); David Smith (VA); and Levi Olson (WI).

1. Adopted a Stress Scenario in the GCC Trial Implementation Instructions and Template

Mr. Rehagen introduced the first agenda item by stating that the purpose of the meeting is to select a standardized percentage to be used for all groups as a stress scenario and adopt the stress scenario instructions and related template changes. He added that in addition to the standard approach, the group capital calculation (GCC) filer manually adds entity categories not adjusted in the standard approach if it is believed that would assist in analyzing the impact of a change in debt allowance on the GCC ratio. The manual entries are not required, but all companies will report at least one GCC result using the standard approach. Mr. Rehagen stated that both the standardized stress tabs and the narrative are intended to be part of the Trial only, and they will not be carried forward. However, there may be some role in the future in the analysis guidance that was recently exposed for reviewing how the group assesses stress scenarios. Mr. Rehagen added that the purpose of the standardized stress scenario is to evaluate its impact on the amount of senior and hybrid debt that can be included as additional capital. If no debt allowance is requested, then the GCC filer can state that such is the case in the separate narrative that is included in the Trial template.

Mr. Rehagen stated that a comment letter from America’s Health Insurance Plans (AHIP) was received and included in the materials (Attachment Two-A1) on the revised stress scenario instructions and separate narrative, along with several emails requesting clarifications. He stated that in response, revisions were made to pages 44, 47, 53 and 54 of the instructions (Attachment Two-A2). Tom Finnell (AHIP) suggested some further revisions to the instructions, and he questioned whether the standard stress scenario was connected to the separate narrative. Lou Felice (NAIC) explained the changes commented on and agreed that some revisions could be made. He also stated that the separate narrative is not necessarily related only to looking at debt. Mr. Finnell stated that the Own Risk and Solvency Assessment (ORSA) is a better way to assess capital adequacy than a simplistic narrative. Mr. Rehagen restated that the stress scenario and the narrative are only for the Trial, and other methods would continue via analysis going forward. Mr. Belfi stated that she would use the narrative to assess the impact on the debt allowance. Mr. Rehagen noted that the stress scenario and narrative are optional. Mr. Felice noted that if the filer supports a different level of stress than is selected for the standardized stress scenario, the lead-state can adjust the percentage in the template as part of its analysis to assess the impact on the debt allowance. He presented some additional language to address the comments by Mr. Finnell and Ms. Belfi. There were no objections or further comments on the new language.

Mr. Felice summarized the remaining revisions made prior to today’s meeting, noting that there are some optional entries that can be added by the filer to adjust the calculated capital for entity types not adjusted in the standardized stress scenario. These entries are optional but if utilized, must be made at the standardized stress percentage; i.e., 30%. Mr. Felice stated that the standardized stress scenario will otherwise be populated and summarized automatically regardless of whether there was a debt allowance included in the Trial template. Ned Tyrrell (NAIC) agreed that this method is preferable to having two different Trial templates. Mr. Felice presented revisions discussed earlier, and there were no comments on those revisions.

Mariana Gomez-Vock (American Council of Life Insurers—ACLI) expressed her organization’s support for a 30% standard stress level based on the impact of such a stress level on the potential movement from current industry risk-based capital (RBC) operating levels to an RBC action level. Kevin Mackay (MetLife) said MetLife supports the 30% standard stress level as a point where procyclicality would materially affect the debt allowance, noting that balance sheet valuation can be affected differently for different entities, such as foreign insurers. Mr. Rehagen asked if there are any objections to using 30% as the standardized stress level. There were no objections or further comments.

Mr. Rehagen asked if any revisions are required to the Trial template. Mr. Tyrrell stated that the now selected standardized stress scenario of 30% will be added to the Trial template.
Ms. Belfi made a motion, seconded by Mr. Spudeck, to adopt the GCC stress scenario instructions with today’s edits along with the template for the Trial Implementation. The motion passed unanimously.

2. **Discussed Next Steps Toward the Start of the 2021 GCC Trial Implementation**

Mr. Rehagen announced that a GCC Trial volunteer call will be held June 17, and a notice will go out soon about the steps to get to the start of the Trial. He stated that NAIC staff can now start taking questions and will provide a question and answer (Q&A) process. Mr. Felice stated that he will check on the status of the confidentiality agreements and work to get them out to the lead-states with volunteers participating in the Trial as soon as possible.

3. **Discussed Other Matters**

Mr. Rehagen and Ms. Belfi recognized the contributions to the GCC project by Mr. Felice, who will be retiring later this year. He also introduced Jane Ren (NAIC), who will be transitioning into her NAIC support staff roll for the Working Group.

Having no further business, the Group Capital Calculation (E) Working Group adjourned
May 25, 2021

Dan Daveline  
Director, Financial Analysis  
National Association of Insurance Commissioners  
By e-mail to: ddaveline@naic.org

Lou Felice  
Consultant to the National Association of Insurance Commissioners  
By e-mail to: lfelice@naic.org

**Re: Further Comments - Revisions to Instructions and Stress Testing Proposal for the 2021 GCC Trial Implementation**

Gentlemen:

America’s Health Insurance Plans (AHIP) is pleased to offer these further comments to the Group Capital Calculation (E) Working Group’s exposure of proposed revisions to the GCC Instructions and Template relating to stress scenarios. Following are a few overarching comments, then some detailed comments accompanying the highlighted excerpts from the GCC Instructions that are subject of the current exposure process. We would be pleased to discuss these comments with you and GCCWG members at your convenience.

**Overarching Comments:**

1. **Relation to ORSA:** While we appreciate the interest in what may be a “reasonably likely” stress scenario, our members believe that is a topic that would be better addressed in the ORSA than in the GCC. Our members currently provide ample information about stress testing and related analysis of capital adequacy in their ORSAs, which include numerous scenarios (not just one) and at levels which exceed what might be deemed “reasonably likely.” There is also much that currently exists in the ORSA that provides underlying context to evaluate stress scenarios. By contrast, the very brief instruction and requested input about a single stress scenario as proposed in the GCC lacks that context, and risks being at conflict with the ORSA. Our members support inclusion of a standardized stress/shock for the purpose of evaluating the appropriateness of the GCC in respect of the possibility of procyclical impact of stress on the debt allowance. However, they believe that
delving into what may be a “reasonably likely” stress would be better addressed through ORSAs than the GCC and its Instructions.

2. Required v. optional inputs: Recent discussion of the GCCWG sought to clarify what may be required or optional in respect of quantitative data elements as well as narrative text to be provided in the GCC template. However, our members find the verbiage in the exposed sections of text to remain unclear; please see detail comments that follow.

3. “Trial Implementation v. actual implementation of the GCC: It is our understanding that the initial stress test proposal which had as its specific purpose to evaluate the appropriateness of the GCC in respect of the debt allowance would be for the upcoming “Trial Implementation” only, i.e., that the stress test would not be included in the template that would be used for reporting to the Lead State once the GCC had been implemented by the state by law or regulation. Could you please confirm our understanding? And would that also be the case for the inputs sought by the current exposure, i.e., a narrative description of a reasonably likely stress for the group (and accompanying group-specific calculations, if applicable)? If not, AHIP and its members would have further concerns.

Detailed Comments:
In the sections that follow, we have excerpted from the exposed documents the relevant highlighted text that is open for exposure, together with AHIP’s comments thereon.

Page 44:
(Note: the highlighted language below would be added to a section of the Instructions that pertains to an “Input 6” tab with other narrative responses and questions. That tab now has a text box with the following instruction: “[Placeholder question on stress scenario] Please provide a high-level narrative of what level or reduction in available capital is reasonable for the Group, potential risk factors leading to the loss (e.g., interest rate changes, catastrophe, etc.) and how calculated capital may be impacted.)”

Stress Scenario Narrative – Provide a high-level description of the anticipated market conditions or other reasonably likely group specific drivers that would lead to the group’s own specified level of stress results (i.e., the group specific potential adjustments to available capital and calculated capital). These may or may not align with the standardized adjustments calculated in the Stress Summary tab. In addition, provide any comments relating to the potential for procyclical GCC ratio results in specific areas of the calculation.

AHIP Comments:
1. It was not clear from the call on May 17 as to how much of the group-specific inputs (as opposed to the standardized calc) and related narrative would be optional on the part of the participating group. Upon seeing the proposed text, the matter seems to
remain unclear. The template ("stress inputs" tab) makes it appear that any inputs to columns Y: AH are "optional." In contrast, the text above suggests a group-specific result is required because a narrative is required to describe it.

a. Does the word "optional" above columns Y: AH mean it does not need to be completed at all? However, if a trial implementation participant left all those cells blank would it imply to the lead state that one of the standardized tests is "appropriate" for its business model?

i. And, if the latter, would the narrative that is requested above ask to describe a specific scenario that could reasonably result in the outcome shown by that standardized calcs? Would any narrative be required if the company submits only the standard calc, thus implying it represents a reasonable stress for the group? Note: AHIP’s view is that neither an omission of input data nor of narrative text should imply anything about stress levels impacting a group; if the firm preparing the template is of the view that the standardized calc is reasonable, the instructions should ask for the preparer to so state in its response.

ii. If a company believes the standard calculation does not represent a reasonable stress, could they (1) explain that in the narrative and describe what may be a reasonable stress, and (2) omit entry in any of the cells in columns Y:AH, i.e., the alternative calculation would be optional, but the narrative is nonetheless required? Alternatively, is the company required to show custom changes in Y:AH to document a result that it believes to be reasonably likely?

iii. If changes were made in Y:AH such that the calculation differs to some degree from the standardized calc, then the narrative is intended to describe a corresponding scenario that could lead to that result instead?

2. The above paragraph is hard to fully grasp without a more complete understanding of the complete stress proposal which is included as an appendix that appears 6-7 pages later in the document. Sequentially, it would be better to completely explain the stress test earlier in the document, i.e., to move the appendix from pages 52-53 ahead of this paragraph. Then, the reader would have the overall context to better understand this more specific instruction dealing with the stress test inputs. At a minimum, the paragraph here should refer the reader to the appendix for a fuller description of the stress test.

3. Please see also the marked text correction in the highlighted text above.
Stress Inputs

93. All entries in columns D:W of this tab are either calculation cells using data from within
the tab or using data populated from elsewhere in the template in a standardized approach.
Available capital and calculated capital for all entities using the standardized stress level
of xx% will be reported in this tab. The calculated values will be summarized in the “Stress
Summary” tab.

94. The filer may use the available Company Input section in the tab (columns Y:AH) that
allows data entry in order to apply the standardized stress level to additional entity
categories not covered in the standardized approach (e.g., foreign insurers subject to scalars
in the sensitivity analysis). The inputted values will be summarized in the “Stress
Summary” tab.

95. A separate text narrative describing the group’s own assumptions on potential stress drivers
should be included in the Input 6 tab as specified in the instructions for the Input 6 tab.
NOTE: Also see Appendix 2 for more detail

Stress Summary

96. Summarized results by entity type will be reported in this tab.

AHIP Comments:

- See suggested changes in marked text above
- Para 94 seems to conflict with AHIP’s comments about Page 44 (included above).
  Whereas there seems to be the ability to make optional changes to any of the
  standardized results, para 53 says that data entry here would only “apply the
  standardized stress level to additional entity categories not covered in the
  standardized approach…” It does not ask for any other group-specific entries that
  could be inconsistent with the standardized approach.
- With regard to para 94 as to “entity categories not covered in the standardized
  approach”, the parenthetical starts with “e.g.” (for example). If that is the only such
  case, it should be “i.e.” Alternatively, if there are other cases of entity categories that
  are not covered in the standardized approach, they should be listed or, at a minimum,
  a reference should be made to the location in the document where it is clear what
  entities are and are not covered.
- Paragraph 95 – See AHIP’s overarching comments, above, in relation to ORSA.

Page 52:

Data for industrywide U.S RBC ratios is sourced from the aggregate RBC
Statistics maintained by the NAIC. Data for industrywide capital ratios for
foreign insurance jurisdictions was derived from publicly available aggregate
industry data where available. If this scalar methodology is retained, then the data will require periodic updating.

AHIP Comments:

- See suggestions in marked text.

Page 53:

(ATF note: there were a couple of insertions of the word “standardized” on page 52; the text from page 52 text is not included as those insertions appeared fine.

112. (continuation of para 112): Further adjustments to the calculated capital based on scalars used in the Sensitivity analysis and other selected adjustments to calculated capital can also be considered (see Company Input section in the “Stress Inputs” tab). Other potential user driven adjustments may be added to the template using the Optional Inputs section in the Stress Inputs tab. Desired inputs will automatically be brought into in the new Stress Summary tab

113. Outputs: The GCC template will be configured to automatically calculate outputs and resulting GCC ratios using the inputs above at various additional standardized levels of stress (e.g., 20%, 30% etc.) including the impact on the allowance for qualifying debt. This can be presented on an additive basis (e.g. start with reduction in available capital alone and then add the impact on each entity type’s calculated capital one at a time building to the full scenario outlined in the chart, above.

Additional Information:

114. Although the impact on adjusted carrying value in this scenario is standardized, such generic assumptions cannot be prescribed. Assumptions vary by industry and product mix as the underlying cause and the effect on the adjusted carrying value varies group to group. Therefore, each group submitting data should provide a high-level narrative in the space provided in the “Input 6” tab, describing the unique assumptions and corresponding stress levels (% adjustments) in available capital and calculated capital considered appropriate by the group. The assumptions provided in the narrative are NOT required to align with the standardized adjustments reported in the “Stress Inputs” tab.

AHIP Comments:

- Para 112: Does the second sentence shown (“Other potential user driven adjustments….”) relate to the first sentence and adjustments based on scalars only? Or is it a separate item altogether? If the latter, it would be better shown as a separate paragraph.
Para 114: This seems to mandate the company to effectively assert that a standard calc is “appropriate” or to define and show one that is. It remains unclear if anything is optional at all, which seems at odds with some of the statements made by working group members and NAIC staff on the May 17 call.

We hope that you find our comments as helpful and directed toward making the entire Group Capital Calculation project a better one. As always, we would be glad to address any questions you may have.

Sincerely,

Bob Ridgeway
Bridgeway@AHIP.org
501-333-2621

Cc: Tom Finnell
NAIC GROUP CAPITAL CALCULATION
INSTRUCTIONS
(REVISED May 27, 2021)
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I. Background

1. In 2015, the ComFrame Development and Analysis (G) Working Group held discussions regarding developing a group capital calculation (GCC) tool. The discussions revealed that developing a GCC was a natural extension of work state insurance regulators had already begun, in part driven by lessons learned from the 2008 financial crisis which include better understanding the risks to insurance groups and their policyholders. While insurance regulators currently have authorities to obtain information regarding the capital positions of non-insurance affiliates, they do not have a consistent analytical framework for evaluating such information. The GCC is designed to address this shortcoming and will serve as an additional financial metric that will assist regulators in identifying risks that may emanate from a holding company system.

2. More specifically, the GCC and related reporting provides more transparency to insurance regulators regarding the insurance group and make risks more identifiable and more easily quantified. In this regard, the tool assists regulators in holistically understanding the financial condition of non-insurance entities, how capital is distributed across an entire group, and whether and to what degree insurance companies may be supporting the operations of non-insurance entities, potentially adversely impacting the insurance company’s financial condition or policyholders. This calculation provides an additional analytical view to regulators so they can begin working with a group to resolve any concerns in a manner that will ensure that policyholders of the insurers in the group will be protected. The GCC is an additional reporting requirement but with important confidentiality protections built into the legal authority. State insurance regulators already have broad authority to take action when an insurer is financially distressed, and the GCC is designed to provide Lead State Regulators with further insights to allow them to reach informed conclusions on the financial condition of the group and the need for further information or discussion.

3. State insurance regulators currently perform group analysis on all U.S. insurance groups, including assessing the risks and financial position of the insurance holding company system based on currently available information; however, they do not have the benefit of a consolidated statutory accounting system and financial statements to assist them in these efforts. It was noted prior to development that a consistent method of calculating group capital for typical group risks would provide a useful tool for state financial regulators to utilize in their group assessment work. It was also noted that a GCC could serve as a baseline quantitative measure to be used by regulators in to compliment the view of group-specific risks and stresses provided by the Own Risk and Solvency Assessment (ORSA) Summary Report filings and in Form F filings that may not be captured in legal entity filings.

4. During the course of several open meetings and exposure periods, the ComFrame Development and Analysis (G) Working Group considered a discussion draft which included three high-level methodologies for the GCC: a risk-based capital (RBC) aggregation approach; a statutory accounting principles (SAP) consolidated approach; and a generally accepted accounting principles (GAAP) consolidated approach. On Sept. 11, 2015, Working Group members unanimously approved a motion to move forward with developing a recommendation for a GCC and directed an appropriate high-level methodology for the recommendation.
5. At a ComFrame Development and Analysis (G) Working Group meeting held Sept. 24, 2015, pros and cons for each methodology were discussed, and a consensus quickly developed in support of using an RBC aggregation approach if a GCC were to be developed. The Executive (EX) Committee and Plenary ultimately adopted the following charge for the Financial Condition (E) Committee:

“Construct a U.S. group capital calculation using an RBC aggregation methodology; liaise as necessary with the ComFrame Development and Analysis (G) Working Group on international capital developments and consider group capital developments by the Federal Reserve Board, both of which may help inform the construction of a U.S. group capital calculation.”

6. The RBC aggregation approach is intended build on existing legal entity capital requirements where they exist rather than developing replacement/additional standards. In selecting this approach, it was recognized as satisfying regulatory needs while at the same time having the advantages of being less burdensome and costly to regulators and industry and respecting other jurisdictions’ existing capital regimes. In order to capture the risks associated with the entire group, including the insurance holding company, RBC calculations would need to be developed in those instances where no RBC calculations currently exist.

7. In early 2016, the Financial Condition (E) Committee appointed the Group Capital Calculation (E) Working Group, which began to address its charge and various details of the items suggested by the ComFrame Development and Analysis (G) Working Group. The instructions included herein represent the data, factors, and approaches that the Working Group believed were appropriate for achieving such an objective. The GCC instructions and template are intended to be modified, improved, and maintained by the NAIC in the future as are the Accounting Practices and Procedures Manual, the Annual Statement Instructions and the Risk-Based Capital Formula and Instructions. This includes, but is not limited to, future disclosure of additional items developed or referred by other NAIC committees, task forces and/or working groups.

8. In December 2020, amendments to NAIC Model Law (#440) and Model Regulation (#450) were adopted to provide States with legislative language to fully implement the GCC as an annual filing. The Model specifies what groups are exempted from the GCC filing requirement and the circumstance under which a limited filing may be submitted. For such information reference should be made not to these instructions, rather to the models and, more specifically, to how they are implemented into laws and regulations of a Lead State.

II. Definitions

9. **Affiliate**: As used in Model #440, an “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. For purposes of the GCC, affiliates will NOT include those affiliates reported on Schedule A or Schedule BA, EXCEPT in cases where there are insurers or other financial entities reported as or owned indirectly through Schedule A or Schedule BA affiliates. All other Schedule A and Schedule BA investments will remain as investments of a Parent insurer will be reported as Parent of the value and capital calculation of the Parent insurer. A full list of Schedule A and BA entities will be reported as described in the instructions for Input 6 – Questions and Other Information. Any entities that would otherwise qualify as Schedule BA affiliates as described above but are
owned by other entities (e.g., foreign insurers or other type of Parent entity) should be treated in the same way.

10. **Broader Group**: The entire set of legal entities that are controlled by the Ultimate Controlling Person of insurers within a corporate group. When consider the use of this term, all entities included in the Broader Group should be included in Schedule 1 and the Inventory, but only those that are denoted as “included” in the Schedule 1 will be considered in the actual GCC.

11. **Control**: As used in the Model #440, the term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by Section 4K of Model #440 that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

12. **Cross-Support Mechanism**: A cross-support mechanism is an agreement or transaction that creates a financial interdependence. Depending on the nature of the transaction and the specific circumstances, these mechanisms may pose material risk. These may include corporate guarantees, capital maintenance agreements (regulatory or ratings based), letters of credit, intercompany indebtedness, bond repurchase agreements, securities lending or other agreements or transactions that create a financial interdependence or link between entities in the group.

13. **Entity Not Subject to A Regulatory Capital Requirement**: This is a financial entity other than an entity that is subject to a specified regulatory capital requirement.

14. **Financial Entity**: A non-insurance entity that engages in or facilitates financial intermediary operations (e.g., accepting deposits, granting of credits, or making loans, managing, or holding investments, etc.). Such entities may or may not be subject to specified regulatory capital requirements of other sectoral supervisory authorities. For purposes of the GCC, entities that are not regulated by an insurance or banking authority [e.g., the U.S. Securities and Exchange Commission (SEC) or the Financial Industry Regulatory Authority (FINRA)] will be considered as not subject to a specified regulatory capital requirement.

The primary examples of financial entities are commercial banks, intermediation banks, investment banks, saving banks, credit unions, savings and loan institutions, swap dealers, and the portion of special purpose and collective investment entities (e.g., investment companies, private funds, commodity pools, and mutual funds) that represents the Broader Group’s aggregate ownership in such entities, whether or not any member of the Broader Group is involved in that entity’s management responsibilities (e.g., via investment advisory or broker-dealer duties) for those entities.

For purposes of this definition, a subsidiary of an insurance company whose predominant purpose is to manage or hold investments or act as a broker-dealer for those investments on
behalf of the insurance company and its affiliated insurance (greater than 90% of all such investment subsidiaries’ assets under management or held are owned by or for the benefit of these insurance affiliates) should NOT be considered a Financial Entity. In the case where an insurer sets up multiple subsidiaries for this purpose, the 90% may be measured in the aggregate for all such entities. Similarly, in the case of collective investment pools (e.g., private funds, commodity pools, and mutual funds) the 90% may be measured individually, or in the aggregate for each subtype (e.g., private funds, commodity pools, and mutual funds).

In addition, other financial entities without a regulatory capital requirement include those which are predominantly engaged in activities that depending on the nature of the transaction and the specific circumstances, could create financial risks through the offering of products or transactions outside the group such as a mortgage, other credit offering or a derivative.

15. **Insurance Group**: For purposes of the GCC, a group that is comprised of two or more entities of which at least one is an insurer, and which includes all insurers in the Broader Group. Another (non-insurance) entity may exercise significant influence on the insurer(s); i.e., a holding company or a mutual holding company; in other cases, such as mutual insurance companies, the mutual insurer itself may be the Ultimate Controlling Person. The exercise of significant influence is determined based on criteria such as (direct or indirect) participation, influence and/or other contractual obligations; interconnectedness; risk exposure; risk concentration; risk transfer; and/or intragroup agreements, transactions and exposures.

An Insurance Group may include entities that facilitate, finance or service the group’s insurance operation, such as holding companies, branches, non-regulated entities, and other regulated financial institutions. An Insurance Group is thus comprised of the head of the Insurance Group and all entities under its direct or indirect control, and includes all members of the Broader Group that exercise significant influence on the insurance entities and/or facilitate, finance or service the insurance operations.

An Insurance Group could be headed by:
- An insurance legal entity;
- A holding company; or
- A mutual holding company.

An Insurance Group may be:
- A subset/part of bank-led or securities-led financial conglomerate; or
- A subset of a wider group.

An Insurance Group is thus comprised of the head of the Insurance Group and all entities under its direct or indirect control.

16. **Insurance Subgroup/U.S. Operations**: Refers to all U.S. insurers within a Broader Group where the groupwide supervisor is in a non-U.S. jurisdiction. It includes all the directly and indirectly held subsidiaries of those U.S. insurers. For purposes of subgroup reporting, capital instruments, loans, reinsurance, guarantees would only include those that exist within the U.S. insurers. Amounts included for the U.S. insurers shall include all amounts contained within the financial statements of those entities included in the subgroup reporting, whether those amounts are directly attributable or allocated to a company in the subgroup from an affiliate outside of the U.S. insurers and its direct or indirect subsidiaries.
17. **Lead State Regulator:** As defined in the *Financial Analysis Handbook*, i.e., generally considered to be the one state that “takes the lead” with respect to conducting groupwide supervision within the U.S. solvency system.

18. **Limited Group Capital Filing:** Refers to a GCC filing that includes sufficient data or information to complete the “Input 4 Analytics” tab and the “Summary 3 – Analytics” tab of the GCC template. This includes Schedule 1 of the template and may include limited data from other input tabs as deemed necessary for purposes of the analytics.

19. **Material Risk:** Risk emanating from a non-insurance/non-financial entity not owned by an insurer in the Insurance Group or is part of the Broader Group that is of a magnitude that could adversely impact the financial stability of the group as a whole such that the ability of insurers within a group to pay policyholder claims or make other policy related payments (e.g., policy loan requests or annuity distributions) may be impacted.

To determine whether an entity within the Broader Group poses material risks to the Insurance Group, the totality of the facts and circumstances must be considered. The determination of whether risk posed by an entity is material requires analysis of various aspects pertaining to the subject entity. A determination that a non-insurance/non-financial entity does not pose material risk allows the filer to request exclusion of that entity from the calculation of the GCC ratio in the “Inventory” tab. A number of items as listed below should be considered in making such a determination, to the extent they apply.

Caution is necessary, however. The fact that one or more of these items may apply does not necessarily indicate risk to the Insurance Group is, or is not, material. The group should be able to support its determination of material risk if requested by the Lead State Regulator. This should not be used as a checklist or as a scorecard. Rather, the list is intended to illuminate relevant facts and circumstances about a subject entity, the risk it poses, how the Insurance Group might be exposed to that risk and means to mitigate that risk.

Primary Considerations:

- Past experience (i.e., the extent to which risk from the entity has impacted the Insurance Group over prior years/cycles).
- The degree to which capital management across the Broader Group has historically relied on funding by the Insurance Group to cover losses of the subject entity.
- The existence of intragroup cross-support mechanisms (as defined below) between the entity and the Insurance Group.
- The means by which risk can be transmitted; i.e., the existence of sufficient capital within the entity itself to absorb losses under stress and/or if adequate capital is designated elsewhere in the Broader Group for that purpose.
- The degree of risk correlation or diversification between the subject entity and the Insurance Group (e.g., where risks of one or more entities outside the Insurance Group are potentially offset (or exacerbated) by risks of other entities) and whether the corporate structure or agreements allow for the benefits of such diversification to protect the Insurance Group.
- The existence and relative strength or effectiveness of structural safeguards that could minimize the transmission of risk to the Insurance Group (e.g., whether the corporate shell can be broken).
Other Considerations (if primary considerations suggest exclusion may be reasonable, these can be used to further support exclusions):

- The location of the entity in relation to the Insurance Group within the Broader Group’s corporate structure and how direct or indirect the linkage, if any, to the Insurance Group may be.
- The activities of the entity and the degree of losses that the entity could pose to the group under the current economic environment or economic outlook.

The guidance above recognizes that there are diverse structures and business models of insurers that make it impracticable to apply a one-size-fits-all checklist that would work for materiality determinations across all groups. Strict or formulaic quantitative measures based on size of the entity or its operations of a non-insurance affiliate are an insufficient proxy for materiality of risk to the insurance operations. The GCC Instructions thus consider the unique circumstances of the relevant entity and group and uses an interactive process whereby the group brings forward its suggestions as to entities that should be excluded from the scope of application for a discussion with the lead state, ultimately culminating in an agreement on the scope of application. The guidance in this section helps to facilitate that process and discussion with criteria for cross-support mechanisms that can potentially transmit material risk, as defined, to the Insurance Group as well as safeguards that can mitigate such risk or its transfer.

20. **Person**: As used in Model #440, a “person” is an individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert but shall not include any joint venture partnership exclusively engaged in owning, managing, leasing or developing real or tangible personal property.

21. **Reciprocal Jurisdiction**: As defined in the *Credit for Reinsurance Model Law* (#785).

22. **Scope of Application**: Refers to the entities that meet the criteria listed herein for inclusion in the GCC ratio. The application of material risk criteria may result in the Scope of Application being the same as, or a subset of, the entities controlled by the Ultimate Controlling Person of the insurer(s).

**NOTE**: U.S. branches of foreign insurers should be listed as separate entities when they are subject to capital requirements imposed by a U.S. insurance regulator, otherwise in as much as they are already included in a reporting legal entity, they are already in the scope of application and there is no need for any additional reporting.

23. **Ultimate Controlling Person**: As used in the *Insurance Holding Company System Regulatory Act* (#440). This is the entity that exercises control directly or indirectly over all entities within the Broader Group.
III. Determining the Scope of Application

A. Groups Exempted from the GCC

24. Refer to changes to Model #440 for guidance on groups that are exempted from filing a GCC. Instead, instructions are provided to ensure Lead State Regulators receive the information necessary to evaluate the Scope of Application.

B. Scope of Application – Legal Entity Inventory

25. When considering the scope of application, preparers of the GCC must first understand the information to be included in Schedule 1 of the template. When developing an initial inventory of all potential entities, the preparers of the GCC shall complete Schedule 1, which, except in the case of an Insurance Subgroup (as defined in Section II), requests data for all of the entities within the Broader Group that are directly or indirectly owned by the Ultimate Controlling Person (including the Ultimate controlling Person) that are listed in the insurer’s most recent Schedule Y or in relevant Holding Company Filings. GCC preparers should provide basic information about each such entity in Schedule 1, including its total assets, and total revenue and net income for this specific year identified. Additionally, the initial filing will require some further information for the prior year (e.g., prior year equity or surplus to policyholders). The primary purpose of the Schedule 1 is to: 1) assist the lead state in making an assessment on the entities within the group that should be included in the Scope of Application; and 2) provide the lead state with valuation information to better understand the group. This valuable information produces various ratios and other financial metrics that will be used in the analysis of the GCC and the group by the lead state for their holding company analysis.

26. To assist the Lead State Regulator in assessing the Scope of Application, the Schedule 1 and the “Inventory” tab of the template will be completed by each preparer to provide information and certain financial data on all the entities in the group. Each preparer will also use the include/exclude column in Schedule 1 to request its own set of entities to be excluded from the calculation after applying criteria for material risk (as defined in Section II). The requests for exclusion will be described by the preparer in the template and evaluated by the Lead State Regulator. A second column will be used by the regulator to reflect entities that the regulator agrees should be excluded.

27. Although all entities must be listed in Schedule 1 and in the “Inventory” tab, the preparer is allowed to group data for certain financial entities not subject to a regulatory capital requirement and certain non-insurance and non-financial entities. Thus, while the Schedule 1 would include the full combined financial results/key financial information (for all entities directly or indirectly owned by the Ultimate Controlling Person, such data may be reported based on major groupings of entities to maximize its usefulness, reduce the number of numeric entries, and allow the Lead State Regulator to better understand the group, its structure, and trends at the sub-group as well as group level. Criteria for grouping are further described in Section V, paragraph 55. Prior to completing the GCC annually, the Insurance Group should determine if the proposed grouping is satisfactory to the lead state or if there are certain non-insurance and non-financial entities (such entities are required to be broken out and reported separately) that should be broken out and reported separately.

C. General Process for Determining the Scope of Application

28. The starting point for “Scope of Application” (i.e., for purposes of the GCC specifically) is the entire group except in the case of an Insurance Subgroup (as defined in Section II). However, in the case of groups with material diverse non-insurance/non-financial activities isolated from the financial/Insurance Group and without cross-support mechanisms as defined in Section II, the preparer may request a narrower scope starting at the entity that controls all insurance and
financial entities within the group [i.e., comprise a subset of, the entities controlled by the Ultimate Controlling Person of the insurer(s) (Broader Group)]. However, the adjustments as to the Scope of Application suggested by the preparer in consultation and in agreement with the Lead State Regulator should include consideration of guidance in paragraph 31 (“Identify and Include all Financial Entities”) the totality of the facts and circumstances, as described in paragraph 19 (“Definition of material risk”). The rationale and criteria applied in allowing the reduced scope should be documented and made available to non-lead states if requested. The decision on reduced scope should be revisited when changes in the group structure or activities occur.

The fundamental reason for state insurance regulation is to protect American insurance consumers. Therefore, the objective of the GCC is to assess quantitatively the collective risks to, and capital of, the entities within the Scope of Application. This assessment should consider risks that originate within the Insurance Group along with risks that emanate from outside the Insurance Group but within the Broader Group. The overall purpose of this assessment is to better understand the risks that could adversely impact the ability of the entities within the Scope of Application to pay policyholder claims consistent with the primary focus of insurance regulators.

D. Guiding Principles and Steps to Determine the Scope of Application

29. For most groups, the Scope of Application is initially determined by the preparer in a series of steps, listed here and then further explained as necessary in the text that follows:
   
   - Develop a full inventory of potential entities using the Inventory of the Group template (Schedule 1). This should correspond to Annual Statement Schedule Y, Part 1A
   
   - Denote in Schedule 1 for each non-financial entity whether it is to be “included in or excluded from” the Scope of Application” using the criteria in the “Identify Risks from the Broader Group” subsection below.
   
   - All non-financial entities, whether to be included in or excluded from the Scope of Application are to be reported in the “Inventory” tab of the template. Information to be provided for excluded entities will be limited to Schedule 1B and the corresponding columns in the Inventory tab. See paragraph 55 for additional information on treatment of non-insurance/non-financial subsidiaries of U.S. RBC filers or such subsidiaries owned by other financial entities with regulatory capital requirements for which the non-insurance/non-financial entity is included in the capital charges for the Parent entity.
   
   - Non-financial entities may qualify for grouping on this Inventory tab as described elsewhere in these instructions.

E. Steps for Determining the Scope of Application

30. Identify and list all entities in the Insurance Group or Insurance Subgroup (where required).

   Include all entities that meet the definition of an affiliate in Section II, above and that fit the criteria identified in the definition of the Insurance Group or Insurance Subgroup (if applicable), in Section II, above except as modified in paragraph 32 (Identify Risks from the Broader Group), below. All insurance entities and entities owned directly or indirectly by the insurance
entities in the group shall be included in the Scope of Application and reported in the Schedule 1 and Inventory of the Group template. Other non-insurance/nonfinancial entities within the Insurance Group may be designated as “exclude” as described in paragraph 30.

31. Identify and include all Financial Entities.

Financial Entities (as defined in Section II) within the Inventory of the Group template shall be included in (i.e., may not be designated as “excluded from”) the Scope of Application, regardless of where they reside within the Broader Group.

As learned from the 2008 financial crisis, U.S. insurers were not materially impacted by their larger group issues; however, materiality of either equity or revenue of an entity might not be an adequate determinant of potential for risk transmission within the group. Furthermore, risks embedded in financial entities are not often mitigated by the activities of the insurers in the group and may amplify their (the insurers’) risks.

Any discretion in evaluating the ultimate risk generated by a defined financial entity that is not subject to a regulatory capital requirement should be applied via review of the material risk definitions/principles included in paragraph 19 to set the level of risk as low, medium or high and not to exclude such entities from the calculation. The rationale should be documented, and all data required in Schedule 1 must be provided for the entity for purposes of analysis and trending.

32. Identify Risks from the Broader Group

An Insurance Group or Insurance Subgroup may be a subset of a Broader Group, such as a larger diversified conglomerate with insurance legal entities, financial entities, and nonfinancial entities. In considering the risks to which the Insurance Group or Insurance subgroup is exposed, it is important to take account of those material risks (as defined in Section II) to the Insurance Group from the Broader Group within which the Insurance Group operates. All non-insurance/non-financial entities included within the Insurance Group or Insurance Subgroup that pose material risk to the insurers in the group should be included within (i.e., may not be designated as “excluded from”) the Scope of the Application. Similarly, all non-financial entities within the Broader Group but outside the Insurance Group that pose material risks to the Insurance Group should be included within (i.e., may not be designated as “excluded from”) the Scope of Application; non-material non-insurance/non-financial entities within the Broader Group or within the Insurance Group (as both terms are defined in Section II) other than those entities owned by entities subject to a specified regulatory capital requirement should be reported as “excluded.” However, no such entities outside an Insurance Subgroup (as defined in Section II) should be included in the GCC. When determining which non-financial entities from the Broader Group to include in the Scope of Application, the preparer must include any entity that could adversely impact the ability of the entities within the Scope of Application to pay policyholder claims or provide services to policyholders consistent with the primary focus of insurance regulators.
33. Review of Submission

The Lead State Regulator should review the inventory of entities provided in the Group template to determine if there are entities excluded by the preparer using the criteria above that the Lead State Regulator agrees do not pose material risk (as defined herein) to its insurance operations. Additional information may be requested by the Lead State Regulator to facilitate this analysis. For entities where the Lead State Regulator agrees with the request to exclude, the GCC may exclude the data for such entities. Ultimately, the decision to include or exclude entities from the GCC will occur based on the Lead State Regulator’s knowledge of the group and related information or filings available to the Lead State and whether they believe an applicable entity would not adversely impact the entities within the Scope of Application to pay policyholder claims.

The template’s sensitivity analysis tab includes a calculation to reflect the impact of excluded entities requested, but not approved for exclusion by the lead state. (see instructions for Input 5 herein).

34. The preparer, together with the Lead State Regulator, would use the above steps, which includes considering the Lead State Regulator’s understanding of the group, including inputs such as Form F, ORSA and other information from other involved regulators, to determine the reasonableness of the suggested Scope of Application.

35. Updating the Scope of Application

The Scope of Application could be re-assessed by the preparer and the Lead State Regulator each successive annual filing of the GCC provided there has been substantial changes in corporate structure or other material changes from the previous year’s filing. Any updates should be driven by the assessment of material risk and changes in group structure as they impact the exclusion or inclusion of entities within the Scope of Application based on material risk considerations.

IV. General Instructions

36. The GCC template consists of a number of tabs (sections) within one workbook. The following provides general instructions on each of these tabs.

37. **Attestation**: This tab is intended to work similar to the annual financial statement and RBC attestations, which are both intended to give the regulator greater comfort that the company has completed in accordance with its (these) instructions. It will also indicate whether the group consists of predominantly life, P/C, or health insurers and whether the submission is a full or limited group capital filing.

38. **Input 1 – Schedule 1**: This tab is intended to provide a full inventory of the group, including the designation by the filer of any non-financial entities to be included in, or excluded from, the Scope of Application and include sufficient data or information on each affiliated entity (see Schedule A and Schedule BA exception as described in paragraph 39) within the group so as to allow for analyzing multiple options for scope, grouping and sensitivity criteria, as well as, allowing the Lead State Regulator to make a determination as to whether the entities to be included in the scope of application or excluded from the scope of application meet the aforementioned criteria. This tab is also used to maximize the value of the calculation by
including various information on the entities in the group that allow the lead state to better understand the group as a whole, the risks of the group, capital allocation, and overall strengths and weaknesses of the group.

39. Except as noted, equity method investments reported in the Section 1B in the Inventory tab that are accounted for based on Statement of Statutory Accounting Principles (SSAP) No. 48—Joint Ventures, Partnerships and Limited Liability Companies are not required to be de-stacked (separately listed) in Schedule 1; i.e., their value would be included in amounts reported by the Parent insurer within the calculation. The basis for this approach is predicated on the purpose of the entire GCC, which is to produce an expected level of capital and a corresponding level of available capital that are derived by aggregating the amounts reported of capital of the individual entities under the GCC methodology. The available capital for such joint ventures, partnerships and limited liability companies is already considered in Schedule 1 by its inclusion in its Parent’s financial statements and can be excluded from an inventory (not separately listed) because the Parent also already receives a corresponding capital charge within its RBC.

NOTE: Data for this tab is required for a Limited Group Capital filing.

40. Input 2 – Inventory: This tab is intended to be used by the consolidated group to provide information on the value and capital calculation for all the entities in the group before any de-stacking of the entities. While some of this information is designed to “pull” information from Schedule 1, other cells (blue cells) require input from the group. This tab will then apply the adjustments for investment in subsidiary other than where an exception is described in these instructions and adjust for intragroup arrangements. This tab is set up to subtract those adjustments from capital and therefore should be entered as: 1) a positive figure if the adjustment currently has a positive impact on the available capital or the capital calculation; or 2) a negative figure if the adjustment currently has a negative impact on the available capital or the capital calculation. It will also be used to add relevant insurance or other financial entities included as equity investments in Schedule A and Schedule BA and to aggregate the resulting adjusted values for use in the actual GCC.

NOTE: For a Limited Group Capital filing, data will be presented in a summarized format in a limited version of the “Inventory” tab in lieu of completing the full “Inventory” tab (see below).

Limited Group Capital Filing Only: Input 2 – Inventory: Manually enter data in Inventory B, Column 8 and Inventory C, Column 8 to report a single aggregated value for each entity category in the group. This will require that eliminations and adjustments normally found in a “full” Inventory B, Column 2 through Column 7 and Inventory C, Column 2 through Column 7 to be addressed offline.

41. Input 3 – Capital Instruments: This tab is intended to be used to gather necessary information to that will be used to calculate an allowance for additional available capital based on the concept of structural subordination applied to senior or other subordinated debt issued by a holding company that is within the scope of application of the GCC filing. It will also provide information on all debt issued by entities within the scope of application.

NOTE: Data for this tab is NOT required for a Limited Group Capital filing.

42. Input 4 – Analytics: In recognizing a primary purpose of the GCC is to enhance groupwide financial analysis, this tab includes or draws from entity-category-level inputs reported in the tab or elsewhere in the GCC template to be used in GCC analytics. Separate guidance for Lead
State Regulators to reference in analysing the data provided in the GCC template (reference applicable location of the guidance; e.g., Financial Analysis Handbook).

NOTE: Data for this tab is required for a Limited Group Capital filing.

43. **Input 5 – Sensitivity Analysis and Inputs**: This tab includes inputs and/or describes informational sensitivity analysis for other than XXX/AXXX captives, permitted and prescribed practices, debt designated as “Other,” unscaled foreign insurer values and other designated sensitivity analysis. The inputs are intended to simply be a disclosure, similar to the disclosure required under Note 1 of the statutory financial statements. The analysis will be applied in the “Summary 2” tab.

NOTE: Data for this tab is NOT required for a Limited Group Capital filing.

44. **Input 6 – Questions and Other Information**: This tab will provide space for participants to describe or explain certain entries in other tabs. Examples include the materiality method applied to exclude entries in Schedule 1 and narrative on adjustments for intragroup debt and adjustments to available capital or capital calculations that are included in the “other adjustment” column in the “Inventory” tab.

NOTE: Data for this tab is NOT required for a Limited Group Capital filing.

45. **Calc 1 – Scaling (Ins)**: This tab list countries predetermined by NAIC and provides the necessary factors for scaling available and required capital from non-US insurers to be used in sensitivity analysis to a comparable basis relative to the U.S. RBC figures. It also allows for set scaling options (which vary by insurance segment such as life, P/C, and health).

NOTE: This tab is NOT required for a Limited Group Capital filing.

46. **Calc 2 – Scaling (Non-Insurance)**: This tab is used to determine calculated capital for non-insurance entities.

NOTE: This tab is NOT required for a Limited Group Capital filing.

47. **Summary 1 – Entity Category Level**: This tab provides a summary of aggregated available capital and calculated capital for each entity category before the application of capital instruments.

NOTE: This tab is NOT required for a Limited Group Capital filing.

48. **Summary 2 – Top Level**: This tab calculates various informational GCC ratios resulting from applying “on top” and entity level adjustments to adjusted carrying value and adjusted calculated capital and are described in the “Sensitivity Inputs and Analysis” tab. These “what if” scenario analysis will not be part of the GCC ratio.

NOTE: This tab is NOT required for a Limited Group Capital filing.

49. **Summary 3 – Analytics**: Provides a summary of various GCC analytics.

NOTE: This tab is required for a Limited Group Capital filing.
50. **Summary 4 – Grouping Alternatives:** This tab currently calculates and displays a selected grouping option for organizing the structure of the group consistent with the way that the entities are managed.

**NOTE:** This tab is NOT required for a Limited Group Capital filing.

51. All cells in the template are color-coded based on the chart below. Inputs should only be made in blue cells. Do not add/delete rows, columns or cells or change the structure of the template in any way. If there appears to be an error in the formulas in the template, contact the NAIC.

The following set of colors is used to identify cells:

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Colors used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Input cells</td>
<td></td>
</tr>
<tr>
<td>Data from other worksheets</td>
<td></td>
</tr>
<tr>
<td>Local calculations</td>
<td></td>
</tr>
<tr>
<td>Results propagated</td>
<td></td>
</tr>
</tbody>
</table>

**V. Detailed Instructions** *(insert link to template)*

**Input 1 – Schedule 1**

52. Schedule 1A indicates the version of the template being prepared.

53. More detailed information on each legal entity should be reported in Schedule 1B through Schedule 1D. The order of the entries in Schedule 1 should match that in the “Inventory” tab. The first entity listed should be the ultimate controlling party.

54. U.S. branches of foreign insurers should be listed as separate entities when they are subject to capital requirements imposed by a U.S. insurance regulator. They should be reported under the appropriate entity category in [Sch 1B Col 6].

55. Entries are required for every entity within the scope of the group. However, while recognizing that Lead State Regulator retain the discretion to ask for greater detail, the following simplifications may be applied as long as information for every entity is entity is listed in Schedule 1B:

- A single numerical entry for like Financial Entities would be allowed at the intermediate holding company level, assuming that the like entities are owned by a common Parent that does not own other entity types, all use the same accounting rules (e.g., all GAAP), and are at least consistent with the way the group manages their business. The entity at which the total data is provided must be assigned an “Entity Category” in Schedule 1 that corresponds to the instructed carrying value and capital calculation for which the entry is made (e.g., an entity that would otherwise be categorized as a non-operating holding company but holds asset managers would be categorized as an asset manager). Entries
for the remaining individual entities in the grouping will be reported in Schedule 1B only as “included.”

• In addition, a single numerical entry would be allowed for all included non-insurance/non-financial entities at the intermediate holding company level assuming that the intermediate holding company owns only non-insurance/non-financial entities (i.e., does not own other entity types), all use the same accounting rules (e.g., all GAAP), and are at least consistent with the way the group manages their business. This would include any positive residual value of the holding company itself. Entries for all individual entities in the grouping will be reported in Schedule 1B only as “included,” but no stand-alone values for each entity would be required.

• Values for, non-insurance/non-financial subsidiaries of U.S. RBC filers or such subsidiaries owned by other financial entities with regulatory capital requirements for which the non-insurance/non-financial entity is included in the capital charges for the Parent entity may remain with their Parent insurers and will not be de-stacked. Entries for these individual entities in the grouping will be reported individually in Schedule 1B Columns 1 and 2 only as “included.” along with other required entries in Schedule 1B, but no stand-alone values for each entity would be required in Schedules 1C or 1D.

• Mutual Insurance Groups may use the Total Adjusted Capital and amount of required capital from the top-level Insurer’s RBC Report at 200% x ACL RBC further adjusted to de-stack foreign insurers and other financial entities owned directly or indirectly (on a look-through basis) via RBC filing subsidiaries. Such foreign insurance subsidiaries or other financial subsidiaries shall be reported at the carrying values and capital calculations as described later herein.

• Data for U.S. Branches of Foreign insurers may be omitted from Schedule 1 if they are otherwise included in the entries, values, and capital requirements of a foreign insurer.

NOTE: These simplifications will be treated in a similar manner in Input 2 – Inventory.

56. Any financial entity owned by a Parent insurer and listed in Schedule A or Schedule BA, and any insurance or financial entity that is owned indirectly through a Schedule BA affiliate should be listed in Schedule 1 and in the Inventory and assigned the appropriated identifying information. (See also the instructions for Part B of the Inventory). These entities will be de-stacked from the values for the Parent insurer. The same treatment for these entities will be afforded when they owned by a foreign insurer or other non-insurance entities.

57. Schedule 1B contains descriptions of each entity. Make selections from drop-down menu where available.

• [Sch 1B Col 1] Include/Exclude (Company) – This column is to select entities where a request is made for exclusion. The filer will indicate which non-insurance/non-financial entities not owned directly or indirectly by an insurer that should be excluded from the GCC as not posing material risk to the group. The filer’s definition of material risk will be reported in the “Other Information” tab.

• [Sch 1B Col 2] Include/Exclude (Supervisor) – Column to be filled in by supervisor. These are entities where the Supervisor agrees with the filer’s assessment of material risk
and these entities will be excluded from the GCC and may be included in a sensitivity analysis later in the template.

**NOTE:** This column may also be completed by the filer after advance consultation with the Lead State Regulator.

- **[Sch 1B Col 3] Include/Exclude (Selected)** – Formula to determine treatment of data for later sensitivity analysis. If supervisor has made a determination of include/exclude in the prior column, that will be used. If not, company’s selection will be used.

- **[Sch 1B Col 4] Entity Grouping** – Column denotes whether this is an insurance or non-insurance/non-financial entity and is also automatically populated based on the entry in Column 8.

- **[Sch 1B Col 5] Entity Identifier** – Provide a unique string for each entity. This will be used as a cross-reference to other parts of the template. If possible, use a standardized entity code such as NAIC Company Code (CoCode) or Insurance Services Office (ISO) Legal Entity Identifier. CoCodes should be entered as text and not number (e.g., if CoCode is 01234, then the entry should be “01234” and not “1234”). If there is a different code that is more appropriate (such as a code used for internal purposes), please use that instead. If no code is available, then input a unique string or number in each row in whatever manner is convenient (e.g., A, B, C, D, … or 1, 2, 3, 4…). Do not leave blank.

- **[Sch 1B Col 6] Entity Identifier Type** – Enter the type of code that was entered in the “Entity Identifier” column. Choices include “NAIC Company Code,” “ISO Legal Entity Identifier,” “Volunteer Defined” and “Other.”

- **[Sch 1B Col 7] Entity Name** – Provide the name of the legal entity.

- **[Sch 1B Col 8] Entity Category** – Select the entity category that applies to the entity from the following choices (all U.S. life captives shall select the option for “RBC Filing Captive,” complete the calculation using the life RBC formula in accordance with instructions below regarding “Additional clarification on capital requirements where a U.S. formula (RBC) is not required,” regardless of whether the company is required by their captive state to complete the RBC formula. Insurers or financial entities that are de-stacked from an insurer’s Schedule A or Schedule BA should be assigned the corresponding insurer or financial entity category:
If the GCC group’s Japanese insurer health business (referred to as “Third Sector”) is greater than 60% of total life business (referred to as “First Sector”) and health business combined, as reflected by annualized premium for the year reported, then that group may elect to use the Japan health scalar set rather than the life scalar set.

**NOTE:** All U.S. captives are required to complete the applicable RBC formula template. In addition, any insurer, other than U.S. captive, that submits an RBC filing to either the state of domicile or the NAIC will be considered an RBC filer.
• [Sch 1B Col 9] Alternative Grouping – This is an optional input field. This field should be used if you wish to show similar entities aggregated into a single line in Summary 4-Alternative Grouping. Exhibit. For example, if you have a dozen small dental HMO businesses, you may wish to show them as a single line called “Dental HMOs,” as opposed to listing each entity separately. This is a level of granularity below “Entity Category” but above individual entities. No entity should be put in the same “Alternative Grouping” as its Parent. It is acceptable to put only one entity in a grouping. If any entries are left blank then, in Column 17, the “Entity Name” will be selected as the grouping. This will not impact the order of the entities for which data is entered in Schedule 1 or the “Inventory” tab.

• [Sch 1B Col 10] Parent Identifier – Provide the Entity Identifier of the immediate Parent legal entity for each entity, as applicable. If there are multiple Parents, select the Parent entity with the largest ownership percentage. Only include one entry. For the top holding company, enter “N/A.”

• [Sch 1B Col 11] Parent Name – This will be populated by a formula, so input is not required.

• [Sch 1B Col 12] % Owned by Parent – Enter the percentage of the entity that is owned by the Parent identified earlier in the worksheet. Percentages of ownership should be based on the percentage of voting class securities (unless ownership is maintained other than by control of voting securities) consistent with what is reported pursuant to state holding company regulation filings (Form B or equivalent).

• [Sch 1B Col 13] % Owned within Group Structure – Enter the percentage of the entity that is owned in the aggregate by any affiliate within the Group.

• [Sch 1B Col 14] State/Country of Domicile – Enter state of domicile for U.S. insurance entities and country of domicile for all other entities. (Use references that are consistent with those use on Schedule Y, where available.)

• [Sch 1B Col 15] Zero Valued and Not Admitted Entities – Report for U.S. Insurers Only. Select the treatment of the entity from following options: “Zero Valued for RBC” or “Nonadmitted for Accounting and RBC (Direct or Indirect).”

Zero Valued for RBC are affiliated insurance and financial entities that are otherwise reported in the RBC filer’s annual financial statement at their accounting value (i.e., per SAP) but are reported at zero value and zero capital requirements for RBC purposes. Examples include non-Canadian foreign insurers directly owned by U.S. life RBC filers. The carrying value and capital calculation specified in these instructions for the specific insurance or financial entity type should be reported in Inventory B, Column 2 and Inventory C, Column 2, respectively.

NOTE: Do not report zero values in Column 2 of Inventory B and Inventory C for these affiliates. Only RBC filing entities with this type of affiliate will report in this column.

Nonadmitted for Accounting and RBC (Direct or Indirect) are insurance or other financial affiliates that owned directly indirectly by an RBC filer via a downstream non-financial entity or holding companies that are reported at zero value per SAP and are also reported
at zero value and zero capital requirements for RBC purposes. Examples include U.S. insurers indirectly owned by a U.S. RBC filer through a nonadmitted holding company that has not been subject to an independent audit. The carrying values and capital calculations specified herein associated with the specific insurance or financial indirectly owned entity type should be reported Inventory B, Column 2 and Inventory C, Column 2, respectively.

NOTE: Do not report zero values in Column 2 of Inventory B and Inventory C for these affiliates. Only RBC filing entities with this type of affiliate will report in this column. The excess value in the nonadmitted Parent entity may be reported at zero value.

No entry is required in this column for any nonadmitted directly or indirectly owned non-insurance/non-financial subsidiary. Report zero for these affiliates in Column 2 of Inventory B and Inventory C.

- **[Sch 1B Col 16] Is Affiliate on Schedule A or Schedule BA an Insurer or Other Financial Entity?** – Column is meant to identify an entity with an insurer or financial entity identifier in Column 8 that is reported on Schedule A or Schedule BA but is being de-stacked and also reported on the Inventory tab. Provide a “Y” response where that is applicable. Otherwise leave blank.

- **[Sch 1B Col 17] Selected Alternative Grouping** – This will be populated by a formula, so input is not required. If there are any blank entries in Column 9 (Alternative Grouping), this column will set them equal to the name of the entity.

58. Schedule 1C contains financials for each entity:

- **[Sch 1C Col 1] Basis of Accounting** – Enter basis of accounting used for the entity’s financial reporting.


- **[Sch 1C Col 6] Book Assets** – This should be valued based on the applicable basis of accounting reported under the entity’s local regime and represents the total assets as reported in the basic financial statements before eliminations (because that is presumed to be less burdensome on the insurance holding company). Other financial data should
similarly be prepared using financial data before eliminations. However, insurance holding companies are allowed to present such figures after eliminations if they do so for all figures and consistently for all years.

- **[Sch 1C Col 7] Book Liabilities** – This should be valued based on the applicable basis of accounting reported under the entity’s local regime and represents the total liabilities as reported in the basic financial statements.

- **[Sch 1C Col 8] Gross Paid-in and contributed Capital and Surplus (U.S. Insurers Only)** – For U.S. insurers, report the current year end amounts from annual financial statement Page 3 as follows:
  
  a. Life Insurers: lines 29, 30 and 33.
  
  b. P/C Insurers: lines 30, 31 and 34.
  
  c. Health Insurers: lines 26, 27 and 28.

59. Generally, Schedule 1D will include entries from regulatory filings or entity specific GAAP financial statements as of the reporting date. The amounts reported should be the entity value on a stand-alone (fully de-stacked) or grouped basis (where applicable). This may require use of company records in certain cases. The amounts should be reported at 100% for the entity listed. Any required adjustments for percentage of ownership will be applied later, if necessary, to calculate a capital charge.

- **[Sch 1D Col 1] Prior Year Entity Identifier** – Report the Legal Entity Identifier, NAIC company code or other identifier used for the entity in the prior year GCC filing for the prior calendar year.

- **[Sch 1D Col 2] Prior Year Equity or Capital and Surplus** – Report the value based on net equity reported in the entity stand-alone balance sheet. This will generally be the same as what is reported in the current year column in the prior year GCC filing. Where grouping is permitted, the balance reported may be on a grouped basis.

- **[Sch 1D Col 3] Net Income** – The final reported income figure from the income statement, and therefore is the figure reported after interest, taxes, extraordinary items, etc. For entities with accounting and reporting requirements that specify that dividends paid or received will be part of “net income,” report the dividends received in this column. Report dividends to policyholders here as a reduction to net income if required by local accounting or reporting requirements.

- **[Sch 1D Col 4] Dividends Paid and Received (Net)** – All entity types report the net amount of dividends paid and received in reporting year to/from and affiliate, a Parent shareholder, public shareholders, or policyholders (if not required to be a reduction/increase in net income by local accounting or reporting requirements). All entity types that are subject to accounting and reporting requirements that specify that dividends paid or received will be reported as a surplus adjustment, will report dividends received in reporting year from affiliates in this column.
• **[Sch 1D Col 5] Capital and Surplus Contributions Received from Affiliates** – All entity types. Report sum of capital contribution (other than via surplus notes) during the reporting year received from any affiliated entity.

• **[Sch 1D Col 6] All Other Changes in Capital and Surplus** – Include total for all adjustments not listed above. This would include any investment income not already reported in Column 3 or Column 5. Also, report all stock repurchases or redemptions in this column.

  NOTE: Greater detail may be made available upon request.

• **[Sch 1D Col 7] Current Year Equity or Capital and Surplus** – Report the value based on net equity reported in the entity stand-alone Balance Sheet for the current year. This will generally be the same as what is reported for the entity in the Inventory B, Column 2. Where grouping is permitted, the balance reported may be on a grouped basis.

• **[Sch 1D Col 8] Capital and Surplus Contributions Paid to Affiliates** – All entity types report the total of capital contributions (other than via surplus notes) during the reporting year paid to any affiliated entity.

• **[Sch 1D Col 9] Dividends Declared and Unpaid** – For all applicable entities report the amount of dividends declared or approved but not yet distributed.

• **[Sch 1D Col 10] Dividends Received and Not Retained** – All holding companies, insurers and financial entities with regulatory capital requirements indicate by “Y” or “N” if part or all of dividends received reported in Column 5 have been paid (passed through) to a Parent company, to public shareholders, or used to repurchase or redeem shares of stock.
Input 2 – Inventory

60. Columns in Inventory A are being pulled from Schedule 1:

- [Column 1] Insurance/Non-Insurance
- [Column 2] Entity Identifier
- [Column 3] Entity Identifier Type
- [Column 4] Entity Name
- [Column 5] Entity Category
- [Column 6] Parent Identifier
- [Column 7] Parent Name
- [Column 8] Basis of Accounting

Columns Requiring Input

61. Enter information on adjustments to carrying value. Considerations specific to different types of entities are located at the end of this subsection.

- **[Inv B Col 1] Carrying Value (Immediate Parent Regime)** – This column is included to accommodate participants with either a U.S. or a non-U.S. based Parent company. In general, carrying values utilized should represent: 1) the subsidiary valuation required by the insurance or other sectoral regulator if the Parent is a regulated entity; or 2) in the case where the Parent is not subject to insurance or other sectoral regulatory valuation, then a subsidiary valuation based U.S. GAAP or other International GAAP as used in the ordinary course of business by the ultimate controlling party in their financial statements. No entry is required for the Ultimate Controlling Person (UCP)

The value in this column will include a zero value for entities not admitted per SAP or other jurisdictional regulatory rules. A single entry for all entities that qualify under the grouping criteria described in Input 1, herein may be made in lieu of individual entries on the line for the affiliate that holds the qualifying entities. This column will include double-counting.

The values recorded for all subsidiaries should be the full value of the subsidiary regardless of percentage of ownership by entities within the group. Where entities are owned partially by entities outside of the group, then report the full value of the subsidiary adjusted to reflect total percentage of ownership within the group.

- **[Inv B Col 2] Carrying Value (Local Regime)** – Record the carrying value recognized by the legal entity’s jurisdictional insurance or other sectoral supervisor. This will include the value of capital instruments (e.g., U.S. insurer issued surplus notes) that are specifically recognized by statute, regulation or accounting rule and included in the carrying value of the entity. In the case where the entity is not subject to insurance or other sectoral regulatory valuation, then U.S. GAAP equity (including OCI) or other International GAAP as used in the ordinary course of business by the ultimate controlling party in their financial statements. If an agreed-upon change in local carrying value should become effective by 2021, Volunteer Groups are expected to report on that basis. If the group is comprised entirely of U.S.-based entities under a U.S.-based Parent company, the entries in this column will be the same as in Column 1 except in cases where the Parent owns not admitted (or otherwise zero valued financial affiliates that
would be reported as not admitted in the Parent Regime column but fully admitted (per SAP valuation) in the Local Regime column. (See instructions for [Sch 1B Col 15].) However, if such an entity has been listed in the [Sch 1B Col 2] Include/Exclude (Supervisor) column, indicating that the Lead State Regulator agrees that the entity does not pose material risk, then a value will be reported here, but the ultimate calculation will show the results without the excluded entity’s value. The carrying value for affiliates that are U.S. RBC filers will be the amount reported TAC on entity’s RBC report. This column will include double-counting. The values recorded for all subsidiaries should be the full value of the subsidiary regardless of percentage of ownership by entities within the group. Where entities are owned partially by entities outside of the group, then report the full value of the subsidiary adjusted to reflect total percentage of ownership within the group. The entry here should generally be the same as the value reported in Inventory B, Column 1, except where TAC for RBC filers differs from their BACV. A single entry for all entities that qualify under the grouping criteria described exceptions described herein under Input 1, above may be made in the line for the affiliate that holds the qualifying entities in lieu of individual entries.

A sensitivity analysis is included to calculate the impact of excluded entities requested but not approved for exclusion by the lead state.

<table>
<thead>
<tr>
<th>Parent Entity</th>
<th>Entity</th>
<th>Inv B, Column 1</th>
<th>Inv B, Column 2</th>
<th>Parent Entity Line Inv C, Column 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. RBC filer</td>
<td>U.S. RBC filer</td>
<td>BACV Per Statutory Accounting</td>
<td>RBC TAC</td>
<td>BACV Per Statutory Accounting</td>
</tr>
<tr>
<td>U.S. RBC filer</td>
<td>Other U.S. Insurer</td>
<td>BACV Per Statutory Accounting</td>
<td>BACV Per Statutory Accounting</td>
<td>BACV Per Statutory Accounting</td>
</tr>
<tr>
<td>U.S. RBC filer</td>
<td>Foreign Insurer or Other Regulated w/ Capital Reqmt</td>
<td>BACV Per Statutory Accounting</td>
<td>Per Local Regulatory Accounting</td>
<td>BACV Per Statutory Accounting</td>
</tr>
<tr>
<td>U.S. RBC filer</td>
<td>Financial w/o Capital Reqmt</td>
<td>BACV Per Statutory Accounting</td>
<td>BACV Per Statutory Accounting</td>
<td>BACV Per Statutory Accounting</td>
</tr>
<tr>
<td>U.S. RBC filer</td>
<td>Non-Financial</td>
<td>BACV Per Statutory Accounting</td>
<td>No entry Required</td>
<td>No entry Required</td>
</tr>
<tr>
<td>Other U.S. Insurer</td>
<td>U.S. RBC filer</td>
<td>BACV Per Statutory Accounting</td>
<td>RBC TAC</td>
<td>BACV Per Statutory Accounting</td>
</tr>
<tr>
<td>Other U.S. Insurer</td>
<td>Any Other Entity Type</td>
<td>BACV Per Statutory Accounting</td>
<td>BACV Per Statutory Accounting</td>
<td>BACV Per Statutory Accounting</td>
</tr>
<tr>
<td>Foreign Insurer or Other Regulated w/ Capital Reqmt</td>
<td>U.S. RBC filer</td>
<td>Per Local Regulatory Accounting</td>
<td>RBC TAC</td>
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<td>BACV Per Statutory Accounting</td>
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<td>Per Local Public Accounting*</td>
<td>Per Local Public Accounting*</td>
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</tbody>
</table>

*Subject to Grouping
In cases where a U.S. life RBC filer owns a foreign insurer and the BACV value reported for the foreign insurer in the Parent U.S. insurers financial statement is adjusted to zero for RBC purposes, then report zero in Inventory B, Column 1 and Column 3 for that foreign insurance entity.

- **[Inv B Col 3] Investment in Subsidiary** – Enter an adjustment to remove the investment carrying value of any directly owned subsidiary(ies) from Parent’s carrying value. This is intended to prevent double-counting of available capital when regulated entities are stacked. The carrying value to be removed should be the investment value carried by the Parent from which the entity is being de-stacked (i.e., the value in Column 1 in Inventory B adjusted for ownership percentage). Thus, there will be no adjustment to the Parent’s value in this column for entities that are reported at zero value by the Parent. Where entities are owned partially by entities outside of the group, then the Parent’s percentage of ownership will be calculated based on the value owned within the group.

Generally, for all non-financial affiliates, Schedule A and Schedule BA assets will remain in the value of the Parent insurer and not entered in this column. However, if the Schedule A or Schedule BA asset is an insurance or financial entity as described herein, the value of that entity will be included in this column. For indirectly owned Schedule A or Schedule BA insurance or financial entities, only the value of that entity will be included in this column and the remaining value of the downstream Schedule BA Parent will remain with the Parent insurer. Similarly, the carrying value of U.S. branch of a foreign insurer that is listed in Schedule 1 and in this section should be entered in this column in the row of the foreign insurer if it is already included in the value of the foreign insurer so that the Parent entity may eliminate double-counting of that available capital which will now be reported by the stand-alone Branch listed in the inventory.

**NOTE:** The “Sum of Subsidiaries” column may provide a useful check against this entry, but it will not necessarily be equal.

When utilizing public accounting (e.g., GAAP) equity values that differ from regulatory values (e.g., SAP), it is the **GAAP equity** of the insurers must be eliminated from the GAAP Parent in this column, not the SAP (regulated capital). This is necessary in order to allow the calculation to appropriately represent SAP capital of regulated entities and GAAP equity of non-regulated entities. Data on the accounting differences between Parent and Local carrying values will be collected in **[Inventory B, Column 9]** and further detail provided in the “Questions and Other Information” tab.

**NOTE:** Values for Schedule A and Schedule BA affiliates that are required to be reported in the “Inventory” tab will be adjusted out of the value reported by the U.S. insurer in this column.

- **[Inv B Col 4] Intragroup Capital Instruments** – This column is automatically calculated from inputs to the “Capital Instruments” tab. It reflects an adjustment to remove carrying value for intragroup financial instruments that are treated as capital by the issuer and consequently create additional capital within the group upon issuance (most notably U.S. surplus notes). Example for surplus notes: In both intragroup and unaffiliated transactions, treat the assets transferred to the issuer of the surplus note as available capital. If the purchaser is an affiliate, eliminate the investment value from the affiliated purchaser of the surplus note in this column. If the purchaser is an insurer or other regulated entity, eliminate the purchaser’s capital charge (e.g., RBC charge) on the
surplus note investment in the corresponding adjustment column for the capital calculation. No adjustments are made for any intragroup capital instrument that is treated as a liability by the issuer.

- **[Inv B Col 5] Reported Intragroup Guarantees, LOCs and Other** – Enter an adjustment to reflect the notional value weighted for expected utilization for reported intragroup guarantees (including solvency insurance and capital maintenance agreements). Enter the notional value for letters of credit, or other intragroup financial support mechanisms. Explain each intragroup arrangement in the “Questions and Other Information” tab.

- **[Inv B Col 6] Other Intragroup Assets** – Enter the amounts to adjust for and to remove double-counting of carrying value for other intragroup assets, which could include intercompany balances, such as (provide an explanation of each entry in the “Questions and Other Information” tab):
  a. Loans, receivables and arrangements to centralize the management of assets or cash;
  b. Derivative transactions;
  c. Purchase, sale or lease of assets; and
  d. Other (describe).

- **[Inv B Col 7] All Other Adjustments** – Include a brief explanation in the “Description of ‘Other Adjustments’” in the “Other Information” tab.

- **[Inv B Col 8] Adjusted Carrying Value** – Stand-alone value of each entity per the calculation to eliminate double-counting. This value includes permitted and prescribed practices.

- **[Inv B Col 9] Accounting Adjustments (e.g., GAAP to SAP)** – Report the total difference between the carrying value reported in Column 1 (and Column 3) and the value reported in Column 2. This column will apply to regulated entities where the stand-alone carrying value is based on regulatory accounting (e.g., SAP) while the value reported for that entity by the Parent is carried at a financial accounting (e.g., GAAP) value. Further detail is reported in the “Questions and Other Information” tab.


- **[Inv B Col 13] Average Revenue over 3-years (Financial Entities without Regulatory Capital Requirements and Non-Financial Entities)** – This column is populated from data in Column 10, Column 11 and Column 12.
This column will support the capital calculation for asset managers, broker-dealers and other Financial Entities without Regulatory Capital Requirements.

62. “Adjusted Capital Calculation” is reported in a similar manner to the “Adjusted Carrying Value” above. The columns are in the same order, although it is likely that fewer entries will be needed for Column 4 through Column 7. Further guidance is below.

- **[Inv C Col 1] Entity Required Capital (Immediate Parent Regime)** – This column is included to accommodate participants with either a U.S. or a non-U.S. based Parent company. No entry is required for the Ultimate Controlling Person. In general, entity required capital should represents the capital requirements of the Parent’s insurance or other sectoral regulator:
  
a. For subsidiaries of foreign insurers or other non-U.S. financial entities, the unscaled capital required by the Parent’s regulator of the regulated entity based on the equivalent of a Prescribed Capital Requirement (PCR) level.
  
b. For subsidiaries, including applicable Schedule A and Schedule BA subsidiaries, of U.S. insurance entities that are subject to RBC, except where the subsidiary is also an RBC filer, the entry should be equivalent of what would be required in the Parent’s RBC, adjusted for covariance where applicable (calculated by the preparer) reported at company action level (or two times authorized control level RBC) for that entity. Where the subsidiary is also an RBC filer, then the amount reported will be at company action level RBC (or two times authorized control level RBC) after covariance.
  
c. For subsidiaries of U.S. insurers that do not file RBC, report the actual amount of capital required in the Parent’s capital requirement (if any) for the subsidiary entity.
  
d. In the case where the Parent is not subject to insurance or other sectoral regulatory valuation, then use zero where applicable. This column will include double-counting. The values recorded for all subsidiaries should be the 100% of the specified capital requirements regardless of percentage of ownership by entities within the group. Where entities are owned partially by entities outside of the group, then report the capital requirements of the subsidiary adjusted to reflect total percentage of ownership within the group. A single entry for all entities that qualify under the grouping criteria described in Section V, herein may be made on the line for the affiliate that holds the qualifying entities in lieu of individual entries.

- **[Inv C Col 2] Entity Required Capital (Local Regime)** – Enter required capital for each de-stacked entity, as applicable entity description below. For U.S. RBC filing subsidiaries under a U.S. RBC filing Parent the amounts will be the same in both the Parent and Local Regime columns, except where the RBC filing subsidiary is subject to an operational risk charge. In such cases the amount reported in this column for the subsidiary will include the operational risk charge while the amount reported in Column 1 will exclude the subsidiary’s operational risk charge. However, for some entity types his will result in entries for the entities under a U.S.-based insurance Parent to be different from what U.S. RBC would dictate. In addition, where a U.S. insurer directly or indirectly owns not admitted (or otherwise zero valued) financial affiliates, those affiliates would be reported with zero value in the Parent Regime column but at the specified regulatory value described below for that financial entity type in this column. However, if such an
entity has been listed in [Sch1B Col 2] Include/Exclude (Supervisor) column, indicating that the Lead State Regulator agrees that the entity does not pose material risk, then report the capital calculation in accordance with entity instructions below, but the ultimate calculation will show the results without the excluded entity’s capital calculation. Directly or indirectly owned non-financial entities that were not admitted or otherwise carried at a zero value in the Parent Regime, may be reported at zero value in this column. A single entry for all entities that qualify under the grouping criteria described herein under Input 1, above may be made in the line for the affiliate that holds the qualifying entities in lieu of individual entries. This column will include double-counting. The values recorded for all subsidiaries should be the 100% of the capital requirements regardless of percentage of ownership by entities within the group. Where entities are owned partially by entities outside of the group, then report the capital requirements of the subsidiary adjusted to reflect total percentage of ownership within the group.

63. Additional clarification on capital requirements where a formula is required:

- **U.S. RBC filing Insurers**: Report RBC at Company Action Level including operational risk (200% x ACL)

- **Foreign Insurance Entities**: The local capital requirement as specified below for each jurisdiction should be reported, by legal entity, at a Prescribed Capital Requirement (PCR) level. This treatment is different than what U.S. RBC would require and recognizes other regulators view of adequate capital for insurers within another jurisdiction. It is more reflective of risk within the group context. A sensitivity analysis will be included in the “Sensitivity Analysis” tab using the jurisdictional PCR scaled per the Excess Relative Ratio method (see Appendix 1) for insurers in foreign jurisdictions that are subject to scaling.

- **European Union subsidiaries**: Use the Solvency II Solo Solvency Capital Requirement (SCR) as the PCR.

- **U.S. RBC filing subsidiaries**: The RBC Company Action Level including operational risk of each insurer should be reported.

- **Australia subsidiaries**: The PCR is the target capital as set by the insurer/group in accordance with APRA requirements. Effectively, this would be “Target capital under ICAAP.” PCR is not a set multiple of MCR.

- **Bermuda subsidiaries**: The Legal Entity PCR in Bermuda for medium and large commercial insurers is called the “Enhanced Capital Requirement” (ECR) and is calibrated to Tail VaR at 99% confidence level over a one-year time horizon.

- **Hong Kong subsidiaries**: Under the current rule-based capital regime, if applied similar to the concept of PCR, the regime’s PCR would be 150% of MCR for life insurers and 200% of MCR for non-life insurers.

- **Japan subsidiaries**: The PCR is the solvency margin ratio of 200%.

- **Korea subsidiaries**: The PCR is 100% of risk-based solvency margin ratio.
• **Singapore subsidiaries**: The PCR is 120% of total risk requirement (i.e., capital requirement).

• **China Taipei subsidiaries**: The PCR is 200% of RBC ratio.

• **Canada life entities**: The baseline PCR should be stated to be “100% of the LICAT Base Solvency Buffer.” The carrying value should include surplus allowances and eligible deposits.

• **Canada P/C entities**: The PCR should be the MCT capital requirement at the target level.

• **South Africa subsidiaries**: The PCR is 100% of the SAM SCR.

• For any entities that cannot be mapped to the above categories, scaling will be at 100%

64. **Additional clarification on capital requirements where a U.S. formula (RBC) is not required:**

• For those U.S. insurers that do not have an RBC formula, the minimum capital per state law should be used as the basis for what is used for that insurer in the GCC. This may differ from what U.S. RBC would require. It is more reflective of the regulatory view of risk in the group context. The following requirements should be used in other specified situations where an RBC does not exist:

• **Mortgage Guaranty Insurers**: The minimum capital requirement shall be based on the NAIC’s requirements set forth in the Mortgage Guaranty Insurance Model Act (#630).

• **Financial Guaranty Insurers**: The minimum capital requirement shall be based on the NAIC’s requirements set forth in the Financial Guaranty Insurance Guideline (#1626), specifically considering Section 2B (minimum capital requirements) and Section 3 (Contingency, Loss and Unearned Premium Reserves) and the other requirements of that guideline that impact capital (e.g., specific limits).

• **Title Companies**: The minimum capital requirement shall represent 200% of the required level of reserves carried by the insurance company.

• **Other Companies**: A selected basis for minimum capital requirements derived from a review of state laws. Where there is a one-off treatment of a certain type of insurer that otherwise would file RBC (e.g., HMOs domiciled in California), the minimum capital required by their respective regulator could be considered in lieu of requiring the entity to complete an RBC blank.

• **Captives**: U.S. insurers that have captives should complete the applicable RBC formula regardless of whether the captive is required to complete it in their captive state. The amounts input into RBC by the captive shall be based on the actual assets and liabilities utilized in the regulatory reporting used by the captive. Captives used exclusively for self-insurance (either by U.S. life insurers or any other type of insurer) or insurance provided exclusively to its own employees and/or its affiliates, should not complete an RBC calculation and the entire entity should be treated as non-insurers and receive the same charge as a non-regulated entity.

65. **Non-insurance financial entities subject to a specified regulatory capital requirement:**
• All banks and other depository institutions – The unscaled minimum required by their regulator. For U.S. banks, that is the Office of the Comptroller of the Currency (OCC) Tier 1 or other applicable capital requirement. This is understood to be consistent with how the Federal Reserve Board would apply its Building Block Approach.

• Any other financial entity that is determined to be subject to a specified regulatory capital requirement will bring that requirement in the GCC at the first level of regulator intervention (if applicable).

• This differs from what U.S. RBC would require. It recognizes the sectoral regulator’s view of risk for a particular financial entity type. It is more reflective of risk in the group context.

66. Non-insurance financial entities NOT subject to a specified regulatory capital requirement:

• All asset managers and registered investment advisors and all other financial entities as defined in Section II: Use the capital calculation specified below based the level of risk assigned to the entity by applying the material risk principles defined in Section II. However, asset managers and investment affiliates (not qualifying to be treated as non-financial entities per paragraph 9) will be reported at either medium or high risk. In certain cases, these entities may be subject to a layer of regulation (e.g., SEC or FINRA) but are not generally subject to a specified capital requirement.

   High Risk: 10% x 3-year average revenue

   NOTE: A Basel Charge of 15% will be used for the IAIS ICS.

   Medium Risk: 5.0% x 3-year average revenue.

   Low Risk: 2.5% x 3-year average revenue

   NOTE: Medium risk could be used as a starting point while the stratified methodology is further developed.

67. Other non-insurance, non-financial entities with material risk:

• Non-insurance, non-financial entities may not be as risky as financial entities. For non-insurance, non-financial entities not owned by RBC filers or other such entities where there is not a regulatory capital charge for the entity in the capital formula, use an equity charge of 10.5% (post tax) for predominantly life Insurance Groups 9.5% for predominantly P/C Insurance Groups and 3.5% for predominantly health Insurance Groups x BACV. If the entity is not subject to a capital charge or is included in the capital charge of another financial entity, then enter zero in Column 1 and the charge specified in this paragraph in Column 2. These factors are based on average after covariance RBC charges for the respective insurer types and are calibrated at 200% x ACL RBC. This is meant to be consistent with how the entity would be treated if owned by an RBC filer while recognizing that the entity may be excluded from the GCC if it does not pose material risk to the insurers in the group.

   Non-insurance/non-financial entities owned by RBC filing insurers (or owned by other entities where a regulatory capital charge applied to the non-insurance/non-financial affiliate) will remain in the Parent’s capital charge and reported at that value in Column 1
but will be reported as zero in Column 2. These non-financial entities may not be excluded from the GCC.

One additional informational capital calculation for all non-financial entities will be applied in the Sensitivity Analysis tab using current year gross revenue from Inventory B, Column 12 with the calculation occurring and results available in the “Calc 2” tab as follows: 5% of reporting year gross revenue based on a medium level risk for a financial entity.

68. Non-operating holding companies:

- Non-operating holding companies will be treated the same as other non-insurance/non-financial entities with material risk. Unless reported on a grouped basis (see paragraph 55), for purposes of applying the capital calculation, the carrying value of stand-alone positive valued and negative valued non-operating holding companies will be netted. If the net value is zero or less (floored at zero for purposes of applying a charge), the charge applied will be zero. If the filer chooses to designate the non-operating holding company as a non-insurance/non-financial entity without material risk and requests exclusion, then no allowance for debt issued by that holding company may be included in the calculation.

<table>
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<tr>
<th>Parent Entity</th>
<th>Entity</th>
<th>Inv C, Column 1</th>
<th>Inv C, Column 2</th>
<th>Parent Entity Line Inv C, Column 3</th>
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<td>RBC ACL (incl. op risk) x 2</td>
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<td>Jurisdictional or Sectoral PCR Level Capital Reqmt</td>
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<td>Per Local Capital Reqmt</td>
<td>Jurisdictional or Sectoral PCR Level Per Local Capital</td>
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Capital Calculation Adjustments

- **[Inv C Col 3] Investment in Subsidiary** – Enter an adjustment to remove the required capital of the directly owned subsidiary(ies) from Parent’s required capital. The capital requirement to be removed should be the capital requirement carried by the Parent from which the entity is being de-stacked (i.e., the value reported in Column 1 in Inventory C adjusted for ownership percentage). Thus, there will be no adjustment to the Parent’s value in this column for entities that are reported at a capital calculation of zero value by the parent. This is intended to prevent double counting required capital when regulated entities are stacked. [Example: When de-stacking an RBC filer from another RBC filer, the amount entered on the Parent line would be the RBC of the subsidiary. When de-stacking financial entities that are subject to diversification in a capital formula (e.g., RBC) the amount entered on the Parent line is the post-diversified capital requirement as calculated by the preparer (which is also the amount to be reported for the de-stacked entity on the entity’s line).

Generally the capital requirements for Schedule A and BA affiliates and other non-financial affiliates will remain in the capital requirements of the Parent insurer and not entered in this column, except that the capital requirements for any financial entity reported in a Parent’s Schedule A and BA, any financial entity indirectly owned through another Schedule A or BA affiliate listed in Schedule 1 and in this section should be entered in this column in the row of the entity that directly or indirectly owns that Schedule A and BA affiliate so that the parent entity may eliminate double counting of that capital requirement capital which will now be reported by the stand-alone Schedule A or BA affiliate listed in the inventory.

For indirectly owned Schedule A and BA financial entities, only the capital requirements for that entity will be included in this column and the remaining capital requirement of the downstream BA Parent will remain with the Parent insurer. Similarly, the capital requirement for any U.S. Branch of a foreign insurer that is listed in Schedule 1 and in this section should be entered in this column in the row of the foreign insurer if it is already included in the capital requirement of the foreign insurer so that the parent entity may eliminate double counting of that capital requirement which will now be reported by the stand-alone Branch listed in the inventory. The amounts entered in this column for a Parent must correspond to the capital required by the parent entity which is being de-stacked from that Parent.

Capital calculations for Schedule A and Schedule BA indirectly owned financial entities that are owned by Schedule A or Schedule BA assets are reported in the Inventory Tab and will be adjusted out of the value reported by the U.S. insurer in this column (since the non-financial direct parent Schedule A or BA affiliate is not listed in the Inventory Tab.

In the “Questions and Other Information” tab, a capital requirement should be reported for the value of the indirectly owned insurance of other financial entity based on the insurers Schedule A or Schedule BA charge rather than a charge (which would be zero) attributable to the Schedule A or Schedule BA entity that directly owns the insurance or other financial entity. As indicated earlier, the remaining capital requirement of the entity that directly owns the insurance or other financial entity will remain with the Parent insurer.

- **[Inv C Col 4] Intragroup Capital Instruments** – This column would generally be used if there is potential double-counting of capital requirements (e.g., RBC charges on surplus notes purchased by an affiliated U.S. insurer from a U.S. insurer issuer).
• **[Inv C Col 5] Reported Intragroup Guarantees, LOCs and Other** – This column would generally be used if there is potential double-counting of capital requirements (e.g., RBC charges on guarantees or LOCs).

• **[Inv C Col 6] Other Intragroup Assets** – This column is not intended to be used for required capital but is included in case an entity believes it is necessary from reporting an inaccurate required capital figure.
  
  a. Loans, receivables and arrangements to centralize the management of assets or cash.
  b. Derivative transactions.
  c. Purchase, sale or lease of assets.
  d. Other (describe in “Questions and Other Information” tab).

• **[Inv C Col 7] All Other Adjustments** – Include a brief explanation in the “Description of ‘Other Adjustments’” in the “Questions and Other Information” tab. Use this column is for adjustments related to required capital that correspond to adjustments in Inventory B, Column 7 and in cases where an entity believes it is necessary to adjust an inaccurate regulatory required capital figure (e.g., the RBC calculation applied as a permitted practice).

  **NOTE:** Consider whether this column should be used rather than Column 2 for zero value entities.

• **[Inv C Col 8] Adjusted Capital Calculation** – Stand-alone capital calculation for each entity per the calculation to eliminate double-counting. This value includes the impact of permitted and prescribed practices.

• Inventory D is for “Reference Calculations Checks.” These are calculations that can serve as checks on the reasonability/consistency of entries.

  a. **[Inv D Col 1 – 3] Sum of Subsidiaries (Carrying Value)** – This automatically generated column calculates the value of the carrying value of the underlying subsidiaries. It is provided for reference when filling out the “Investment in Subsidiary” column. This sum will often, but not always, be equal to the “Investment in Subsidiary” column.

  b. **[Inv D Col 4 – 6] Sum of Subsidiaries (Calculated Capital)** – Similar to above but for calculated capital.

  c. **[Inv D Col 7 – 8] Carrying Value/Adj Calc Cap** – This is a capital ratio on the adjusted and unadjusted figures. Double-check entities with abnormally large/small/negative figures to make sure that adjustments were done correctly.

**Input 3 – Capital Instruments**

69. Provide all relevant information pertaining to paid-up (i.e., any receivables for non-paid-in amounts would not be included for purposes of calculating the allowance) financial instruments issued by the Group (including senior debt issued by a holding company), except for common or ordinary shares and preferred shares. This worksheet aims to capture all financial instruments such as surplus notes, senior debt, hybrid instruments and other subordinated debt. Where a Volunteer Group has issued multiple instruments, the Volunteer Group should not use a single
row to report that information; one instrument per row should be reported (multiple instruments
issued under the same terms may be combined on a single line). All qualifying debt should be
reported as follows.

70. Debt issued by U.S.-led groups:

- Surplus Notes – Report the outstanding value of all surplus notes in Column 8 whether
  issued to purchasers within or outside the group. The outstanding value of surplus notes
  issued to entities outside the group and that is already recognized by state insurance
  regulators and reported 100% as capital in the carrying value of U.S. insurer issuers in
  “Inventory B” will not be included in the calculation for an additional capital allowance.
  Surplus notes issued within the group generally result in double-counting and will not be
  included in the additional capital allowance. (See instructions below.)

- Subordinated Senior Debt and Hybrid Debt Issued (e.g., debt issuances that receive an
  amount of equity credit from rating agencies) – The outstanding value will be reported in
  Column 8. Recognition for structurally subordinated debt will be allowed to increase
  available capital. For purposes of qualifying for recognition as additional capital, both of
  the following criteria must be met:
    a. The instrument has a fixed term (a minimum of five years at the date of issue or
       refinance, including any call options other than make whole provisions\(^1\). However,
       if the instrument is callable within the first five years from the date of issue it may be
       considered qualifying debt if any such call is at the option of the issuer only (the
       instrument is not retractable by the holder) AND it is the intent of management to
       replace the called instrument in full before or at redemption by a new issuance of the
       same or higher quality instrument.
    b. Supervisory review or approval is required for any ordinary* or extraordinary
       dividend respectively or distribution from any insurance subsidiary to fund the
       repurchase or redemption of the instrument. Supervisory approval of ordinary
       dividends is met if the supervisor has in place direct or indirect supervisory controls
       over distributions, including the ability for the supervisor to limit, defer and/or
       disallow the payment of any distributions should it find that the insurer is presently,
       or may potentially become, financially distressed. There shall be no expectation,
       either implied or through the terms of the instrument, that such approval will be
       granted without supervisory review.

*The concept of approval for ordinary dividends is for GCC purposes and is met as described
in subparagraph b, above. It is not intended to require explicit regulatory approval or in any
way alter current provisions of Model #440 or the Insurance Holding Company System Model
Regulation (#450).

- “Other” Debt – The outstanding value will be reported in Column 8 and will be further
  described in the “Other Information” tab and will be reported in a manner that is

\(^1\) NAIC staff have been informed that make whole provisions are a form of a call feature that can be exercised by the issuer
at any time; that they nonetheless are most frequently utilized near the end of the term of the instrument, generally in
connection with refinancing; and that the cost to the issuer to exercise the make whole provision and associated financial
reporting impacts, combined with the very low interest rate environment, make it much less likely that such provisions will
be triggered, particularly within five years of issuance. Staff will continue their research, and assuming these observations
are confirmed, the referenced criteria will continue to scope out make whole provisions.
consistent with Senior Subordinated Debt, as described above. Such debt will not initially be included in the additional capital allowance for the GCC. An additional allowance of this debt as additional capital will be calculated in this tab and reported as a sensitivity analysis in the “Summary” 2 tab, subject to future determination on whether it will become part of the GCC calculation.

- **Foreign Debt** – Report the outstanding value of Non-U.S. senior debt issued to entities outside the group in Column 8. Debt specifically recognized by statute, regulation or accounting rule as additional capital resources by the lead jurisdiction based on contractual subordination or where a regulatory regime proactively enforces structural subordination through appropriate regulatory/supervisory controls over distributions from insurers in the group will not be included in the calculation of an additional capital allowance if it is already reported as capital in the carrying value of the issuer in “Inventory B”. It will be included in the calculation of an additional capital allowance if recognized by the local jurisdiction and NOT already included in the value of the issuer in “Inventory B”. Cases where the value of debt instruments issued to purchasers outside the group has not been recognized by the legal entity’s insurance or other sectoral supervisor will not be included in the additional capital allowance.

71. Please fill in columns in Section 3A as follows for all capital instruments:

- **[Sec 3A Col 1] Name of Issuer** – Name of the company that issued the capital financial instrument. Will populate automatically from the “Entity Identifier” column in this subsection.

- **[Sec 3A Col 2] Entity Identifier** – Provide the reference number that was input in Schedule 1.

- **[Sec 3A Col 3] Type of Financial Instrument** – Select type from the drop-down menu. Selections include Senior Debt, Surplus Notes (or similar), Hybrid Instruments and “Other” Subordinated Debt.

- **[Sec 3A Col 4] Instrument Identifier** – Provide a unique security identifier (such as CUSIP). ALL debt instruments must include an internal identifier if not external identifier is available.

- **[Sec 3A Col 5] Entity Category** – Links automatically to selection made on the “Inventory” tab worksheet.

- **[Sec 3A Col 6] Year of Issue** – Provide the year in which the financial instrument was issued or refinanced.

- **[Sec 3A Col 7] Year of Maturity** – Enter the year in which the financial instrument will mature.

- **[Sec 3A Col 8] Balance as of Reporting Date** – Enter the principal balance outstanding as reported in the general-purpose financial statements of the issuer.
• **[Sec 3A Col 9] Intragroup Issuance** – Select whether the instrument was issued on an intragroup basis (that is, issued to a related entity within the group). This column will be used to remove “double-counting.” This column is a drop-down menu box with options “Y” and “N.”

• **[Sec 3A Col 10] Treatment in Inventory B** – Select option that applies:

  a. **Capital** – This instrument is recognized by the applicable regulator or credited as capital in local regulatory regime and reported as part of the adjusted carrying value of the issuer and was not purchased by an affiliate. This includes the value of qualifying senior and hybrid debt instruments (if recognized as capital) and U.S. surplus notes (or similar local regime instruments) that are issued to entities outside the group and included in the issuing entity’s value in the “Inventory B” tab. The outstanding value of those debt instruments will not be included in the calculation of a proxy allowance for additional capital.

  b. **Liability** – This instrument is reflected by the issuer as a liability in the adjusted carrying value in the “Inventory B” tab and was not purchased by an affiliate. This would apply to all qualifying senior and hybrid debt issued to purchasers outside the group that is not recognized as capital by the local regulator and therefore is not included in the issuing entity’s value in the “Inventory B” tab. The value will be included in the calculation of a proxy allowance for additional capital.

  c. **Liability designation** would also apply to all non-qualifying senior and hybrid instruments and all debt categorized as “Other” issued to purchasers outside the group that is not recognized as capital by the local regulator. The value of these instruments will NOT be included the calculation for the in the calculation of a proxy allowance for additional capital.

  d. **Intragroup** – This would apply to all qualifying instruments purchased by an affiliate within the group. The outstanding value of those debt instruments will not be included in the calculation of a proxy allowance for additional capital. If the financial instrument is recognized or credited as part of the issuer’s available capital in Inventory B, then an adjustment for intragroup capital instruments is made in Inventory B, Column 4 and Inventory C adjustments (if necessary to eliminate an associated capital requirement). If the financial instrument is treated as a liability by the issuer, then no intragroup capital instrument adjustment is required in Inventory B or Inventory C.

  e. The outstanding value of all non-qualifying senior and hybrid instruments and financial instruments categorized as “Other Debt” whether issued to purchasers inside or outside the group will not be included in the calculation of a proxy allowance for additional capital and no other adjustments are required in the template. However, in the unlikely event that the instrument is treated as available capital to the issuer in Inventory B, an adjustment in Inventory B, Column 4 to remove the available capital would be required.

**NOTE**: Additional information on instruments categorized as “Other Debt” in the Type of Financial Instrument Column will require additional information to be provided in the “Questions and Other Information” tab.
For intragroup surplus notes, the adjustment will impact the carrying value and associated capital calculation of the purchasing affiliated entity.

- **[Sec 3A Col 11] Intragroup Purchaser Identifier** – Enter the entity identify for the affiliate entity that purchased the instrument.

- **[Sec 3A Col 12] Description of Other Debt Instruments** – Provide a description of instruments designated as “Other.”

- **[Sec 3A Col 13] Call Provisions Criteria** – Respond “Y” or “N” as to whether the instrument is subject to a call provision (other than a make whole provision) in the first five years AND it is management’s intent to replace the called instrument in full before or at redemption by a new issuance of the same or higher quality instrument. Respond “X” if the instrument has a maturity of greater than five years including any call provisions.

- **[Sec 3A Col 14] Potentially Recognized Instrument** – This is an automatic calculation to determine if this instrument has potential to be recognized as additional capital in the GCC and/or in sensitivity analysis. The column will show “Y” if each of the following is true: 1) it is Senior Debt, Hybrid or Other instrument; 2) the instrument is not intragroup; and 3) the instrument is treated as liability on Inventory B. These are calculated using Column 3, Column 9, and Column 10, respectively.

- **[Sec 3A Col 15] Other Criteria Met** – This is an automatic calculation to determine if instrument qualifies due to criteria beyond those in Column 14. The column will show “Y” if: 1) the instrument has initial maturity of greater than five years including any call provision (i.e., “X” is reported in Column 13); and 2) it meets the “Call provisions criteria” in Column 13 (i.e., “Y” is reported in Column 13).

- **[Sec 3A Col 16] Qualified Debt** – This column is calculated automatically using data from the entries in Column 14 and Column 15. To qualify, an instrument needs a “Y” in both columns. It represents the amount of qualifying debt that will be used in the calculation of an allowance for addition capital under the alternate subordination method and the proxy allowance method. This amount will be carried into Section 3C, Column 1, Line 3.

72. Section 3C will be auto-filled, with the exception of Column 1, Line 2.

- **[Sec 3C Col 1, Line 1] Total Paid-In and Contributed Capital and Surplus** – This is the amount reported on Page 3 of the annual financial statement submitted to regulators by a U.S. insurer.

- **[Sec 3C Col 1, Line 2] Alternate Subordination Calculation** – This manual entry is the excess of qualifying debt issued over liquid assets held by the issuing consolidated holding company as reported in the consolidated financial statements. No entry is expected for a mutual group.

- **[Sec 3C Col 1, Line 4] Downstream Estimate** - The total reported under the alternate subordination approach will be compared to the total amount of gross paid-in or contributed capital and surplus reported by the insurance entities within the group as
reported in Schedule 1. The greater value will be carried into the calculation for an additional capital allowance.

**NOTE:** No more than 100% of the total outstanding value of qualified senior and hybrid debt will be allowed into the calculation.

- **[Sec 3C Col 1, Line 5] Proxy Calculation for Additional Capital Allowance** – A calculation will be made in this tab in Section 3B that will apply 30% of available capital plus the value of all qualifying debt to become part of the proxy allowance for additional capital for qualifying senior subordinated. An additional amount of 15% of available capital plus the value of all qualifying debt will be calculated to become part of a proxy allowance for additional capital be for hybrid debt.

  **Summary Formula:** Proxy Amount = (30% x (Available Capital + Qualifying Senior and Hybrid Debt)) + (15% x (Available Capital + Qualifying Senior and Hybrid Debt)).

  **NOTE:** No more than 100% of the total outstanding value of qualified senior and hybrid debt will be allowed into the calculation.

- **[Sec 3C Col 1, Line 6 through Line 8]** – The greater of the proxy calculation or the larger of paid in capital or alternate subordination calculation will be allowed as additional capital in **[Sec 3C Col 6]**. However, an overall limit of no more than 75% of the total adjusted carrying value in Inventory B will be applied in **[Sec 3C Col 7]**. Adjustments to increase available capital will be calculated from data on this page. The summary results of the components of the calculation (paid in capital and surplus, alternate subordination, proxy calculation and limitations) are populated as titled in the calculation columns in this section. The final amount recognized as additional capital is shown in **[Sec 3C Col 8]**.

  - The additional capital allowance recognized for capital instruments will be shown as an “on-top” adjustment in the “Summary 1 – Entity Level” tab.

**Summary Calculation for Debt Allowed as Additional Capital:**

Step 1: Calculate the following amounts:
- a) The greater of Total paid-in capital and surplus of U.S. insurers or the alternative subordination calculation (defined above)
- b) A proxy value (defined above)

Step 2: Take the greater of a) or b) from Step 1, and subject that amount to two limitations:
- First, the total amount to qualify as capital cannot exceed 100% of the total outstanding value of qualified senior and hybrid debt.
- Second, the total amount to qualify as capital cannot exceed 75% of the total adjusted carrying value in Inventory B.

After applying the two limitations in Step 2, the remaining amount is allowed as additional capital.
73. **Informational calculation to include “Other Subordinated Debt”** – A sensitivity analysis will be applied in [Sec 3C Col 2, Line 1 through Line 8] and carried into the “Summary 2” tab to adjust the amount of additional capital in the proxy calculation by the amount of “Other Debt” reported in [Sec 3C Col 8] issued to purchasers outside the group. This informational sensitivity analysis will include an additional allowance for such debt up to 15% of available capital plus the value of all qualifying debt including qualifying “Other” debt subject to the same limitations noted for the proxy allowance in general.

**Input 4 – Analytics**

74. The entity type information supporting analytics summarized in Summary 3 – Analytics are pulled into this tab from data or information reported in other tabs in the GCC template. That data is exported into summaries in the “Summary 3 – Analytics” tab. Only 2020 data is currently to be populated. However, it is contemplated that going forward, data for prior years will also be populated such that it will provide the Lead State Regulator with metrics to identify trends over time.

**Input 5 – Sensitivity Analysis and Inputs**

75. All sensitivity analysis is ultimately calculated in the “Summary 2” tab. Inputs for Analysis 1, 2, 5, 6, and 7 are not required in this tab. They are populated from other tabs as described below and automatically calculated in the “Summary 2” tab. However certain analysis requires inputs from this tab. Inputs are required in this tab for Analysis 3, Analysis 4, Analysis 8, and Analysis 9. Those inputs are automatically pulled into the calculation in the Summary 2 tab. Sensitivity Analysis are intended to provide the Lead State Regulator additional information that helps them better understand the financial condition of the group. Similar to the sensitivity analysis included in the legal entity RBC, it provides the regulator with additional information and allows them to consider “what-if” scenarios to better understand the impact of such items. The results of these analysis will not impact the GCC ratio.

- **[Analysis 1]: GCC overall sensitivity analysis** – No additional data is needed in the tab. The overall GCC ratio will be presented at 300% x ACL level. This calculation will increase the calculated capital for most entity types by a factor of 1.5. However, entities with existing regulatory capital requirements (e.g., foreign insurers and banks) will be reported at the same level specified in these instructions for both the GCC and the sensitivity analysis (i.e., at 100% of the jurisdictional or sectoral PCR requirements).

- **[Analysis 2]: Excluded non-insurance/non-financial entities without material risk** – No additional data is needed in the tab. The data for entities where exclusion has been requested and the lead state does not agree will be populated based on entries in [Sch 1B Col 3] and data in Inventory B, Column 2 and Inventory C, Column 2. This analysis will be applied and reported in the “Summary 2” tab. It will provide the regulator with the impact of excluding non-agreed-upon entities on the GCC ratio.

- **[Analysis 3 and Analysis 4]: Permitted practices** – This information shows the amount of U.S. permitted practices as described in the Preamble of the *Accounting Practices and
Procedures Manual and the sensitivity analysis allows the state to understand the size of the practices related to the overall group capital position and their impact on the GCC ratio.

- **Prescribed Practices** – This information to be entered on this tab shows the amount of U.S. prescribed and prescribed practices as described in the Preamble of the Accounting Practices and Procedures Manual and the sensitivity analysis allows the state to understand the size of the practices related to the overall group capital position and their impact on the GCC ratio. This analysis will be applied and reported in the “Summary 2” tab.

- **Permitted and Prescribed Practices** – Report values from annual financial statement Note 1 (excluding those pertaining to XXX/AXXX captives):
  a. Entity identifier
  b. Value of permitted practice
  c. Capital Requirement attributable to permitted practice (if any)
  d. Description of permitted practice
  e. Value of prescribed practice
  f. Capital requirement attributable to permitted practice (if any)
  g. Description of prescribed practice

- **[Analysis 5]: Foreign Insurer Capital Requirements Scaled** – No additional data is needed in the tab. This information shows the amount of foreign insurer capital calculations scaled by applying scalars using the Excess Relative Ratio approach at a 200% x ACL RBC calibration level and at 300% x ACL for all non-U.S. jurisdictions where scalar data is available (see Appendix 1). The sensitivity analysis allows the state to understand the impact of this specific scaling method on the GCC ratio. This information is populated from the “Scalar” tab. This analysis will be applied and reported in the “Summary 2” tab.

- **[Analysis 6]: Debt Classified as “Other”** – No additional data is needed in the tab. The analysis data will be populated from the “Capital Instruments” tab and the analysis and will be applied and reported in the “Summary 2” tab.

- **[Analysis 7]: Alternative Capital Calculation for Non-Financial Entities** – No additional data is needed in the tab. The values reported will represent the alternative revenue-based values for capital calculation that is being captured in the template. The data will be populated from Schedule 1 and Inventory B and the analysis will be applied and reported in the “Scaling Non-Insurance” tab (Calc 2).

- **[Analysis 8]** For captives other than XXX/AXXX, all other U.S. captives shall make an asset adjustment as described below;
Asset Impact

76. For the asset impact, it is ONLY required for the assets included in a captive or an entity not required to follow the statutory accounting guidance in the Accounting Practices and Procedures Manual. It is not required for assets for those groups that retain such business in a non-captive traditional insurance company(ies) already required to follow the Accounting Practices and Procedures Manual.

NOTE: Variations for state prescribed and permitted practices are captured in the separate sensitivity analysis.

77. The asset impact amount shall be determined based on a valuation that is equivalent to what is required by the Accounting Practices and Procedures Manual (SAP). For this purpose, “equivalent” means that, at a minimum the listed adjustments (as follows) be made with the intent of deriving a valuation materially equivalent to what is required by the Accounting Practices and Procedures Manual, however, without requiring adjustments that are overly burdensome (e.g., mark-to market bonds used by some captives under U.S. GAAP versus full SAP that considers NAIC designations). To be more specific, the asset impact shall be developed by accumulating the impact on surplus because of an accumulation of all the following in paragraph 78 and paragraph 79 combined.

NOTE: Letters of credit or other financial instruments that operate in a manner like a letter of credit, which are not designated as an asset under either SAP or U.S. GAAP and are required to be adjusted out of the available assets (i.e., the asset reduction is recorded as a negative figure in the template).

78. To achieve the above, accumulate the effect of making the following impact and record as a negative figure in the template, an asset adjustment for all the following explicit assets not allowed to be admitted under SAP:

- Assets specifically not allowed under the Accounting Practices and Procedures Manual in accordance with paragraph 9 of SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities.
- SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due from Agents and Brokers.
- SSAP No. 16R—Electronic Data Processing Equipment and Software.
- SSAP No. 19—Furniture, Fixtures, Equipment and Leasehold Improvements.
- SSAP No. 20—Nonadmitted Assets.
- SSAP No. 21—Other Admitted Assets (e.g., collateral loans secured by assets that do not qualify as investments are nonadmitted under SAP).
- SSAP No. 29—Prepaid Expenses.
- Expense costs that are capitalized in accordance with GAAP but are expensed pursuant to statutory accounting as promulgated by the NAIC in the Accounting Practices and Procedures Manual (e.g., deferred policy acquisition costs, pre-operating, development and research costs, etc.).
Depreciation for certain assets in accordance with the following SSAPs:
  o SSAP No. 16R—Electronic Data Processing Equipment and Software.
  o SSAP No. 19—Furniture, Fixtures, Equipment and Leasehold Improvements.
  o SSAP No. 68—Business Combinations and Goodwill.

- The amount of goodwill of the SCA more than 10% of the audited U.S. GAAP equity of the SCA’s last audited financial statements.
- The amount of the net deferred tax assets (DTAs) of the SCA more than 10% of the audited U.S. GAAP equity of the SCA’s last audited financial statements.
- Any surplus notes held by the SCA issued by the reporting entity.

79. In addition, record as a negative figure, an asset impact for any assets that are not recognized as an admitted asset under the principles of SSAP No. 4—Assets and Nonadmitted Assets, including:

- Letters of credit, or other similar instruments, that operate in a manner like a letter of credit and, therefore, do not meet the definition of “asset” as required under paragraph 2.
- Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets that are unavailable due to encumbrances or other third-party interests, should not be recognized on the balance sheet and are, therefore, considered nonadmitted.
- Assets of an insurance entity pledged or otherwise restricted by the action of a related party, the assets are not under the exclusive control of the insurance entity and are not available to satisfy policyholder obligations due to these encumbrances or other third-party interests. Thus, such assets shall not be recognized as an admitted asset on the balance sheet.

[Analysis 9]: Other Regulator Discretion – This analysis is designed to reflect other regulator adjustments including for transactions other than XXX/AXXX reinsurance where there are differences in regulatory regimes exist and there is a desire to fully reflect U.S. Statutory Accounting treatment or to reflect the lead state’s view of risk posed by financial entities without specified regulatory capital requirements or risk posed by non-insurance/non-financial entities that have been included in the GCC. This will be a post-submission item completed by the Lead State Regulator. Enter the following information here:

a. Entity identifier.
b. Amount of adjustment.
c. Description of regulatory issue.

NOTE: This column may also be completed by the filer after advance consultation with the Lead State Regulator.
Input 6 – Questions and Other Information

80. This tab provides space for participants to describe or provide greater detail for specified entries in other tabs (as noted in the instructions for the columns in those tabs) or additional relevant information not captured in the template. Examples include; adjustments for intragroup debt, description of permitted practices; and adjustments to available capital or capital calculations that are included in the “other adjustment” column in the “Inventory” tab. Specified items are included in the tab. Other information that the filer believes is relevant should be added freeform in this tab.

Information or Detail for Items Not Captured in the Template

- Intercompany Guarantees – Provide requested information:
  a. Entity identifier issuing the guarantee.
  b. Entity identifier of entity or entities that are covered by the guarantee.
  c. Indicate the notional or fixed value of the guarantee.
  d. Describe the nature of the guarantee.

- Capital Maintenance Agreements – Provide requested information:
  a. Entity identifier obligated under the agreement.
  b. Entity identifier for entity or entities that are covered by the guarantee.
  c. Indicate the notional or fixed value of the agreement.
  d. Describe the nature of the agreement.

- Value of intangible assets included in non-insurance Holding Companies – Provide the requested information for all entities designated in the non-operating holding company entity category.
  a. Entity identifier.
  b. All goodwill.
  c. All intangibles related to health care services acquisitions included in local carrying value column in Inventory B. Examples include, but are not limited to, customer relationships (policy retention, long-term health services contracts) and technology/patents/trade names and provider network contracts.
  d. All other intangible assets included in local carrying value column in Inventory B.
  e. Total of line b, line c and line d.*
  f. A description of each intangible asset included in line d.
  
* Auto populated.

Further detail on amounts reported for specific intangibles other than goodwill may be requested by the Lead State Regulator during review of the GCC template.

Information or Detail for Items Captured in the Template

- Currency Adjustments – Provide requested information only for entities where the amount reported for an entity in Inventory B, Column 2 is different than the amount in Inventory B, Column 1 due to currency conversion.
a. Entity identifier.
b. Currency type reported in Inventory B, Column 1 and Inventory C, Column 1 (foreign currency).
c. Conversion rate applied.
d. Source of conversion rate applied.

- Intragroup Assets – Description of Adjustments for intragroup assets reported in Inventory B, Column 6 and Inventory C, Column 6. Provide the following information:
  a. Entity identifier.
  b. Amount reported in Inventory B, Column 6.
  c. Description of adjustment.

- Other Adjustments – Description of adjustments reported in Inventory B, Column 7 and Inventory C, Column 7. Provide the following information:
  a. Entity identifier.
  b. Amount reported in Inventory B, Column 7.
  c. Description of adjustment.

- Accounting Adjustments – Provide requested information only for entities where the amount reported for an entity in Inventory B, Column 1 is different than the amount in Inventory B, Column 2 due to differences in accounting basis
  a. Entity identifier.
  b. Value reported in Inventory B, Column 1.*
  c. Value reported in Inventory B, Column 2.*
  d. Total amount of adjustments related to difference in accounting basis.*
  e. Nature of adjustment (e.g., GAAP to SAP).
  * Auto populated.

- Stress Scenario Narrative – If the participating group believes that the standard stress scenario represents a reasonable adverse scenario, they can state so in the narrative and no further work is required. However, to further inform the GCC and lead state regulators and to enhance the value of the Trial, participating groups may provide a high-level description of the anticipated market conditions or other reasonably likely group-specific drivers that would lead to the group’s own specified level of stress results (i.e., the group specific potential adjustments to available capital and calculated capital) with focus on the impact on the debt allowance. These are independent assumptions from those automatically calculated in the Stress inputs tab (as described in the Stress Inputs section and in Appendix 2). The group assumed percentage adjustment may or may not align with the standardized thirty percent in general or any entity specific adjustments calculated in the Stress Summary tab. In addition, provide any comments relating to the potential for procyclical or otherwise unintended GCC ratio results in specific areas of the calculation.

- The tab also includes a listing of all Schedule A and Schedule BA affiliates, along with the following information:
a. Parent identifier (if available) – This is the same information as is included in Schedule 1 [Sch 1B Col 3] as would be entered for non-Schedule A/Schedule BA affiliates.

b. Parent Name – Enter the Name of the Parent.

c. Is Parent a Schedule A or Schedule BA Asset? – This column is only required for financial entities that are Directly owned by a Schedule A or Schedule BA Affiliate. No other downstream affiliates owned by Schedule A or Schedule BA entities need to be listed. These entities are not normally independently reported in Schedule A and Schedule BA so are extra entries.

d. Financial? (Y/N) – If the entity meets the criteria as being a financial entity, indicate with a “Yes” response. A “No” response is not required for other entities listed. “Yes” entries should correspond to “Yes” entries in Schedule 1 [Sch 1B Col 16].

e. Carrying Value of Immediate Parent – Report the value listed in Schedule A and Schedule BA of the Parent insurer. For those cases where an indirect financial entity is reported use the value used by the direct Parent.

f. Capital Requirement for Immediate Parent – Report the value listed in the RBC report of the Parent insurer (pre-tax where applicable). For those cases where an indirect financial entity is listed, report the value of the capital requirement attributable to the Insurer rather than the direct non-financial Schedule BA Parent. The capital requirement reported in this column for the immediate Schedule BA Parent should be adjusted to deduct the amount moved to Schedule 1 and Inventory C.

Calc 1 – Scaling (Insurance Entities)

81. All entries in this tab are calculation cells populated using data from within the tab or using data from elsewhere in the template. Scaled values for calculated capital will become part of the GCC ratio. The calculated values will be summarized by entity type in the “Summary 1 – Entity Level” tab. The concept of a scalar was first introduced to address the issue of comparability of accounting systems and capital requirements between insurance regulatory jurisdictions. The idea is to scale capital requirements imposed on non-U.S. insurers so as to be comparable to an RBC-based requirement. Two approaches for scaling related to foreign insurers were presented, and others are being explored and will be reviewed. A decision on the scaling methodology to be adopted into the GCC template will be made at the end of the review. In the interim a scalar of 100% of the jurisdictional PCR will be applied to all jurisdictions where a risk-sensitive capital requirement is in place.

82. Information on the Excess Relative Ratio (ERR) scalar methodology will be collected and applied in the “Sensitivity Analysis” tab.

NOTE: See Appendix 1 for more information and examples on how the ERR scalars are calculated.

83. For jurisdictions without risk-sensitive capital requirements a 100% charge will be applied to adjusted carrying value.
Calc 2 – Capital Calculations for Non-insurance Entities

84. All entries in this tab are either calculation cells using data from within the tab or using data populated from elsewhere in the template. Calculated capital for all entities except insurers will be reported in this tab. The calculated values will be summarized by entity type in the “Summary 1 – Entity Level” tab.

85. In addition, one informational option for calculated capital for financial entities without an existing regulatory capital requirement and one informational option for calculated capital for non-financial entities will be reported in this tab. Those calculation will not be carried into the “Summary 1 – Entity Level” tab and will not be part of the GCC ratio.

86. Only amounts for entities that the filer and the Lead State Regulator agree should not be excluded [Sch 1B Col 2] will be brought into the calculation in this tab and the “Summary 1 – Entity Level” tab. Entities where the Lead State Regulator does not agree with the filer’s request to exclude an entity will be part of the GCC ratio.

Summary 1 – Entity Level GCC Summary

87. Summarized results by entity type for the GCC ratio will be reported in this tab. An on top adjustment for debt allowed as additional capital will be added at the bottom of the table. All informational sensitivity analysis will be reported in Summary 2 and will not impact the GCC ratio.

Summary 2 – Informational Sensitivity Tests

88. Summary results for each informational sensitivity analysis described in the “Sensitivity Analysis Inputs” tab will be shown here. Each sensitivity analysis will be shown on a stand-alone basis. It is expected that each informational sensitivity analysis will run automatically in the background and the results for each displayed in this tab. The results for the informational sensitivity analysis will not be included in the “Summary 1 – Entity Level” tab.

Summary 3 – Analytics

89. Summary results for metrics described in the Analytics Guidance [insert attachment or appendix reference] and utilizing data collected in the “Input 4 – Analytics” tab or other tabs in the GCC will be calculated and presented here.

Summary 4 – Alternative Grouping Option(s)

90. One sample alternative structure for grouping by entity type or jurisdiction in the GCC is displayed based on a suggested method. It can be modified, or other suggestions can be accommodated based on combining data from Schedule 1 and the Inventory in defined ways.
This tab is intended to be an additional analytical tool. The tool summarizes the GCC based on how a reporting entity views its organization, and provides regulators that view, to align it with regulatory information, other than what is reported elsewhere in the GCC template, that the reporting entity has submitted such as current filings, communications, etc. In this summary view, entities are organized into like regimes (e.g., RBC filers, foreign insurers, banks, financial, or non-financial entities) and multiple entities may be grouped together, in order to create a view of capital that is easy to review and analyze within each grouping. The intent of this approach is to provide an additional analytical tool designed to enhance dialogue between the Lead State Regulator and the company contemplated by the GCC filing. This view is transparent (no scalers, no adjustments, no de-stacking) so that financial information may be cross-walked to other financial submissions such as RBC filings. However, it does contain double counting of available and required capital “(i.e., intra-company investments and transactions are not eliminated) and cannot be used to create a GCC ratio.

91. The results are dependent on how the reporting entity populated. Input 1 – Schedule 1, Column 9 Alternative Grouping. For example, if you have a dozen small dental HMO businesses, you may wish to collapse the results to a single line called “Dental HMOs,” by populating Input 1 – Schedule 1, Column 9 Alternative Grouping for each dental HMO as “Dental HMOs.” Then right-click and select “Refresh” to see the results with the “Dental HMOs” combined.

92. For reference, the data for the Summary 4 – Grouping Alternative is from Calc 1 – Scaling (Ins, Bank), which is fed by the inputs made in Input 1 – Schedule 1, Input 2 – Inventory, etc.

**Stress Inputs**

93. All entries in this tab (Columns D thru W) are either calculation cells using data from within the tab or using data populated from elsewhere in the template in a standardized approach. Available capital and calculated capital for all entities using the standardized stress level of 30% will be reported in this tab. The calculated values will be summarized in the “Stress Summary” tab.

93-94. The filer may use the available Company Input section in the tab (Columns Y thru AH) that allows data entry in order to apply the standardized 30% stress level to additional entity categories not adjusted in the standardized approach (e.g., foreign insurers subject to scalars in the sensitivity analysis). If utilized, the additional adjustments are considered the group’s view on enhancements to the standardized approach. As with the standardized stress scenario generally, these are independent of the text narrative included in the Input 6 tab. Completion of these columns is not required and would be used for review purposes. The inputted values will be summarized in the “Stress Summary tab.

**NOTE:** This tab is not required for groups that are not including an allowance for qualifying debt as additional capital. However, automated entries will appear in the tab as currently constructed.
94.54. Separate from this standardized stress scenario, a text narrative describing the group’s own assumptions on potential stress drivers should be included in the Input 6 tab as specified in the instructions for the Input 6 tab.

**NOTE:** Also see Appendix 2 for more detail related to the Stress inputs and separate narrative.

**Stress Summary**

96. Summarized results by entity type will be reported in this tab.
Appendix 1 – Explanation of Scalars

95.97. The concept of a scalar is to equate the local capital requirement to an adjusted required capital level that is comparable to U.S. levels. The purpose of a scalar is to address the issue of comparability of accounting systems and capital requirements between jurisdictions. The following provides details on how the scalars were calculated by the NAIC, or how they are to be used when the NAIC has not developed a scalar for a country due to lack of public data.

Excess Relative Ratio Approach

96.98. Included below are various steps to be taken in calculating the excess relative ratio approach to developing jurisdiction-specific scalars. In order to numerically demonstrate how this approach could work, hypothetical capital requirements and financial amounts have been developed for Country A. Based on preliminary research that has been performed by NAIC staff, it appears that the level of conservatism built into accounting and capital requirements within a jurisdiction may differ significantly for life insurers and non-life insurers. Therefore, ideally each jurisdiction would have two different scalars based on the type of business. The example below includes information related to life insurers in the U.S. and Country A.

Step 1: Understand the Jurisdiction’s Capital Requirements and Identify the First Intervention Level

a. The first step in the process is to gain an understanding of the jurisdiction’s capital requirements. This can be done in a variety of ways including reviewing publicly available information on the regulator’s website, reviewing the jurisdiction’s Financial Sector Assessment Program (FSAP) reports and discussions with the regulator.

In Country A, assume that the capital requirements for life insurers are based on a capital ratio, which is calculated as follows:

\[
\text{Capital ratio} = \frac{\text{Total available capital}}{\text{Base required capital (BRC)}}
\]

In the U.S., capital requirements are related to the insurer’s RBC ratio. For purposes of the Relative Ratio Approach, an Anchor RBC ratio is used and calculated as follows:

\[
\text{Anchor RBC ratio} = \frac{\text{Total adjusted capital}}{100\% \text{ Company Action Level RBC}^*}
\]

* 100% Company Action Level RBC is equal to the Total RBC After Covariance including operational risk, without adjustment or 200% Authorized Control Level RBC.

b. Similar to legal entity RBC requirements in the U.S., Country A utilizes an early intervention approach by establishing target capital levels above the prescribed minimums that provide an early signal so that intervention will be timely and for there to be a reasonable expectation that actions can successfully address difficulties. Presume that this target capital level is similar to the U.S. Company Action Level (CAL) event, both of which can be considered the first intervention level in which some sort of action—either on the part of the insurer or the regulator—is mandated.
A separate sensitivity calculation will be applied in the GCC template using trend test level RBC.

c. For Country A, the target capital level is presumed to be a capital ratio of 150%. That is, the insurer’s ratio of total available capital to its BRC should be above 150% to avoid the first level of regulatory intervention. Again, this is similar to the U.S. CAL event, which is usually represented as an RBC ratio of 200% of Authorized Control Level (ACL) RBC (ignoring the RBC trend test). In the Relative Ratio approach, the Anchor RBC ratio represents the Company Action Level event (or first level of regulatory intervention) as 100% CAL RBC (instead of 200% ACL RBC), because CAL RBC is the reference point that is used to calibrate against other regimes. The Anchor RBC Ratio (Total Adjusted Capital ÷ 100% CAL RBC) tells us how many “multiples of trigger level capital” that the company holds. Conceptualizing the CAL event as 100% CAL RBC allows the consistent definition of local capital ratios that are calibrated against a “multiples of the trigger level” approach, to ensure an “apples-to-apples” comparison.3

Step 2: Obtain Aggregate Industry Financial Data

The next step is to obtain aggregate industry financial data, and many jurisdictions include current aggregate industry data on their websites. Included below are the financial amounts for use in this exercise.

<table>
<thead>
<tr>
<th>U.S. Life Insurers – Aggregate Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Adjusted Capital = $495B</td>
</tr>
<tr>
<td>Authorized Control Level RBC = $51B</td>
</tr>
<tr>
<td>Company Action Level RBC = $102B</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Country A Life Insurers – Aggregate Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Available Capital = $83B</td>
</tr>
<tr>
<td>BRC = $36B</td>
</tr>
</tbody>
</table>

Step 3: Calculate a Jurisdiction’s Industry Average Capital Ratio

To calculate a jurisdiction’s average capital ratio, the aggregate total available capital for the industry would be divided by the minimum or base capital requirement for the industry in computing the applicable capital ratio. In Country A, this would be the BRC. In the U.S., this base or minimum capital requirement is usually seen as the ACL RBC, but because the Relative Ratio Approach is using 100% CAL RBC as a reference point to calibrate other regimes to, the Relative Ratio formula uses 100% CAL RBC as the baseline and the first-intervention level to calculate the Average Capital Ratio and Excess Capital Ratio. As a result, the scaled ratio of a non-U.S. company should inform regulators how many multiples of first-intervention level

---

While it is mathematically equivalent to use 200% ACL RBC as the denominator, the Approach is designed to use the representation of first-intervention level capital levels as the conceptual underpinning of the Relative Ratio Approach, where 100% CAL RBC is the reference point to calibrate against other regimes.
capital the non-U.S. company holds. Included below is the formula to calculate a jurisdiction’s industry average capital ratio:

<table>
<thead>
<tr>
<th>Calculation of U.S. Industry Average Capital Ratio – Life Insurers</th>
</tr>
</thead>
<tbody>
<tr>
<td>$495B (Total Adjusted Capital)</td>
</tr>
<tr>
<td>$102B (CAL RBC)</td>
</tr>
<tr>
<td>$495B - $102B = 485%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Calculation of Country A Industry Average Capital Ratio – Life Insurers</th>
</tr>
</thead>
<tbody>
<tr>
<td>$83B (Total Available Capital)</td>
</tr>
<tr>
<td>$36B (BRC)</td>
</tr>
<tr>
<td>$83B - $36B = 231%</td>
</tr>
</tbody>
</table>

**Step 4: Calculate a Jurisdiction’s Excess Capital Ratio**

The next step is to understand the level of capital the industry is holding above the first intervention level. Therefore, to calculate a jurisdiction’s excess capital ratio, one would first need to calculate the amount of the capital ratio carried in excess of the capital ratio required at the first intervention level. This amount would then need to be divided by the capital ratio required at the first intervention level.

**General Excess Capital Ratio Formula**

\[
\frac{\text{Average Capital Ratio} - \text{Capital Ratio at the First Intervention Level}}{\text{Capital Ratio at the First Intervention Level}} = \text{Excess Capital Ratio}
\]

Based on the formula above and information provided in Step 2 and Step 3, included below are how to calculate each jurisdiction’s excess capital ratio.

**NOTE:** The first intervention level in the U.S. is defined in the Relative Ratio Approach as 100% CAL RBC, while the first intervention level in Country A is a capital ratio of 150%.

<table>
<thead>
<tr>
<th>Calculation of U.S. Excess Capital Ratio – Life Insurers</th>
</tr>
</thead>
<tbody>
<tr>
<td>485% (Average Capital Ratio) – 100% (Capital Ratio at the First Intervention Level)</td>
</tr>
<tr>
<td>485% - 100% = 385%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Calculation of Country A Excess Capital Ratio – Life Insurers</th>
</tr>
</thead>
<tbody>
<tr>
<td>231% (Average Capital Ratio) – 150% (Capital Ratio at the First Intervention Level)</td>
</tr>
<tr>
<td>231% - 150% = 54%</td>
</tr>
</tbody>
</table>

---

4 100% CAL RBC translates to an ACL RBC level of 200%, but for conceptual purposes, the Relative Ratio Approach refers to the U.S. first intervention level as 100% CAL RBC, as 100% CAL RBC is the reference point to which the Relative Ratio Approach calibrates other regimes. In other words, 100% CAL RBC ensures that the scaled ratio of Country A results in a ratio that determines how many multiples of first-intervention level capital that the company in Country A is holding.
Step 5: Compare a Jurisdiction’s Excess Capital Ratio to the U.S. Excess Capital Ratio to Develop the Scalar

101.103. Based on the information above, the U.S. excess capital is 385%. In other words, life insurers in the U.S. carry approximately 385% more capital than what is needed over the first intervention level. Country A’s excess capital ratio is 54%. That is, life insurers in Country A carry approximately 54% more capital than what is needed over the first intervention level.

102.104. To calculate the scalar, one would divide a jurisdiction’s excess capital ratio by the U.S. excess capital ratio. Therefore, the calculation of Country A’s scalar for life insurers would be 54% ÷ 385% = 14%. Therefore, Country A’s scalar for life insurers would be 14%.

Step 6: Apply to the Scalar to the Non-U.S. Insurer’s Amounts in the GCC

103.105. In order to demonstrate how the calculation of the scalar works, it would be best to provide a numerical example. For purposes of this memo, assume that a life insurer in Country A reports required capital of $341,866 and total available capital of $1,367,463. (These are the amounts previously used in a hypothetical calculation example that was discussed by the Working Group during its July 20, 2016, conference call.) As noted previously, the above information and calculation suggests that U.S. life insurers carry capital far above the minimum levels, while life insurers in Country A carry capital far closer to the minimum. Therefore, in order to equate the company’s $341,866 of required capital, we must first calibrate the BRC to the first regulatory intervention level by multiplying it by 150%, or Country A’s capital ratio at the first intervention level. The resulting amount of $512,799 is then multiplied by the scalar of 14% to get a scaled minimum required capital of $71,792.

104.106. Further, the above rationale suggests that the available capital might also be overstated (because it does not use the same level of conservatism in the reserves) by the difference between the calibrated required capital of $512,799 and the required capital after scaling of $71,792, or $441,007. Therefore, we should now deduct the $441,007 from the total available capital of $1,367,463 for a new total available capital of $926,456. These two recalculated figures of required capital of $71,792 and total available capital of $926,456 is what would be included in the group’s capital calculation for this insurer. These figures are further demonstrated below.
Calculation of Scaled Amounts for GCC

Amounts as Reported by the Insurer in Country A

Total available capital = 1,367,463

Minimum required capital (BRC) = 341,866

Calibration of BRC to 1st Regulatory Intervention Level

341,866 (BRC) * 150% = 512,799

Scaling of Calibrated Minimum Required Capital

512,799 (Calibrated BRC) * 14% (Scalar) = 71,792 (Difference of 441,007)

Scaled Total Available Capital

1,367,463 (Total Available Capital) – 441,007 (Difference in scaled required capital) = 926,456

105.107. Given these scaled amounts, one can calculate the numerical effect on the company’s relative capital ratio by using the unscaled and scaled amounts included below.

<table>
<thead>
<tr>
<th></th>
<th>Unscaled Amounts from Table Above</th>
<th>Scaled Amounts from Table Above</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Available Capital (TAC)</td>
<td>1,367,463</td>
<td>926,456</td>
</tr>
<tr>
<td>Base Required Capital (BRC)</td>
<td>341,866</td>
<td>71,792</td>
</tr>
<tr>
<td>Capital Ratio (= TAC ÷ BRC)</td>
<td>400%</td>
<td>1290%</td>
</tr>
</tbody>
</table>

106.108. Considering the fact that life insurers in Country A hold much lower levels of capital over the first intervention level as compared to U.S. life insurers, the change in the capital ratio from 400% (unscaled) to 1290% (scaled) appears reasonable and consistent with the level of conservatism that we understand is built into the U.S. life RBC formula driven primarily from the conservative reserve valuation.

Note: In the above example, the company has an unscaled ratio (400%) that is above the industry average in Country A (231%) and a scaled ratio (1290%) that is higher than the US life industry average (485%). If the company had unscaled ratio that was lower than the industry average in Country A, its scaled ratio would be lower than the US life industry average. company with an unscaled ratio equal to its own country’s industry average will have a scaled ratio equal to the anchor RBC ratio.”

Data for industrywide U.S RBC ratios is sourced from the aggregate RBC Statistics maintained by the NAIC. Data for industrywide capital ratios for foreign insurance jurisdictions was derived from publicly available aggregate industry data. If this scalar methodology is retained, then the data will require periodic updating.
Appendix 2 – Stress Scenario

107.109. What follows is a proposal for a 30% standardized stress to be applied to the GCC to test how the limits on recognition of capital instruments as capital behave under stress. In designing this stress, an emphasis was placed on simplicity. The proposed scenario requires no input or calculation on the part of volunteers beyond that already necessary for completing the GCC template. Further scenarios, if any, could follow this same structure:

- (1) A scenario that includes one (or more) stresses to a Group’s financial position
- (2) Specification of how each stress impacts the available capital and calculated capital for each type of legal entity
- (3) Input of the adjusted carrying value and adjusted calculated capital after the impact of the stress(es)
- (4) Re-calculation of the same calculations (e.g., application of limits on debt and scaling) and summary tables (including sensitivity tests)

Proposal

108.110. Scenario: A standardized loss event that results in a proportional reduction in available capital across the Group’s entire operations. What follows is a description based on a 10% reduction.

109.111. Specification: The scenario should result in 30% reduction in the adjusted available capital for all non-holding company entities. For entities where calculated capital is a fixed percentage of available capital (e.g., non-insurance / nonfinancial entities and foreign insurers in jurisdictions without a risk-based capital requirements) and for entities where capital is a fixed percentage of revenue, 30% reductions in calculated capital are assumed to result as well. As an approximation of the impact of the impact of this scenario on revenue, the calculated capital for financial entities with revenue-based exposure should reduce by 30% as well.

110.112. Inputs: No direct input needed. Instead, the inputs will be automatically calculated in the new Stress Inputs tab and summarized in the new Stress summary tab as follows:

<table>
<thead>
<tr>
<th>Type of Entity</th>
<th>Impact on Adj Carrying Value</th>
<th>Impact on Adj Calc Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Insurance Entities</td>
<td>30% reduction</td>
<td>No Impact</td>
</tr>
<tr>
<td>Fin (Banking and Other W Cap Req)</td>
<td>30% reduction</td>
<td>No Impact</td>
</tr>
<tr>
<td>Fin (Asset Mgmt and Other W/O Req)</td>
<td>30% reduction</td>
<td>10% reduction based on corresponding revenue reduction</td>
</tr>
<tr>
<td>Non-US (w/ Risk Based CC)</td>
<td>30% reduction</td>
<td>No Impact on unscaled GCC though XS Relative Ratio factors should be adjusted for sensitivity test</td>
</tr>
<tr>
<td>Non-US (non-Risk Based))</td>
<td>30% reduction</td>
<td>10% reduction based on corresponding reduction in equity value</td>
</tr>
<tr>
<td>HoldCo</td>
<td>No Impact</td>
<td>No Impact</td>
</tr>
<tr>
<td>Other</td>
<td>30% reduction</td>
<td>10% Reduction based on corresponding reduction in equity value</td>
</tr>
</tbody>
</table>
Further adjustments to the calculated capital based on scalars used in the Sensitivity analysis and other selected adjustments to calculated capital can also be considered (see Company Input section in the “Stress Inputs” tab). Other potential user driven adjustments may be added to the template using the optional Inputs section in the Stress Inputs tab in columns Y thru AH. Such adjustments will be at the standardized 30% stress level. Any user inputs will automatically be brought into in the new Stress Summary tab.

### Outputs:
The GCC template will be configured to automatically calculate outputs and resulting GCC ratios using the inputs above, at various additional stress levels (e.g., 20%, 30%, etc.). Various additional levels of stress can be tested during the review. All will include the impact on the allowance for qualifying debt. This can be presented on an additive basis (e.g., start with reduction in available capital alone and then add the impact on each entity type’s calculated capital one at a time building to the full scenario outlined in the chart, above.

### Additional Information:

Although the impact on adjusted carrying value in this scenario is standardized, such generic assumptions cannot be prescribed. Assumptions vary by industry and product mix as the underlying cause and the effect on the adjusted carrying value varies group to group. Therefore, in addition to completing the Stress Input tab, each group submitting data may provide its own independent high-level narrative in the space provided in the “Input 6” tab, describing the unique assumptions and corresponding stress levels (% adjustments) in available capital and calculated capital considered appropriate by the group. The assumptions provided in the narrative are NOT required to align with the standardized adjustments reported in the “Stress Inputs” tab.

The narrative should be submitted with the completed template.
The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee met May 17, 2021. The following Working Group members participated: John Rehagen, Chair (MO); Kathy Belfi, Vice Chair (CT); Susan Bernard (CA); Carrie Mears (IA); Susan Berry (IL); Roy Eft (IN); John Turchi and Christopher Joyce (MA); Judy Weaver (MI); Barbara Carey (MN); Jackie Obusek (NC); Justin Schrader (NE); Dave Wolf (NJ); Bob Kasinow (NY); Dale Bruggeman and Tim Biler (OH); Melissa Greiner and Kimberly Rankin (PA); Trey Hancock (TN); Jamie Walker (TX); David Smith (VA); and Amy Malm (WI).

1. Adopted Instructions for the GCC Trial Implementation

Mr. Rehagen stated that no additional comments specifically addressing the text of the instructions were during the most recent exposure. He further stated that there were several places where new language was added, but mainly for the addition of a stress scenario to the group capital calculation (GCC) instructions and template. He directed the meeting participants to a copy of the instructions included in the materials, which highlighted only the new language (Attachment Two-B1). He added that new language related to the stress scenario will be covered under agenda item #2, and he asked Lou Felice (NAIC) to go through the few other places where some additional language was added. Mr. Felice described the new language, which was mostly related to how risk-based capital (RBC) for operational risk RBC will be treated in the GCC for U.S. insurers. Ralph Blanchard (Travelers) stated that the Excess Relative Ratio (ERR) scaling sensitivity analysis may overstate the required capital, and more clarity on the source of data used for the data supporting the scalars is needed. Mr. Felice responded that the U.S. RBC data came from the publicly available aggregated RBC statistics, which will include some double counting; and the required data for the foreign jurisdictions subject to scaling was similarly sourced from publicly available aggregated data, which also includes some double counting. Mr. Blanchard stated that the scalars were directionally correct but could be off by several percentage points. Mr. Rehagen asked Mr. Felice to add some additional clarifying language regarding the data sources for the ERR scalars. Tom Finnell (America’s Health Insurance Plans—AHIP) noted that AHIP members will have questions during the Trial Implementation, but they have no specific comments at this time.

Ms. Belfi made a motion, seconded by Mr. Eft, to adopt the GCC instructions for the Trial Implementation with the exception of language related to the stress scenario. The motion passed unanimously.

2. Exposed Revised Language for a Proposed Scenario Test in the 2021 GCC Trial Implementation

Mr. Rehagen stated that comment letters were received from AHIP and the American Council of Life Insurers (ACLI) (Attachment Two-B2) related to the proposed stress scenarios. He asked the commenters to present their comments.

Mr. Finnell stated that he is not clear how the company specific assumptions requested in the narrative coordinate with the hypothetical capital adjustments in the stress scenario data calculated in the template. He added that AHIP members were not comfortable providing assumptions for a hypothetical approach.

Mr. Felice stated that he understood that the starting point was a standardized approach—i.e., a template specified percentage adjustment to available and calculated capital—for the stress scenario calculation in the template, but there was a desire to tailor the adjustment to align with the separate narrative with some opportunities for adding adjustments for specific entity types. Ned Tyrrell (NAIC) stated that he understood that the level of stress adjustment was prescribed and some entity specific adjustments could be made by the group to the prescribed stress, but the narrative would be distinct and based on the group’s own assumptions as to stress level and drivers. Ms. Belfi stated that her thinking is along the lines of what Mr. Tyrrell stated with some potential for tailoring, but she believes that a group could forego the tailoring in the template. She said the narrative is meant to add value for state insurance regulators. Mr. Rehagen agreed. Mariana Gomez-Vock (ACLI) stated that the ACLI is generally aligned with Mr. Finnell’s comments, but she questioned whether the purpose of the stress scenario had shifted from the primary goal of identifying the impact of the prescribed stress on the amount of qualifying debt that can be counted as additional capital. Mr. Rehagen stated that the narrative was added, rather than the purpose shifted. Ms. Gomez-Vock said she supports the narrative, but it should be distinct from the prescribed scenario.
Keith Bell (Travelers) stated that some clarity should be added to the instructions to explain how the prescribed approach works in conjunction with the narrative. Mr. Felice explained that as currently drafted, the selected level of stress in the stress scenario calculation can be by the group to align with the narrative, but that is not required. Ms. Belfi said she supports aligning the narrative with a prescribed stress scenario only where the group believes they are aligned, and if not, then the group can use its own assumed stress level in the narrative without changing the standardized stress in the template. She added that all groups should use a standardized level of stress in the template calculation. Mr. Rehagen, Ms. Belfi, Mr. Bell and Mr. Finnell agreed. Mr. Rehagen asked Mr. Felice to make the required changes to the instructions. Mr. Felice stated that the instructions could be revised within a day to achieve that end, but the standardized percentage adjustment would need to be finalized (e.g., 10% or 20%, etc.). He suggested a brief exposure for any additional comments.

Mr. Rehagen asked if there were objections to exposing the revised language in the instructions for the stress scenario until May 25. There were no objections, and NAIC staff were directed to expose the document through the close of business on May 25.


Mr. Rehagen referred to two documents in the materials related to GCC guidance to be included in the Financial Analysis Handbook. He stated that early in 2020, the Working Group formed a very small drafting group consisting of a handful of state insurance regulators and industry members, and they were asked to bring to the Working Group draft regulatory guidance of “how the GCC was planned to be used.” He added that the two documents consist of: 1) the actual step-by-step procedures; and 2) what is referred to as “the analyst reference guide” that provides more detail on the purpose of each procedure generally and how the procedures are intended to be utilized. He said he would like to expose the documents and send them to the Financial Analysis Solvency Tools (E) Working Group, which will be asked to comment upon it to the Group Capital Calculation (E) Working Group during the same exposure period. He further stated that states could use this during the Trial Implementation, so there should be an extended comment period to coincide with the timing for the Trial Implementation. Mr. Finnell supported the extended period, noting that AHIP participated in the initial drafting of the guidance. Ms. Belfi said she also supports an extended comment period.

Mr. Rehagen asked if there were objections to exposing the documents stress scenario until July 31. There were no objections, and NAIC staff were directed to expose the document through the close of business on July 31.

4. Discussed Next Steps Toward the Start of the 2021 GCC Trial Implementation

Mr. Rehagen outlined the steps to get to the start of the Trial. He stated that the Working Group will finalize the stress scenario issue on its next call. He added that the confidentiality agreement templates will be going out soon, but that should not affect the Trial start date of June 1, since data will not be shred until the submissions are received by the lead states and certainly not before the agreements are in place. He mentioned that a question and answer (Q&A) process will be established and maintained by NAIC staff. He noted that the overall timing for the Trial is to receive the template submissions by July 31 and complete the Trial by Oct. 31.

5. Discussed Other Matters

Mr. Rehagen asked if there is value in a call with volunteers at the beginning of the Trial or after the volunteers have a few weeks with the final Trial template and instructions. John Dubois (Mass Mutual) asked that the call be held before July 1. Mr. Rehagen suggested mid-June. Mr. Bell agreed.

Mr. Rehagen stated that the next Working Group call would be scheduled later this month or in early June.

Having no further business, the Group Capital Calculation (E) Working Group adjourned

W:\National Meetings\2021\Summer\Cmte\E\GCCWG\GCCWG 4-27-21 Meeting Minutes

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NAIC GROUP CAPITAL CALCULATION INSTRUCTIONS
(REVISED May 11, 2021)
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I. **Background**

1. In 2015, the ComFrame Development and Analysis (G) Working Group held discussions regarding developing a group capital calculation (GCC) tool. The discussions revealed that developing a GCC was a natural extension of work state insurance regulators had already begun, in part driven by lessons learned from the 2008 financial crisis which include better understanding the risks to insurance groups and their policyholders. While insurance regulators currently have authorities to obtain information regarding the capital positions of non-insurance affiliates, they do not have a consistent analytical framework for evaluating such information. The GCC is designed to address this shortcoming and will serve as an additional financial metric that will assist regulators in identifying risks that may emanate from a holding company system.

2. More specifically, the GCC and related reporting provides more transparency to insurance regulators regarding the insurance group and make risks more identifiable and more easily quantified. In this regard, the tool assists regulators in holistically understanding the financial condition of non-insurance entities, how capital is distributed across an entire group, and whether and to what degree insurance companies may be supporting the operations of non-insurance entities, potentially adversely impacting the insurance company’s financial condition or policyholders. This calculation provides an additional analytical view to regulators so they can begin working with a group to resolve any concerns in a manner that will ensure that policyholders of the insurers in the group will be protected. The GCC is an additional reporting requirement but with important confidentiality protections built into the legal authority. State insurance regulators already have broad authority to take action when an insurer is financially distressed, and the GCC is designed to provide Lead State Regulators with further insights to allow them to reach informed conclusions on the financial condition of the group and the need for further information or discussion.

3. State insurance regulators currently perform group analysis on all U.S. insurance groups, including assessing the risks and financial position of the insurance holding company system based on currently available information; however, they do not have the benefit of a consolidated statutory accounting system and financial statements to assist them in these efforts. It was noted prior to development that a consistent method of calculating group capital for typical group risks would provide a useful tool for state financial regulators to utilize in their group assessment work. It was also noted that a GCC could serve as a baseline quantitative measure to be used by regulators in to compliment the view of group-specific risks and stresses provided by the Own Risk and Solvency Assessment (ORSA) Summary Report filings and in Form F filings that may not be captured in legal entity filings.

4. During the course of several open meetings and exposure periods, the ComFrame Development and Analysis (G) Working Group considered a discussion draft which included three high-level methodologies for the GCC: a risk-based capital (RBC) aggregation approach; a statutory accounting principles (SAP) consolidated approach; and a generally accepted accounting principles (GAAP) consolidated approach. On Sept. 11, 2015, Working Group members unanimously approved a motion to move forward with developing a recommendation for a GCC and directed an appropriate high-level methodology for the recommendation.
5. At a ComFrame Development and Analysis (G) Working Group meeting held Sept. 24, 2015, pros and cons for each methodology were discussed, and a consensus quickly developed in support of using an RBC aggregation approach if a GCC were to be developed. The Executive (EX) Committee and Plenary ultimately adopted the following charge for the Financial Condition (E) Committee:

“Construct a U.S. group capital calculation using an RBC aggregation methodology; liaise as necessary with the ComFrame Development and Analysis (G) Working Group on international capital developments and consider group capital developments by the Federal Reserve Board, both of which may help inform the construction of a U.S. group capital calculation.”

6. The RBC aggregation approach is intended to build on existing legal entity capital requirements where they exist rather than developing replacement/additional standards. In selecting this approach, it was recognized as satisfying regulatory needs while at the same time having the advantages of being less burdensome and costly to regulators and industry and respecting other jurisdictions’ existing capital regimes. In order to capture the risks associated with the entire group, including the insurance holding company, RBC calculations would need to be developed in those instances where no RBC calculations currently exist.

7. In early 2016, the Financial Condition (E) Committee appointed the Group Capital Calculation (E) Working Group, which began to address its charge and various details of the items suggested by the ComFrame Development and Analysis (G) Working Group. The instructions included herein represent the data, factors, and approaches that the Working Group believed were appropriate for achieving such an objective. The GCC instructions and template are intended to be modified, improved, and maintained by the NAIC in the future as are the Accounting Practices and Procedures Manual, the Annual Statement Instructions and the Risk-Based Capital Formula and Instructions. This includes, but is not limited to, future disclosure of additional items developed or referred by other NAIC committees, task forces and/or working groups.

8. In December 2020, amendments to NAIC Model Law (#440) and Model Regulation (#450) were adopted to provide States with legislative language to fully implement the GCC as an annual filing. The Model specifies what groups are exempted from the GCC filing requirement and the circumstance under which a limited filing may be submitted. For such information reference should be made not to these instructions, rather to the models and, more specifically, to how they are implemented into laws and regulations of a Lead State.

II. Definitions

9. **Affiliate**: As used in Model #440, an “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. For purposes of the GCC, affiliates will NOT include those affiliates reported on Schedule A or Schedule BA, EXCEPT in cases where there are insurers or other financial entities reported as or owned indirectly through Schedule A or Schedule BA affiliates. All other Schedule A and Schedule BA investments will remain as investments of a Parent insurer will be reported as Parent of the value and capital calculation of the Parent insurer. A full list of Schedule A and BA entities will be reported as described in the instructions for Input 6 – Questions and Other Information. Any entities that would otherwise qualify as Schedule BA affiliates as described above but are...
owned by other entities (e.g., foreign insurers or other type of Parent entity) should be treated in the same way.

10. **Broader Group**: The entire set of legal entities that are controlled by the Ultimate Controlling Person of insurers within a corporate group. When considering the use of this term, all entities included in the Broader Group should be included in Schedule 1 and the Inventory, but only those that are denoted as “included” in the Schedule 1 will be considered in the actual GCC.

11. **Control**: As used in the Model #440, the term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by Section 4K of Model #440 that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

12. **Cross-Support Mechanism**: A cross-support mechanism is an agreement or transaction that creates a financial interdependence. Depending on the nature of the transaction and the specific circumstances, these mechanisms may pose material risk. These may include corporate guarantees, capital maintenance agreements (regulatory or ratings based), letters of credit, intercompany indebtedness, bond repurchase agreements, securities lending or other agreements or transactions that create a financial interdependence or link between entities in the group.

13. **Entity Not Subject to A Regulatory Capital Requirement**: This is a financial entity other than an entity that is subject to a specified regulatory capital requirement.

14. **Financial Entity**: A non-insurance entity that engages in or facilitates financial intermediary operations (e.g., accepting deposits, granting of credits, or making loans, managing, or holding investments, etc.). Such entities may or may not be subject to specified regulatory capital requirements of other sectoral supervisory authorities. For purposes of the GCC, entities that are not regulated by an insurance or banking authority [e.g., the U.S. Securities and Exchange Commission (SEC) or the Financial Industry Regulatory Authority (FINRA)] will be considered as not subject to a specified regulatory capital requirement.

The primary examples of financial entities are commercial banks, intermediation banks, investment banks, saving banks, credit unions, savings and loan institutions, swap dealers, and the portion of special purpose and collective investment entities (e.g., investment companies, private funds, commodity pools, and mutual funds) that represents the Broader Group’s aggregate ownership in such entities, whether or not any member of the Broader Group is involved in that entity’s management responsibilities (e.g., via investment advisory or broker-dealer duties) for those entities.

For purposes of this definition, a subsidiary of an insurance company whose predominant purpose is to manage or hold investments or act as a broker-dealer for those investments on
behalf of the insurance company and its affiliated insurance (greater than 90% of all such investment subsidiaries’ assets under management or held are owned by or for the benefit of these insurance affiliates) should NOT be considered a Financial Entity. In the case where an insurer sets up multiple subsidiaries for this purpose, the 90% may be measured in the aggregate for all such entities. Similarly, in the case of collective investment pools (e.g., private funds, commodity pools, and mutual funds) the 90% may be measured individually, or in the aggregate for each subtype (e.g., private funds, commodity pools, and mutual funds).

In addition, other financial entities without a regulatory capital requirement include those which are predominantly engaged in activities that depending on the nature of the transaction and the specific circumstances, could create financial risks through the offering of products or transactions outside the group such as a mortgage, other credit offering or a derivative.

15. **Insurance Group**: For purposes of the GCC, a group that is comprised of two or more entities of which at least one is an insurer, and which includes all insurers in the Broader Group. Another (non-insurance) entity may exercise significant influence on the insurer(s); i.e., a holding company or a mutual holding company; in other cases, such as mutual insurance companies, the mutual insurer itself may be the Ultimate Controlling Person. The exercise of significant influence is determined based on criteria such as (direct or indirect) participation, influence and/or other contractual obligations; interconnectedness; risk exposure; risk concentration; risk transfer; and/or intragroup agreements, transactions and exposures.

An Insurance Group may include entities that facilitate, finance or service the group’s insurance operation, such as holding companies, branches, non-regulated entities, and other regulated financial institutions. An Insurance Group is thus comprised of the head of the Insurance Group and all entities under its direct or indirect control, and includes all members of the Broader Group that exercise significant influence on the insurance entities and/or facilitate, finance or service the insurance operations.

An Insurance Group could be headed by:
- An insurance legal entity;
- A holding company; or
- A mutual holding company.

An Insurance Group may be:
- A subset/part of bank-led or securities-led financial conglomerate; or
- A subset of a wider group.

An Insurance Group is thus comprised of the head of the Insurance Group and all entities under its direct or indirect control.

16. **Insurance Subgroup/U.S. Operations**: Refers to all U.S. insurers within a Broader Group where the groupwide supervisor is in a non-U.S. jurisdiction. It includes all the directly and indirectly held subsidiaries of those U.S. insurers. For purposes of subgroup reporting, capital instruments, loans, reinsurance, guarantees would only include those that exist within the U.S. insurers. Amounts included for the U.S. insurers shall include all amounts contained within the financial statements of those entities included in the subgroup reporting, whether those amounts are directly attributable or allocated to a company in the subgroup from an affiliate outside of the U.S. insurers and its direct or indirect subsidiaries.
17. **Lead State Regulator**: As defined in the *Financial Analysis Handbook*; i.e., generally considered to be the one state that “takes the lead” with respect to conducting groupwide supervision within the U.S. solvency system.

18. **Limited Group Capital Filing**: Refers to a GCC filing that includes sufficient data or information to complete the “Input 4 Analytics” tab and the “Summary 3 – Analytics” tab of the GCC template. This includes Schedule 1 of the template and may include limited data from other input tabs as deemed necessary for purposes of the analytics.

19. **Material Risk**: Risk emanating from a non-insurance/non-financial entity not owned by an insurer in the Insurance Group or is part of the Broader Group that is of a magnitude that could adversely impact the financial stability of the group as a whole such that the ability of insurers within a group to pay policyholder claims or make other policy related payments (e.g., policy loan requests or annuity distributions) may be impacted.

To determine whether an entity within the Broader Group poses material risks to the Insurance Group, the totality of the facts and circumstances must be considered. The determination of whether risk posed by an entity is material requires analysis of various aspects pertaining to the subject entity. A determination that a non-insurance/non-financial entity does not pose material risk allows the filer to request exclusion of that entity from the calculation of the GCC ratio in the “Inventory” tab. A number of items as listed below should be considered in making such a determination, to the extent they apply.

Caution is necessary, however. The fact that one or more of these items may apply does not necessarily indicate risk to the Insurance Group is, or is not, material. The group should be able to support its determination of material risk if requested by the Lead State Regulator. This should not be used as a checklist or as a scorecard. Rather, the list is intended to illuminate relevant facts and circumstances about a subject entity, the risk it poses, how the Insurance Group might be exposed to that risk and means to mitigate that risk.

**Primary Considerations:**

- Past experience (i.e., the extent to which risk from the entity has impacted the Insurance Group over prior years/cycles).
- The degree to which capital management across the Broader Group has historically relied on funding by the Insurance Group to cover losses of the subject entity.
- The existence of intragroup cross-support mechanisms (as defined below) between the entity and the Insurance Group.
- The means by which risk can be transmitted; i.e., the existence of sufficient capital within the entity itself to absorb losses under stress and/or if adequate capital is designated elsewhere in the Broader Group for that purpose.
- The degree of risk correlation or diversification between the subject entity and the Insurance Group (e.g., where risks of one or more entities outside the Insurance Group are potentially offset (or exacerbated) by risks of other entities) and whether the corporate structure or agreements allow for the benefits of such diversification to protect the Insurance Group.
- The existence and relative strength or effectiveness of structural safeguards that could minimize the transmission of risk to the Insurance Group (e.g., whether the corporate shell can be broken).
Other Considerations (if primary considerations suggest exclusion may be reasonable, these can be used to further support exclusions):

- The location of the entity in relation to the Insurance Group within the Broader Group’s corporate structure and how direct or indirect the linkage, if any, to the Insurance Group may be.
- The activities of the entity and the degree of losses that the entity could pose to the group under the current economic environment or economic outlook.

The guidance above recognizes that there are diverse structures and business models of insurers that make it impracticable to apply a one-size-fits-all checklist that would work for materiality determinations across all groups. Strict or formulaic quantitative measures based on size of the entity or its operations of a non-insurance affiliate are an insufficient proxy for materiality of risk to the insurance operations. The GCC Instructions thus consider the unique circumstances of the relevant entity and group and uses an interactive process whereby the group brings forward its suggestions as to entities that should be excluded from the scope of application for a discussion with the lead state, ultimately culminating in an agreement on the scope of application. The guidance in this section helps to facilitate that process and discussion with criteria for cross-support mechanisms that can potentially transmit material risk, as defined, to the Insurance Group as well as safeguards that can mitigate such risk or its transfer.

20. **Person**: As used in Model #440, a “person” is an individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert but shall not include any joint venture partnership exclusively engaged in owning, managing, leasing or developing real or tangible personal property.

21. **Reciprocal Jurisdiction**: As defined in the Credit for Reinsurance Model Law (#785).

22. **Scope of Application**: Refers to the entities that meet the criteria listed herein for inclusion in the GCC ratio. The application of material risk criteria may result in the Scope of Application being the same as, or a subset of, the entities controlled by the Ultimate Controlling Person of the insurer(s).

NOTE: U.S. branches of foreign insurers should be listed as separate entities when they are subject to capital requirements imposed by a U.S. insurance regulator, otherwise in as much as they are already included in a reporting legal entity, they are already in the scope of application and there is no need for any additional reporting.

23. **Ultimate Controlling Person**: As used in the Insurance Holding Company System Regulatory Act (#440). This is the entity that exercises control directly or indirectly over all entities within the Broader Group.

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III. Determining the Scope of Application

A. Groups Exempted from the GCC

24. Refer to changes to Model #440 for guidance on groups that are exempted from filing a GCC. Instead, instructions are provided to ensure Lead State Regulators receive the information necessary to evaluate the Scope of Application.

B. Scope of Application – Legal Entity Inventory

25. When considering the scope of application, preparers of the GCC must first understand the information to be included in Schedule 1 of the template. When developing an initial inventory of all potential entities, the preparers of the GCC shall complete Schedule 1, which, except in the case of an Insurance Subgroup (as defined in Section II), requests data for all of the entities within the Broader Group that are directly or indirectly owned by the Ultimate Controlling Person (including the Ultimate controlling Person) that are listed in the insurer’s most recent Schedule Y or in relevant Holding Company Filings. GCC preparers should provide basic information about each such entity in Schedule 1, including its total assets, and total revenue and net income for this specific year identified. Additionally, the initial filing will require some further information for the prior year (e.g., prior year equity or surplus to policyholders). The primary purpose of the Schedule 1 is to: 1) assist the lead state in making an assessment on the entities within the group that should be included in the Scope of Application; and 2) provide the lead state with valuation information to better understand the group. This valuable information produces various ratios and other financial metrics that will be used in the analysis of the GCC and the group by the lead state for their holding company analysis.

26. To assist the Lead State Regulator in assessing the Scope of Application, the Schedule 1 and the “Inventory” tab of the template will be completed by each preparer to provide information and certain financial data on all the entities in the group. Each preparer will also use the include/exclude column in Schedule 1 to request its own set of entities to be excluded from the calculation after applying criteria for material risk (as defined in Section II). The requests for exclusion will be described by the preparer in the template and evaluated by the Lead State Regulator. A second column will be used by the regulator to reflect entities that the regulator agrees should be excluded.

27. Although all entities must be listed in Schedule 1 and in the “Inventory” tab, the preparer is allowed to group data for certain financial entities not subject to a regulatory capital requirement and certain non-insurance and non-financial entities. Thus, while the Schedule 1 would include the full combined financial results/key financial information (for all entities directly or indirectly owned by the Ultimate Controlling Person, such data may be reported based on major groupings of entities to maximize its usefulness, reduce the number of numeric entries, and allow the Lead State Regulator to better understand the group, its structure, and trends at the sub-group as well as group level. Criteria for grouping are further described in Section V, paragraph 55. Prior to completing the GCC annually, the Insurance Group should determine if the proposed grouping is satisfactory to the lead state or if there are certain non-insurance and non-financial entities (such entities are required to be broken out and reported separately) that should be broken out and reported separately.

C. General Process for Determining the Scope of Application

28. The starting point for “Scope of Application” (i.e., for purposes of the GCC specifically) is the entire group except in the case of an Insurance Subgroup (as defined in Section II). However, in the case of groups with material diverse non-insurance/non-financial activities isolated from the financial/Insurance Group and without cross-support mechanisms as defined in Section II, the preparer may request a narrower scope starting at the entity that controls all insurance and
financial entities within the group [i.e., comprise a subset of, the entities controlled by the Ultimate Controlling Person of the insurer(s) (Broader Group)]. However, the adjustments as to the Scope of Application suggested by the preparer in consultation and in agreement with the Lead State Regulator should include consideration of guidance in paragraph 31 (“Identify and Include all Financial Entities”) the totality of the facts and circumstances, as described in paragraph 19 (“Definition of material risk”). The rationale and criteria applied in allowing the reduced scope should be documented and made available to non-lead states if requested. The decision on reduced scope should be revisited when changes in the group structure or activities occur.

The fundamental reason for state insurance regulation is to protect American insurance consumers. Therefore, the objective of the GCC is to assess quantitatively the collective risks to, and capital of, the entities within the Scope of Application. This assessment should consider risks that originate within the Insurance Group along with risks that emanate from outside the Insurance Group but within the Broader Group. The overall purpose of this assessment is to better understand the risks that could adversely impact the ability of the entities within the Scope of Application to pay policyholder claims consistent with the primary focus of insurance regulators.

D. Guiding Principles and Steps to Determine the Scope of Application

29. For most groups, the Scope of Application is initially determined by the preparer in a series of steps, listed here and then further explained as necessary in the text that follows:

- Develop a full inventory of potential entities using the Inventory of the Group template (Schedule 1). This should correspond to Annual Statement Schedule Y, Part 1A

- Denote in Schedule 1 for each non-financial entity whether it is to be “included in or excluded from” the Scope of Application” using the criteria in the “Identify Risks from the Broader Group” subsection below.

- All non-financial entities, whether to be included in or excluded from the Scope of Application are to be reported in the “Inventory” tab of the template. Information to be provided for excluded entities will be limited to Schedule 1B and the corresponding columns in the Inventory tab. See paragraph 55 for additional information on treatment of non-insurance/non-financial subsidiaries of U.S. RBC filers or such subsidiaries owned by other financial entities with regulatory capital requirements for which the non-insurance/non-financial entity is included in the capital charges for the Parent entity.

- Non-financial entities may qualify for grouping on this Inventory tab as described elsewhere in these instructions.

E. Steps for Determining the Scope of Application

30. Identify and list all entities in the Insurance Group or Insurance Subgroup (where required).

Include all entities that meet the definition of an affiliate in Section II, above and that fit the criteria identified in the definition of the Insurance Group or Insurance Subgroup (if applicable), in Section II, above except as modified in paragraph 32 (Identify Risks from the Broader Group), below. All insurance entities and entities owned directly or indirectly by the insurance
entities in the group shall be included in the Scope of Application and reported in the Schedule 1 and Inventory of the Group template. Other non-insurance/nonfinancial entities within the Insurance Group may be designated as “exclude” as described in paragraph 30.

31. Identify and include all Financial Entities.

Financial Entities (as defined in Section II) within the Inventory of the Group template shall be included in (i.e., may not be designated as “excluded from”) the Scope of Application, regardless of where they reside within the Broader Group.

As learned from the 2008 financial crisis, U.S. insurers were not materially impacted by their larger group issues; however, materiality of either equity or revenue of an entity might not be an adequate determinant of potential for risk transmission within the group. Furthermore, risks embedded in financial entities are not often mitigated by the activities of the insurers in the group and may amplify their (the insurers’) risks.

Any discretion in evaluating the ultimate risk generated by a defined financial entity that is not subject to a regulatory capital requirement should be applied via review of the material risk definitions/principles included in paragraph 19 to set the level of risk as low, medium or high and not to exclude such entities from the calculation. The rationale should be documented, and all data required in Schedule 1 must be provided for the entity for purposes of analysis and trending.

32. Identify Risks from the Broader Group

An Insurance Group or Insurance Subgroup may be a subset of a Broader Group, such as a larger diversified conglomerate with insurance legal entities, financial entities, and non-financial entities. In considering the risks to which the Insurance Group or Insurance subgroup is exposed, it is important to take account of those material risks (as defined in Section II) to the Insurance Group from the Broader Group within which the Insurance Group operates. All non-insurance/non-financial entities included within the Insurance Group or Insurance Subgroup that pose material risk to the insurers in the group should be included within (i.e., may not be designated as “excluded from”) the Scope of the Application. Similarly, all non-financial entities within the Broader Group but outside the Insurance Group that pose material risks to the Insurance Group should be included within (i.e., may not be designated as “excluded from”) the Scope of Application; non-material non-insurance/non-financial entities within the Broader Group or within the Insurance Group (as both terms are defined in Section II) other than those entities owned by entities subject to a specified regulatory capital requirement should be reported as “excluded.” However, no such entities outside an Insurance Subgroup (as defined in Section II) should be included in the GCC. When determining which non-financial entities from the Broader Group to include in the Scope of Application, the preparer must include any entity that could adversely impact the ability of the entities within the Scope of Application to pay policyholder claims or provide services to policyholders consistent with the primary focus of insurance regulators.
33. Review of Submission

The Lead State Regulator should review the inventory of entities provided in the Group template to determine if there are entities excluded by the preparer using the criteria above that the Lead State Regulator agrees do not pose material risk (as defined herein) to its insurance operations. Additional information may be requested by the Lead State Regulator to facilitate this analysis. For entities where the Lead State Regulator agrees with the request to exclude, the GCC may exclude the data for such entities. Ultimately, the decision to include or exclude entities from the GCC will occur based on the Lead State Regulator’s knowledge of the group and related information or filings available to the Lead State and whether they believe an applicable entity would not adversely impact the entities within the Scope of Application to pay policyholder claims.

The template’s sensitivity analysis tab includes a calculation to reflect the impact of excluded entities requested, but not approved for exclusion by the lead state. (see instructions for Input 5 herein).

34. The preparer, together with the Lead State Regulator, would use the above steps, which includes considering the Lead State Regulator’s understanding of the group, including inputs such as Form F, ORSA and other information from other involved regulators, to determine the reasonableness of the suggested Scope of Application.

35. Updating the Scope of Application

The Scope of Application could be re-assessed by the preparer and the Lead State Regulator each successive annual filing of the GCC provided there has been substantial changes in corporate structure or other material changes from the previous year’s filing. Any updates should be driven by the assessment of material risk and changes in group structure as they impact the exclusion or inclusion of entities within the Scope of Application based on material risk considerations.

IV. General Instructions

36. The GCC template consists of a number of tabs (sections) within one workbook. The following provides general instructions on each of these tabs.

37. **Attestation:** This tab is intended to work similar to the annual financial statement and RBC attestations, which are both intended to give the regulator greater comfort that the company has completed in accordance with its (these) instructions. It will also indicate whether the group consists of predominantly life, P/C, or health insurers and whether the submission is a full or limited group capital filing.

38. **Input 1 – Schedule 1:** This tab is intended to provide a full inventory of the group, including the designation by the filer of any non-financial entities to be included in, or excluded from, the Scope of Application and include sufficient data or information on each affiliated entity (see Schedule A and Schedule BA exception as described in paragraph 39) within the group so as to allow for analyzing multiple options for scope, grouping and sensitivity criteria, as well as, allowing the Lead State Regulator to make a determination as to whether the entities to be included in the scope of application or excluded from the scope of application meet the aforementioned criteria. This tab is also used to maximize the value of the calculation by
including various information on the entities in the group that allow the lead state to better understand the group as a whole, the risks of the group, capital allocation, and overall strengths and weaknesses of the group.

39. Except as noted, equity method investments reported in the Section 1B in the Inventory tab that are accounted for based on Statement of Statutory Accounting Principles (SSAP) No. 48—Joint Ventures, Partnerships and Limited Liability Companies are not required to be de-stacked (separately listed) in Schedule 1; i.e., their value would be included in amounts reported by the Parent insurer within the calculation. The basis for this approach is predicated on the purpose of the entire GCC, which is to produce an expected level of capital and a corresponding level of available capital that are derived by aggregating the amounts reported of capital of the individual entities under the GCC methodology. The available capital for such joint ventures, partnerships and limited liability companies is already considered in Schedule 1 by its inclusion in its Parent’s financial statements and can be excluded from an inventory (not separately listed) because the Parent also already receives a corresponding capital charge within its RBC.

NOTE: Data for this tab is required for a Limited Group Capital filing.

40. **Input 2 – Inventory:** This tab is intended to be used by the consolidated group to provide information on the value and capital calculation for all the entities in the group before any de-stacking of the entities. While some of this information is designed to “pull” information from Schedule 1, other cells (blue cells) require input from the group. This tab will then apply the adjustments for investment in subsidiary other than where an exception is described in these instructions and adjust for intragroup arrangements. This tab is set up to subtract those adjustments from capital and therefore should be entered as: 1) a positive figure if the adjustment currently has a positive impact on the available capital or the capital calculation; or 2) a negative figure if the adjustment currently has a negative impact on the available capital or the capital calculation. It will also be used to add relevant insurance or other financial entities included as equity investments in Schedule A and Schedule BA and to aggregate the resulting adjusted values for use in the actual GCC.

NOTE: For a Limited Group Capital filing, data will be presented in a summarized format in a limited version of the “Inventory” tab in lieu of completing the full “Inventory” tab (see below).

**Limited Group Capital Filing Only: Input 2 – Inventory:** Manually enter data in Inventory B, Column 8 and Inventory C, Column 8 to report a single aggregated value for each entity category in the group. This will require that eliminations and adjustments normally found in a “full” Inventory B, Column 2 through Column 7 and Inventory C, Column 2 through Column 7 to be addressed offline.

41. **Input 3 – Capital Instruments:** This tab is intended to be used to gather necessary information to that will be used to calculate an allowance for additional available capital based on the concept of structural subordination applied to senior or other subordinated debt issued by a holding company that is within the scope of application of the GCC filing. It will also provide information on all debt issued by entities within the scope of application.

NOTE: Data for this tab is NOT required for a Limited Group Capital filing.

42. **Input 4 – Analytics:** In recognizing a primary purpose of the GCC is to enhance groupwide financial analysis, this tab includes or draws from entity-category-level inputs reported in the tab or elsewhere in the GCC template to be used in GCC analytics. Separate guidance for Lead
State Regulators to reference in analyzing the data provided in the GCC template (reference applicable location of the guidance; e.g., *Financial Analysis Handbook*).

NOTE: Data for this tab is required for a Limited Group Capital filing.

43. **Input 5 – Sensitivity Analysis and Inputs**: This tab includes inputs and/or describes informational sensitivity analysis for other than XXX/AXXX captives, permitted and prescribed practices, debt designated as “Other,” unscaled foreign insurer values and other designated sensitivity analysis. The inputs are intended to simply be a disclosure, similar to the disclosure required under Note 1 of the statutory financial statements. The analysis will be applied in the “Summary 2” tab.

NOTE: Data for this tab is NOT required for a Limited Group Capital filing.

44. **Input 6 – Questions and Other Information**: This tab will provide space for participants to describe or explain certain entries in other tabs. Examples include the materiality method applied to exclude entities in Schedule 1 and narrative on adjustments for intragroup debt and adjustments to available capital or capital calculations that are included in the “other adjustment” column in the “Inventory” tab.

NOTE: Data for this tab is NOT required for a Limited Group Capital filing.

45. **Calc 1 – Scaling (Ins)**: This tab list countries predetermined by NAIC and provides the necessary factors for scaling available and required capital from non-US insurers to be used in sensitivity analysis to a comparable basis relative to the U.S. RBC figures. It also allows for set scaling options (which vary by insurance segment such as life, P/C, and health).

NOTE: This tab is NOT required for a Limited Group Capital filing.

46. **Calc 2 – Scaling (Non-Insurance)**: This tab is used to determine calculated capital for non-insurance entities.

NOTE: This tab is NOT required for a Limited Group Capital filing.

47. **Summary 1 – Entity Category Level**: This tab provides a summary of aggregated available capital and calculated capital for each entity category before the application of capital instruments.

NOTE: This tab is NOT required for a Limited Group Capital filing.

48. **Summary 2 – Top Level**: This tab calculates various informational GCC ratios resulting from applying “on top” and entity level adjustments to adjusted carrying value and adjusted calculated capital and are described in the “Sensitivity Inputs and Analysis” tab. These “what if” scenario analysis will not be part of the GCC ratio.

NOTE: This tab is NOT required for a Limited Group Capital filing.

49. **Summary 3 – Analytics**: Provides a summary of various GCC analytics.

NOTE: This tab is required for a Limited Group Capital filing.
50. **Summary 4 – Grouping Alternatives**: This tab currently calculates and displays a selected grouping option for organizing the structure of the group consistent with the way that the entities are managed. 

   **NOTE**: This tab is NOT required for a Limited Group Capital filing.

51. All cells in the template are color-coded based on the chart below. Inputs should only be made in blue cells. Do not add/delete rows, columns or cells or change the structure of the template in any way. If there appears to be an error in the formulas in the template, contact the NAIC.

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Colors used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Input cells</td>
<td></td>
</tr>
<tr>
<td>Data from other worksheets</td>
<td></td>
</tr>
<tr>
<td>Local calculations</td>
<td></td>
</tr>
<tr>
<td>Results propagated</td>
<td></td>
</tr>
</tbody>
</table>

### V. Detailed Instructions (insert link to template)

#### Input 1 – Schedule 1

52. Schedule 1A indicates the version of the template being prepared.

53. More detailed information on each legal entity should be reported in Schedule 1B through Schedule 1D. The order of the entries in Schedule 1 should match that in the “Inventory” tab. The first entity listed should be the ultimate controlling party.

54. U.S. branches of foreign insurers should be listed as separate entities when they are subject to capital requirements imposed by a U.S. insurance regulator. They should be reported under the appropriate entity category in [Sch 1B Col 6].

55. Entries are required for every entity within the scope of the group. However, while recognizing that Lead State Regulator retain the discretion to ask for greater detail, the following simplifications may be applied as long as information for every entity is entity is listed in Schedule 1B:

   - A single numerical entry for like Financial Entities would be allowed at the intermediate holding company level, assuming that the like entities are owned by a common Parent that does not own other entity types, all use the same accounting rules (e.g., all GAAP), and are at least consistent with the way the group manages their business. The entity at which the total data is provided must be assigned an “Entity Category” in Schedule 1 that corresponds to the instructed carrying value and capital calculation for which the entry is made (e.g., an entity that would otherwise be categorized as a non-operating holding company but holds asset managers would be categorized as an asset manager). Entries
for the remaining individual entities in the grouping will be reported in Schedule 1B only as “included.”

- In addition, a single numerical entry would be allowed for all included non-insurance/non-financial entities at the intermediate holding company level assuming that the intermediate holding company owns only non-insurance/non-financial entities (i.e., does not own other entity types), all use the same accounting rules (e.g., all GAAP), and are at least consistent with the way the group manages their business. This would include any positive residual value of the holding company itself. Entries for all individual entities in the grouping will be reported in Schedule 1B only as “included.”, but no stand-alone values for each entity would be required.

- Values for, non-insurance/non-financial subsidiaries of U.S. RBC filers or such subsidiaries owned by other financial entities with regulatory capital requirements for which the non-insurance/non-financial entity is included in the capital charges for the Parent entity may remain with their Parent insurers and will not be de-stacked. Entries for these individual entities in the grouping will be reported individually in Schedule 1B Columns 1 and 2 only as “included.” along with other required entries in Schedule 1B, but no stand-alone values for each entity would be required in Schedules 1C or 1D.

- Mutual Insurance Groups may use the Total Adjusted Capital and amount of required capital from the top-level Insurer’s RBC Report at 200% x ACL RBC further adjusted to de-stack foreign insurers and other financial entities owned directly or indirectly (on a look-through basis) via RBC filing subsidiaries. Such foreign insurance subsidiaries or other financial subsidiaries shall be reported at the carrying values and capital calculations as described later herein.

- Data for U.S. Branches of Foreign insurers may be omitted from Schedule 1 if they are otherwise included in the entries, values, and capital requirements of a foreign insurer.

NOTE: These simplifications will be treated in a similar manner in Input 2 – Inventory.

56. Any financial entity owned by a Parent insurer and listed in Schedule A or Schedule BA, and any insurance or financial entity that is owned indirectly through a Schedule BA affiliate should be listed in Schedule 1 and in the Inventory and assigned the appropriated identifying information. (See also the instructions for Part B of the Inventory). These entities will be de-stacked from the values for the Parent insurer. The same treatment for these entities will be afforded when they owned by a foreign insurer or other non-insurance entities.

57. Schedule 1B contains descriptions of each entity. Make selections from drop-down menu where available.

- [Sch 1B Col 1] Include/Exclude (Company) – This column is to select entities where a request is made for exclusion. The filer will indicate which non-insurance/non-financial entities not owned directly or indirectly by an insurer that should be excluded from the GCC as not posing material risk to the group. The filer’s definition of material risk will be reported in the “Other Information” tab.

- [Sch 1B Col 2] Include/Exclude (Supervisor) – Column to be filled in by supervisor. These are entities where the Supervisor agrees with the filer’s assessment of material risk...
and these entities will be excluded from the GCC and may be included in a sensitivity analysis later in the template.

**NOTE:** This column may also be completed by the filer after advance consultation with the Lead State Regulator.

- **[Sch 1B Col 3] Include/Exclude (Selected)** – Formula to determine treatment of data for later sensitivity analysis. If supervisor has made a determination of include/exclude in the prior column, that will be used. If not, company’s selection will be used.

- **[Sch 1B Col 4] Entity Grouping** – Column denotes whether this is an insurance or non-insurance/non-financial entity and is also automatically populated based on the entry in Column 8.

- **[Sch 1B Col 5] Entity Identifier** – Provide a unique string for each entity. This will be used as a cross-reference to other parts of the template. If possible, use a standardized entity code such as NAIC Company Code (CoCode) or Insurance Services Office (ISO) Legal Entity Identifier. CoCodes should be entered as text and not number (e.g., if CoCode is 01234, then the entry should be “01234” and not “1234”). If there is a different code that is more appropriate (such as a code used for internal purposes), please use that instead. If no code is available, then input a unique string or number in each row in whatever manner is convenient (e.g., A, B, C, D, … or 1, 2, 3, 4…). Do not leave blank.

- **[Sch 1B Col 6] Entity Identifier Type** – Enter the type of code that was entered in the “Entity Identifier” column. Choices include “NAIC Company Code,” “ISO Legal Entity Identifier,” “Volunteer Defined” and “Other.”

- **[Sch 1B Col 7] Entity Name** – Provide the name of the legal entity.

- **[Sch 1B Col 8] Entity Category** – Select the entity category that applies to the entity from the following choices (all U.S. life captives shall select the option for “RBC Filing Captive,” complete the calculation using the life RBC formula in accordance with instructions below regarding “Additional clarification on capital requirements where a U.S. formula (RBC) is not required,” regardless of whether the company is required by their captive state to complete the RBC formula. Insurers or financial entities that are de-stacked from an insurer’s Schedule A or Schedule BA should be assigned the corresponding insurer or financial entity category:
If the GCC group’s Japanese insurer health business (referred to as “Third Sector”) is greater than 60% of total life business (referred to as “First Sector”) and health business combined, as reflected by annualized premium for the year reported, then that group may elect to use the Japan health scalar set rather than the life scalar set.

**NOTE**: All U.S. captives are required to complete the applicable RBC formula template. In addition, any insurer, other than U.S. captive, that submits an RBC filing to either the state of domicile or the NAIC will be considered an RBC filer.

<table>
<thead>
<tr>
<th>RBC Filing U.S. Insurer (Life)</th>
<th>UK Solvency II – Life</th>
<th>Colombia</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC Filing U.S. Insurer (P/C)</td>
<td>UK Solvency II – Composite</td>
<td>Indonesia</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>Australia – All</td>
<td>Thailand</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Other)</td>
<td>Switzerland – Life</td>
<td>Barbados</td>
</tr>
<tr>
<td>U.S. Mortgage Guaranty Insurers</td>
<td>Switzerland – Non-Life</td>
<td>Regime A (Participant Defined)</td>
</tr>
<tr>
<td>U.S. Title Insurers</td>
<td>Hong Kong – Life</td>
<td>Regime B (Participant Defined)</td>
</tr>
<tr>
<td>Other Non-RBC Filing U.S. Insurers</td>
<td>Hong Kong – Non-Life</td>
<td>Regime C (Participant Defined)</td>
</tr>
<tr>
<td>RBC filing (U.S. Captive)</td>
<td>Singapore – All</td>
<td>Regime D (Participant Defined)</td>
</tr>
<tr>
<td>Canada – Life</td>
<td>Chinese Taipei – All</td>
<td>Regime E (Participant Defined)</td>
</tr>
<tr>
<td>Canadian – P/C</td>
<td>South Africa – Life</td>
<td>Bank (Basel III)</td>
</tr>
<tr>
<td>Bermuda – Other</td>
<td>South Africa – Composite</td>
<td>Bank (Other)</td>
</tr>
<tr>
<td>Bermuda – Commercial Insurers</td>
<td>South Africa – Non-Life</td>
<td>Financial Entity with a Regulatory Capital Requirement</td>
</tr>
<tr>
<td>Japan – Life</td>
<td>Mexico</td>
<td>Asset Manager/Registered Investment Advisor – High Risk</td>
</tr>
<tr>
<td>Japan – Non-Life</td>
<td>China</td>
<td>Asset Manager/Registered Investment Advisor – Medium Risk</td>
</tr>
<tr>
<td>Japan – Health*</td>
<td>South Korea</td>
<td>Other Financial Entity without a Regulatory Capital Requirement – High Risk</td>
</tr>
<tr>
<td>Solvency II – Life</td>
<td>Malaysia</td>
<td>Other Financial Entity without a Regulatory Capital Requirement – Medium Risk</td>
</tr>
<tr>
<td>Solvency II – Composite</td>
<td>Chile</td>
<td>Other Financial Entity without a Regulatory Capital Requirement – Low Risk</td>
</tr>
<tr>
<td>Solvency II – Non-Life</td>
<td>India</td>
<td>Other Non-Ins/Non-Fin with Material Risk</td>
</tr>
<tr>
<td>Solvency II – Non-Life</td>
<td>Brazil</td>
<td>Other Non-Ins/Non-Fin without Material Risk</td>
</tr>
<tr>
<td>UK Solvency II – Non-Life</td>
<td>Argentina</td>
<td>Non-Operating Holding Co.</td>
</tr>
</tbody>
</table>

* If the GCC group’s Japanese insurer health business (referred to as “Third Sector”) is greater than 60% of total life business (referred to as “First Sector”) and health business combined, as reflected by annualized premium for the year reported, then that group may elect to use the Japan health scalar set rather than the life scalar set.

**NOTE**: All U.S. captives are required to complete the applicable RBC formula template. In addition, any insurer, other than U.S. captive, that submits an RBC filing to either the state of domicile or the NAIC will be considered an RBC filer.
- **[Sch 1B Col 9] Alternative Grouping** – This is an optional input field. This field should be used if you wish to show similar entities aggregated into a single line in Summary 4-Alternative Grouping. Exhibit. For example, if you have a dozen small dental HMO businesses, you may wish to show them as a single line called “Dental HMOs,” as opposed to listing each entity separately. This is a level of granularity below “Entity Category” but above individual entities. No entity should be put in the same “Alternative Grouping” as its Parent. It is acceptable to put only one entity in a grouping. If any entries are left blank then, in Column 17, the “Entity Name” will be selected as the grouping. This will not impact the order of the entities for which data is entered in Schedule 1 or the “Inventory” tab.

- **[Sch 1B Col 10] Parent Identifier** – Provide the Entity Identifier of the immediate Parent legal entity for each entity, as applicable. If there are multiple Parents, select the Parent entity with the largest ownership percentage. Only include one entry. For the top holding company, enter “N/A.”

- **[Sch 1B Col 11] Parent Name** – This will be populated by a formula, so input is not required.

- **[Sch 1B Col 12] % Owned by Parent** – Enter the percentage of the entity that is owned by the Parent identified earlier in the worksheet. Percentages of ownership should be based on the percentage of voting class securities (unless ownership is maintained other than by control of voting securities) consistent with what is reported pursuant to state holding company regulation filings (Form B or equivalent).

- **[Sch 1B Col 13] % Owned within Group Structure** – Enter the percentage of the entity that is owned in the aggregate by any affiliate within the Group.

- **[Sch 1B Col 14] State/Country of Domicile** – Enter state of domicile for U.S. insurance entities and country of domicile for all other entities. (Use references that are consistent with those use on Schedule Y, where available.)

- **[Sch 1B Col 15] Zero Valued and Not Admitted Entities – Report for U.S. Insurers Only.** Select the treatment of the entity from following options: “Zero Valued for RBC” or “Nonadmitted for Accounting and RBC (Direct or Indirect).”

Zero Valued for RBC are affiliated insurance and financial entities that are otherwise reported in the RBC filer’s annual financial statement at their accounting value (i.e., per SAP) but are reported at zero value and zero capital requirements for RBC purposes. Examples include non-Canadian foreign insurers directly owned by U.S. life RBC filers. The carrying value and capital calculation specified in these instructions for the specific insurance or financial entity type should be reported in Inventory B, Column 2 and Inventory C, Column 2, respectively.

**NOTE:** Do not report zero values in Column 2 of Inventory B and Inventory C for these affiliates. Only RBC filing entities with this type of affiliate will report in this column.

Nonadmitted for Accounting and RBC (Direct or Indirect) are insurance or other financial affiliates that owned directly indirectly by an RBC filer via a downstream non-financial entity or holding companies that are reported at zero value per SAP and are also reported...
at zero value and zero capital requirements for RBC purposes. Examples include U.S. insurers indirectly owned by a U.S. RBC filer through a nonadmitted holding company that has not been subject to an independent audit. The carrying values and capital calculations specified herein associated with the specific insurance or financial indirectly owned entity type should be reported Inventory B, Column 2 and Inventory C, Column 2, respectively.

NOTE: Do not report zero values in Column 2 of Inventory B and Inventory C for these affiliates. Only RBC filing entities with this type of affiliate will report in this column. The excess value in the nonadmitted Parent entity may be reported at zero value.

No entry is required in this column for any nonadmitted directly or indirectly owned non-insurance/non-financial subsidiary. Report zero for these affiliates in Column 2 of Inventory B and Inventory C.

- **[Sch 1B Col 16] Is Affiliate on Schedule A or Schedule BA an Insurer or Other Financial Entity?** – Column is meant to identify an entity with an insurer or financial entity identifier in Column 8 that is reported on Schedule A or Schedule BA but is being de-stacked and also reported on the Inventory tab. Provide a “Y” response where that is applicable. Otherwise leave blank.

- **[Sch 1B Col 17] Selected Alternative Grouping** – This will be populated by a formula, so input is not required. If there are any blank entries in Column 9 (Alternative Grouping), this column will set them equal to the name of the entity.

58. Schedule 1C contains financials for each entity:

- **[Sch 1C Col 1] Basis of Accounting** – Enter basis of accounting used for the entity’s financial reporting.


- **[Sch 1C Col 4] Reinsurance Assumed from Affiliates** – Report for all U.S. and non-U.S. insurers. Use applicable entity annual financial statement data source for U.S. insurers (assumed premiums from P/C Schedule F, Part 1 and life and health Schedule S, Part 1, Section 1, and Section 2). Use equivalent local source for non-U.S. insurers or company records when available.[FL3]

- **[Sch 1C Col 5] Reinsurance Ceded to Affiliates** – Report for all U.S. and non-U.S. insurers. Use applicable entity annual financial statement data source for U.S. insurers (assumed premiums from P/C Schedule F, Part 3 and life and health Schedule S, Part 3, Section 1, and Section 2). Use equivalent local source for non-U.S. insurers or company records when available. [FL4]

- **[Sch 1C Col 6] Book Assets** – This should be valued based on the applicable basis of accounting reported under the entity’s local regime and represents the total assets as reported in the basic financial statements before eliminations (because that is presumed to be less burdensome on the insurance holding company). Other financial data should
similarly be prepared using financial data before eliminations. However, insurance holding companies are allowed to present such figures after eliminations if they do so for all figures and consistently for all years.

- **[Sch 1C Col 7] Book Liabilities** – This should be valued based on the applicable basis of accounting reported under the entity’s local regime and represents the total liabilities as reported in the basic financial statements.

- **[Sch 1C Col 8] Gross Paid-in and contributed Capital and Surplus (U.S. Insurers Only)** – For U.S. insurers, report the current year end amounts from annual financial statement Page 3 as follows:
  a. Life Insurers: lines 29, 30 and 33.
  b. P/C Insurers: lines 30, 31 and 34.
  c. Health Insurers: lines 26, 27 and 28. [FL5]

59. Generally, Schedule 1D will include entries from regulatory filings or entity specific GAAP financial statements as of the reporting date. The amounts reported should be the entity value on a stand-alone (fully de-stacked) or grouped basis (where applicable). This may require use of company records in certain cases. The amounts should be reported at 100% for the entity listed. Any required adjustments for percentage of ownership will be applied later, if necessary, to calculate a capital charge.

- **[Sch 1D Col 1] Prior Year Entity Identifier** – Report the Legal Entity Identifier, NAIC company code or other identifier used for the entity in the prior year GCC filing for the prior calendar year.

- **[Sch 1D Col 2] Prior Year Equity or Capital and Surplus** – Report the value based on net equity reported in the entity stand-alone balance sheet. This will generally be the same as what is reported in the current year column in the prior year GCC filing. Where grouping is permitted, the balance reported may be on a grouped basis.

- **[Sch 1D Col 3] Net Income** – The final reported income figure from the income statement, and therefore is the figure reported after interest, taxes, extraordinary items, etc. For entities with accounting and reporting requirements that specify that dividends paid or received will be part of “net income,” report the dividends received in this column. Report dividends to policyholders here as a reduction to net income if required by local accounting or reporting requirements.

- **[Sch 1D Col 4] Dividends Paid and Received (Net)** – All entity types report the net amount of dividends paid and received in reporting year to/from and affiliate, a Parent shareholder, public shareholders, or policyholders (if not required to be a reduction/increase in net income by local accounting or reporting requirements). All entity types that are subject to accounting and reporting requirements that specify that dividends paid or received will be reported as a surplus adjustment, will report dividends received in reporting year from affiliates in this column.
• **[Sch 1D Col 5] Capital and Surplus Contributions Received from Affiliates** – All entity types. Report sum of capital contribution (other than via surplus notes) during the reporting year received from any affiliated entity.

• **[Sch 1D Col 6] All Other Changes in Capital and Surplus** – Include total for all adjustments not listed above. This would include any investment income not already reported in Column 3 or Column 5. Also, report all stock repurchases or redemptions in this column.

NOTE: Greater detail may be made available upon request.

• **[Sch 1D Col 7] Current Year Equity or Capital and Surplus** – Report the value based on net equity reported in the entity stand-alone Balance Sheet for the current year. This will generally be the same as what is reported for the entity in the Inventory B, Column 2. Where grouping is permitted, the balance reported may be on a grouped basis.

• **[Sch 1D Col 8] Capital and Surplus Contributions Paid to Affiliates** – All entity types report the total of capital contributions (other than via surplus notes) during the reporting year paid to any affiliated entity.

• **[Sch 1D Col 9] Dividends Declared and Unpaid** – For all applicable entities report the amount of dividends declared or approved but not yet distributed.

• **[Sch 1D Col 10] Dividends Received and Not Retained** – All holding companies, insurers and financial entities with regulatory capital requirements indicate by “Y” or “N” if part or all of dividends received reported in Column 5 have been paid (passed through) to a Parent company, to public shareholders, or used to repurchase or redeem shares of stock.
Input 2 – Inventory

60. Columns in Inventory A are being pulled from Schedule 1:

- [Column 1] Insurance/Non-Insurance
- [Column 2] Entity Identifier
- [Column 3] Entity Identifier Type
- [Column 4] Entity Name
- [Column 5] Entity Category
- [Column 6] Parent Identifier
- [Column 7] Parent Name
- [Column 8] Basis of Accounting

Columns Requiring Input

61. Enter information on adjustments to carrying value. Considerations specific to different types of entities are located at the end of this subsection.

- **[Inv B Col 1] Carrying Value (Immediate Parent Regime)** – This column is included to accommodate participants with either a U.S. or a non-U.S. based Parent company. In general, carrying values utilized should represent: 1) the subsidiary valuation required by the insurance or other sectoral regulator if the Parent is a regulated entity; or 2) in the case where the Parent is not subject to insurance or other sectoral regulatory valuation, then a subsidiary valuation based U.S. GAAP or other International GAAP as used in the ordinary course of business by the ultimate controlling party in their financial statements. No entry is required for the Ultimate Controlling Person (UCP)

The value in this column will include a zero value for entities not admitted per SAP or other jurisdictional regulatory rules. A single entry for all entities that qualify under the grouping criteria described in Input 1, herein may be made in lieu of individual entries on the line for the affiliate that holds the qualifying entities. This column will include double-counting.

The values recorded for all subsidiaries should be the full value of the subsidiary regardless of percentage of ownership by entities within the group. Where entities are owned partially by entities outside of the group, then report the full value of the subsidiary adjusted to reflect total percentage of ownership within the group.

- **[Inv B Col 2] Carrying Value (Local Regime)** – Record the carrying value recognized by the legal entity’s jurisdictional insurance or other sectoral supervisor. This will include the value of capital instruments (e.g., U.S. insurer issued surplus notes) that are specifically recognized by statute, regulation or accounting rule and included in the carrying value of the entity. In the case where the entity is not subject to insurance or other sectoral regulatory valuation, then U.S. GAAP equity (including OCI) or other International GAAP as used in the ordinary course of business by the ultimate controlling party in their financial statements. If an agreed-upon change in local carrying value should become effective by 2021, Volunteer Groups are expected to report on that basis. If the group is comprised entirely of U.S.-based entities under a U.S.-based Parent company, the entries in this column will be the same as in Column 1 except in cases where the Parent owns not admitted (or otherwise zero valued financial affiliates that
would be reported as not admitted in the Parent Regime column but fully admitted (per SAP valuation) in the Local Regime column. (See instructions for **Sch 1B Col 15**.) However, if such an entity has been listed in the **Sch 1B Col 2 Include/Exclude (Supervisor)** column, indicating that the Lead State Regulator agrees that the entity does not pose material risk, then a value will be reported here, but the ultimate calculation will show the results without the excluded entity’s value. The carrying value for affiliates that are U.S. RBC filers will be the amount reported TAC on entity’s RBC report. This column will include double-counting. The values recorded for all subsidiaries should be the full value of the subsidiary regardless of percentage of ownership by entities within the group. Where entities are owned partially by entities outside of the group, then report the full value of the subsidiary adjusted to reflect total percentage of ownership within the group. The entry here should generally be the same as the value reported in Inventory B, Column 1, except where TAC for RBC filers differs from their BACV. A single entry for all entities that qualify under the grouping criteria described exceptions described herein under Input 1, above may be made in the line for the affiliate that holds the qualifying entities in lieu of individual entries.

A sensitivity analysis is included to calculate the impact of excluded entities requested but not approved for exclusion by the lead state.

<table>
<thead>
<tr>
<th>Parent Entity</th>
<th>Entity</th>
<th>Inv B, Column 1</th>
<th>Inv B, Column 2</th>
<th>Parent Entity Line Inv C, Column 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. RBC filer</td>
<td>U.S. RBC filer</td>
<td>BACV Per Statutory Accounting</td>
<td>RBC TAC</td>
<td>BACV Per Statutory Accounting</td>
</tr>
<tr>
<td>U.S. RBC filer</td>
<td>Other U.S. Insurer</td>
<td>BACV Per Statutory Accounting</td>
<td>BACV Per Statutory Accounting</td>
<td>BACV Per Statutory Accounting</td>
</tr>
<tr>
<td>U.S. RBC filer</td>
<td>Foreign Insurer or Other Regulated w/ Capital Reqmt</td>
<td>BACV Per Statutory Accounting</td>
<td>Per Local Regulatory Accounting</td>
<td>BACV Per Statutory Accounting</td>
</tr>
<tr>
<td>U.S. RBC filer</td>
<td>Financial w/o Capital Reqmt</td>
<td>BACV Per Statutory Accounting</td>
<td>BACV Per Statutory Accounting</td>
<td>BACV Per Statutory Accounting</td>
</tr>
<tr>
<td>U.S. RBC filer</td>
<td>Non-Financial</td>
<td>BACV Per Statutory Accounting</td>
<td>No entry Required</td>
<td>No entry Required - Do not de-stack</td>
</tr>
<tr>
<td>Other U.S. Insurer</td>
<td>U.S. RBC filer</td>
<td>BACV Per Statutory Accounting</td>
<td>RBC TAC</td>
<td>BACV Per Statutory Accounting</td>
</tr>
<tr>
<td>Other U.S. Insurer</td>
<td>Any Other Entity Type</td>
<td>BACV Per Statutory Accounting</td>
<td>BACV Per Statutory Accounting</td>
<td>BACV Per Statutory Accounting</td>
</tr>
<tr>
<td>Foreign Insurer or Other Regulated w/ Capital Reqmt</td>
<td>U.S. RBC filer</td>
<td>Per Local Regulatory Accounting</td>
<td>RBC TAC</td>
<td>Per Local Regulatory Accounting</td>
</tr>
<tr>
<td>Foreign Insurer or Other Regulated w/ Capital Reqmt</td>
<td>Other U.S. Insurer</td>
<td>Per Local Regulatory Accounting</td>
<td>BACV Per Statutory Accounting</td>
<td>Per Local Regulatory Accounting</td>
</tr>
<tr>
<td>Foreign Insurer or Other Regulated w/ Capital Reqmt</td>
<td>Foreign Insurer or Other Regulated w/ Capital Reqmt</td>
<td>Per Local Regulatory Accounting</td>
<td>Per Local Regulatory Accounting</td>
<td>Per Local Regulatory Accounting</td>
</tr>
<tr>
<td>Foreign Insurer or Other Regulated w/ Capital Reqmt</td>
<td>Financial w/o Capital Reqmt</td>
<td>Per Local Regulatory Accounting</td>
<td>Per risk level factor x 3-year avg revenue</td>
<td>Per Local Regulatory Accounting</td>
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<tr>
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<td>Non-Financial</td>
<td>Per Local Regulatory Accounting</td>
<td>No entry Required</td>
<td>No entry Required – Do not de-stack</td>
</tr>
<tr>
<td>Financial w/o Capital Reqmt or Non-Financial</td>
<td>U.S. RBC filer</td>
<td>Per Local Public Accounting</td>
<td>RBC TAC</td>
<td>Per Local Public Accounting</td>
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<tr>
<td>Financial w/o Capital Reqmt or Non-Financial</td>
<td>Other U.S. Insurer</td>
<td>Per Local Public Accounting</td>
<td>BACV Per Statutory Accounting</td>
<td>Per Local Public Accounting</td>
</tr>
<tr>
<td>Financial w/o Capital Reqmt or Non-Financial</td>
<td>Foreign Insurer or Other Regulated w/ Capital Reqmt</td>
<td>Per Local Public Accounting</td>
<td>Per Local Regulatory Accounting</td>
<td>Per Local Public Accounting</td>
</tr>
<tr>
<td>Financial w/o Capital Reqmt or Non-Financial</td>
<td>Financial w/o Capital Reqmt</td>
<td>Per Local Public Accounting</td>
<td>Per Local Regulatory Accounting</td>
<td>Per Local Public Accounting</td>
</tr>
<tr>
<td>Financial w/o Capital Reqmt or Non-Financial</td>
<td>Non-Financial</td>
<td>Per Local Public Accounting*</td>
<td>Per Local Public Accounting*</td>
<td>Per Local Public Accounting</td>
</tr>
</tbody>
</table>

*Subject to Grouping
In cases where a U.S. life RBC filer owns a foreign insurer and the BACV value reported for the foreign insurer in the Parent U.S. insurers financial statement is adjusted to zero for RBC purposes, then report zero in Inventory B, Column 1 and Column 3 for that foreign insurance entity.

- **[Inv B Col 3] Investment in Subsidiary** – Enter an adjustment to remove the investment carrying value of any directly owned subsidiary(ies) from Parent’s carrying value. This is intended to prevent double-counting of available capital when regulated entities are stacked. The carrying value to be removed should be the investment value carried by the Parent from which the entity is being de-stacked (i.e., the value in Column 1 in Inventory B adjusted for ownership percentage). Thus, there will be no adjustment to the Parent’s value in this column for entities that are reported at zero value by the Parent. Where entities are owned partially by entities outside of the group, then the Parent’s percentage of ownership will be calculated based on the value owned within the group.

Generally, for all non-financial affiliates, Schedule A and Schedule BA assets will remain in the value of the Parent insurer and not entered in this column. However, if the Schedule A or Schedule BA asset is an insurance or financial entity as described herein, the value of that entity will be included in this column. For indirectly owned Schedule A or Schedule BA insurance or financial entities, only the value of that entity will be included in this column and the remaining value of the downstream Schedule BA Parent will remain with the Parent insurer. Similarly, the carrying value of U.S. branch of a foreign insurer that is listed in Schedule 1 and in this section should be entered in this column in the row of the foreign insurer if it is already included in the value of the foreign insurer so that the Parent entity may eliminate double-counting of that available capital which will now be reported by the stand-alone Branch listed in the inventory.

**NOTE:** The “Sum of Subsidiaries” column may provide a useful check against this entry, but it will not necessarily be equal.

When utilizing public accounting (e.g., GAAP) equity values that differ from regulatory values (e.g., SAP), it is the **GAAP equity** of the insurers must be eliminated from the GAAP Parent in this column, not the SAP (regulated capital). This is necessary in order to allow the calculation to appropriately represent SAP capital of regulated entities and GAAP equity of non-regulated entities. Data on the accounting differences between Parent and Local carrying values will be collected in **[Inventory B, Column 9]** and further detail provided in the “Questions and Other Information” tab.

**NOTE:** Values for Schedule A and Schedule BA affiliates that are required to be reported in the “Inventory” tab will be adjusted out of the value reported by the U.S. insurer in this column.

- **[Inv B Col 4] Intragroup Capital Instruments** – This column is automatically calculated from inputs to the “Capital Instruments” tab. It reflects an adjustment to remove carrying value for intragroup financial instruments that that are treated as capital by the issuer and consequently create additional capital within the group upon issuance (most notably U.S. surplus notes). Example for surplus notes: In both intragroup and unaffiliated transactions, treat the assets transferred to the issuer of the surplus note as available capital. If the purchaser is an affiliate, eliminate the investment value from the affiliated purchaser of the surplus note in this column. If the purchaser is an insurer or other regulated entity, eliminate the purchaser’s capital charge (e.g., RBC charge) on the
surplus note investment in the corresponding adjustment column for the capital calculation. No adjustments are made for any intragroup capital instrument that is treated as a liability by the issuer.

- **[Inv B Col 5] Reported Intragroup Guarantees, LOCs and Other** – Enter an adjustment to reflect the notional value weighted for expected utilization for reported intragroup guarantees (including solvency insurance and capital maintenance agreements). Enter the notional value for letters of credit, or other intragroup financial support mechanisms. Explain each intragroup arrangement in the “Questions and Other Information” tab.

- **[Inv B Col 6] Other Intragroup Assets** – Enter the amounts to adjust for and to remove double-counting of carrying value for other intragroup assets, which could include intercompany balances, such as (provide an explanation of each entry in the “Questions and Other Information” tab):
  a. Loans, receivables and arrangements to centralize the management of assets or cash;
  b. Derivative transactions;
  c. Purchase, sale or lease of assets; and
  d. Other (describe).

- **[Inv B Col 7] All Other Adjustments** – Include a brief explanation in the “Description of ‘Other Adjustments’” in the “Other Information” tab.

- **[Inv B Col 8] Adjusted Carrying Value** – Stand-alone value of each entity per the calculation to eliminate double-counting. This value includes permitted and prescribed practices.

- **[Inv B Col 9] Accounting Adjustments (e.g., GAAP to SAP)** – Report the total difference between the carrying value reported in Column 1 (and Column 3) and the value reported in Column 2. This column will apply to regulated entities where the stand-alone carrying value is based on regulatory accounting (e.g., SAP) while the value reported for that entity by the Parent is carried at a financial accounting (e.g., GAAP) value. Further detail is reported in the “Questions and Other Information” tab.


- **[Inv B Col 13] Average Revenue over 3-years (Financial Entities without Regulatory Capital Requirements and Non-Financial Entities)** – This column is populated from data in Column 10, Column 11 and Column 12.
This column will support the capital calculation for asset managers, broker-dealers and other Financial Entities without Regulatory Capital Requirements.

62. “Adjusted Capital Calculation” is reported in a similar manner to the “Adjusted Carrying Value” above. The columns are in the same order, although it is likely that fewer entries will be needed for Column 4 through Column 7. Further guidance is below.

- **[Inv C Col 1] Entity Required Capital (Immediate Parent Regime)** – This column is included to accommodate participants with either a U.S. or a non-U.S. based Parent company. No entry is required for the Ultimate Controlling Person. In general, entity required capital should represent the capital requirements of the Parent’s insurance or other sectoral regulator:
  
a. For subsidiaries of foreign insurers or other non-U.S. financial entities, the unscaled capital required by the Parent’s regulator of the regulated entity based on the equivalent of a Prescribed Capital Requirement (PCR) level.

b. For subsidiaries, including applicable Schedule A and Schedule BA subsidiaries, of U.S. insurance entities that are subject to RBC, except where the subsidiary is also an RBC filer, the entry should be equivalent of what would be required in the Parent’s RBC, adjusted for covariance where applicable (calculated by the preparer) reported at company action level (or two times authorized control level RBC) for that entity. Where the subsidiary is also an RBC filer, then the amount reported will be at company action level RBC (or two times authorized control level RBC) after covariance.

c. For subsidiaries of U.S. insurers that do not file RBC, report the actual amount of capital required in the Parent’s capital requirement (if any) for the subsidiary entity.

d. In the case where the Parent is not subject to insurance or other sectoral regulatory valuation, then use zero where applicable. This column will include double-counting. The values recorded for all subsidiaries should be the 100% of the specified capital requirements regardless of percentage of ownership by entities within the group. Where entities are owned partially by entities outside of the group, then report the capital requirements of the subsidiary adjusted to reflect total percentage of ownership within the group. A single entry for all entities that qualify under the grouping criteria described in Section V, herein may be made on the line for the affiliate that holds the qualifying entities in lieu of individual entries.

- **[Inv C Col 2] Entity Required Capital (Local Regime)** – Enter required capital for each de-stacked entity, as applicable entity description below. For U.S. RBC filing subsidiaries under a U.S. RBC filing Parent the amounts will be the same in both the Parent and Local Regime columns, except where the RBC filing subsidiary is subject to an operational risk charge. In such cases the amount reported in this column for the subsidiary will include the operational risk charge while the amount reported in Column 1 will exclude the subsidiary’s operational risk charge. However, for some entity types his will result in entries for the entities under a U.S.-based insurance Parent to be different from what U.S. RBC would dictate. In addition, where a U.S. insurer directly or indirectly owns not admitted (or otherwise zero valued) financial affiliates, those affiliates would be reported with zero value in the Parent Regime column but at the specified regulatory value described below for that financial entity type in this column. However, if such an
entity has been listed in [Sch1B Col 2] Include/Exclude (Supervisor) column, indicating that the Lead State Regulator agrees that the entity does not pose material risk, then report the capital calculation in accordance with entity instructions below, but the ultimate calculation will show the results without the excluded entity’s capital calculation. Directly or indirectly owned non-financial entities that were not admitted or otherwise carried at a zero value in the Parent Regime, may be carried at zero value in this column. A single entry for all entities that qualify under the grouping criteria described herein under Input 1, above may be made in the line for the affiliate that holds the qualifying entities in lieu of individual entries. This column will include double-counting. The values recorded for all subsidiaries should be the 100% of the capital requirements regardless of percentage of ownership by entities within the group. Where entities are owned partially by entities outside of the group, then report the capital requirements of the subsidiary adjusted to reflect total percentage of ownership within the group.

63. Additional clarification on capital requirements where a formula is required:

- **U.S. RBC filing Insurers**: Report RBC at Company Action Level including excluding operational risk (200% x ACL)

- **Foreign Insurance Entities**: The local capital requirement as specified below for each jurisdiction should be reported, by legal entity, at a Prescribed Capital Requirement (PCR) level. This treatment is different than what U.S. RBC would require and recognizes other regulators view of adequate capital for insurers within another jurisdiction. It is more reflective of risk within the group context. A sensitivity analysis will be included in the “Sensitivity Analysis” tab using the jurisdictional PCR scaled per the Excess Relative Ratio method (see Appendix 1) for insurers in foreign jurisdictions that are subject to scaling.

- **European Union subsidiaries**: Use the Solvency II Solo Solvency Capital Requirement (SCR) as the PCR.

- **U.S. RBC filing subsidiaries**: The RBC Company Action Level including operational risk of each insurer should be reported.

- **Australia subsidiaries**: The PCR is the target capital as set by the insurer/group in accordance with APRA requirements. Effectively, this would be “Target capital under ICAAP.” PCR is not a set multiple of MCR.

- **Bermuda subsidiaries**: The Legal Entity PCR in Bermuda for medium and large commercial insurers is called the “Enhanced Capital Requirement” (ECR) and is calibrated to Tail VaR at 99% confidence level over a one-year time horizon.

- **Hong Kong subsidiaries**: Under the current rule-based capital regime, if applied similar to the concept of PCR, the regime’s PCR would be 150% of MCR for life insurers and 200% of MCR for non-life insurers.

- **Japan subsidiaries**: The PCR is the solvency margin ratio of 200%.

- **Korea subsidiaries**: The PCR is 100% of risk-based solvency margin ratio.
- **Singapore subsidiaries**: The PCR is 120% of total risk requirement (i.e., capital requirement).

- **China Taipei subsidiaries**: The PCR is 200% of RBC ratio.

- **Canada life entities**: The baseline PCR should be stated to be “100% of the LICAT Base Solvency Buffer.” The carrying value should include surplus allowances and eligible deposits.

- **Canada P/C entities**: The PCR should be the MCT capital requirement at the target level.

- **South Africa subsidiaries**: The PCR is 100% of the SAM SCR.

- For any entities that cannot be mapped to the above categories, scaling will be at 100%

64. Additional clarification on capital requirements where a U.S. formula (RBC) is not required:

- For those U.S. insurers that do not have an RBC formula, the minimum capital per state law should be used as the basis for what is used for that insurer in the GCC. This may differ from what U.S. RBC would require. It is more reflective of the regulatory view of risk in the group context. The following requirements should be used in other specified situations where an RBC does not exist:

  - **Mortgage Guaranty Insurers**: The minimum capital requirement shall be based on the NAIC’s requirements set forth in the *Mortgage Guaranty Insurance Model Act* (#630).

  - **Financial Guaranty Insurers**: The minimum capital requirement shall be based on the NAIC’s requirements set forth in the *Financial Guaranty Insurance Guideline* (#1626), specifically considering Section 2B (minimum capital requirements) and Section 3 (Contingency, Loss and Unearned Premium Reserves) and the other requirements of that guideline that impact capital (e.g., specific limits).

  - **Title Companies**: The minimum capital requirement shall represent 200% of the required level of reserves carried by the insurance company.

  - **Other Companies**: A selected basis for minimum capital requirements derived from a review of state laws. Where there is a one-off treatment of a certain type of insurer that otherwise would file RBC (e.g., HMOs domiciled in California), the minimum capital required by their respective regulator could be considered in lieu of requiring the entity to complete an RBC blank.

  - **Captives**: U.S. insurers that have captives should complete the applicable RBC formula regardless of whether the captive is required to complete it in their captive state. The amounts input into RBC by the captive shall be based on the actual assets and liabilities utilized in the regulatory reporting used by the captive. Captives used exclusively for self-insurance (either by U.S. life insurers or any other type of insurer) or insurance provided exclusively to its own employees and/or its affiliates, should not complete an RBC calculation and the entire entity should be treated as non-insurers and receive the same charge as a non-regulated entity.

65. Non-insurance financial entities subject to a specified regulatory capital requirement:
• All banks and other depository institutions – The unscaled minimum required by their regulator. For U.S. banks, that is the Office of the Comptroller of the Currency (OCC) Tier 1 or other applicable capital requirement. This is understood to be consistent with how the Federal Reserve Board would apply its Building Block Approach.

• Any other financial entity that is determined to be subject to a specified regulatory capital requirement will bring that requirement in the GCC at the first level of regulator intervention (if applicable).

• This differs from what U.S. RBC would require. It recognizes the sectoral regulator’s view of risk for a particular financial entity type. It is more reflective of risk in the group context.

66. Non-insurance financial entities NOT subject to a specified regulatory capital requirement:

• All asset managers and registered investment advisors and all other financial entities as defined in Section II: Use the capital calculation specified below based the level of risk assigned to the entity by applying the material risk principles defined in Section II. However, asset managers and investment affiliates (not qualifying to be treated as non-financial entities per paragraph 9) will be reported at either medium or high risk. In certain cases, these entities may be subject to a layer of regulation (e.g., SEC or FINRA) but are not generally subject to a specified capital requirement.

High Risk: 10% x 3-year average revenue

NOTE: A Basel Charge of 15% will be used for the IAIS ICS.

Medium Risk: 5.0% x 3-year average revenue.

Low Risk: 2.5% x 3-year average revenue

NOTE: Medium risk could be used as a starting point while the stratified methodology is further developed.

67. Other non-insurance, non-financial entities with material risk:

• Non-insurance, non-financial entities may not be as risky as financial entities. For non-insurance, non-financial entities not owned by RBC filers or other such entities where there is not a regulatory capital charge for the entity in the capital formula, use an equity charge of 10.5% (post tax) for predominantly life Insurance Groups 9.5% for predominantly P/C Insurance Groups and 3.5% for predominantly health Insurance Groups x BACV. If the entity is not subject to a capital charge or is included in the capital charge of another financial entity, then enter zero in Column 1 and the charge specified in this paragraph in Column 2. These factors are based on average after covariance RBC charges for the respective insurer types and are calibrated at 200% x ACL RBC. This is meant to be consistent with how the entity would be treated if owned by an RBC filer while recognizing that the entity may be excluded from the GCC if it does not pose material risk to the insurers in the group.

Non-insurance/non-financial entities owned by RBC filing insurers (or owned by other entities where a regulatory capital charge applied to the non-insurance/non-financial affiliate) will remain in the Parent’s capital charge and reported at that value in Column 1.
but will be reported as zero in Column 2. These non-financial entities may not be excluded from the GCC.

One additional informational capital calculation for all non-financial entities will be applied in the Sensitivity Analysis tab using current year gross revenue from Inventory B, Column 12 with the calculation occurring and results available in the “Calc 2” tab as follows: 5% of reporting year gross revenue based on a medium level risk for a financial entity.

68. Non-operating holding companies:

- Non-operating holding companies will be treated the same as other non-insurance/non-financial entities with material risk. Unless reported on a grouped basis (see paragraph 55), for purposes of applying the capital calculation, the carrying value of stand-alone positive valued and negative valued non-operating holding companies will be netted. If the net value is zero or less (floored at zero for purposes of applying a charge), the charge applied will be zero. If the filer chooses to designate the non-operating holding company as a non-insurance/non-financial entity without material risk and requests exclusion, then no allowance for debt issued by that holding company may be included in the calculation.

<table>
<thead>
<tr>
<th>Parent Entity Line Inv C, Column 3</th>
<th>Parent Entity</th>
<th>Entity</th>
<th>Inv C, Column 1</th>
<th>Inv C, Column 2</th>
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<td>U.S. RBC filer</td>
<td>U.S. RBC filer</td>
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<td>RBC ACL (incl. op risk) x 2</td>
<td>RBC ACL (excl. op Risk) x 2</td>
</tr>
<tr>
<td>U.S. RBC filer</td>
<td>Other U.S. Insurer</td>
<td>Affiliate risk RBC</td>
<td>Per GCC Entity Instructions</td>
<td>Affiliate risk RBC</td>
</tr>
<tr>
<td>U.S. RBC filer</td>
<td>Foreign Insurer or Other Regulated w/ Capital Regmt</td>
<td>Affiliate risk RBC</td>
<td>Jurisdictional or Sectoral PCR Level Capital Regmt</td>
<td>Affiliate risk RBC</td>
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<tr>
<td>U.S. RBC filer</td>
<td>Financial w/o Capital Reqmt</td>
<td>Asset risk RBC</td>
<td>Per risk level factor x 3-year avg revenue</td>
<td>Asset risk RBC</td>
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<td>No entry Required - Do not de-stack</td>
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<td>Per GCC Entity Instructions</td>
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<tr>
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<td>Per Local Capital Regmt</td>
<td>RBC ACL (incl. op risk) x 2</td>
<td>Per Local Capital Regmt</td>
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<tr>
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<td>Per Local Capital Regmt</td>
<td>Per GCC Instructions</td>
<td>Per Local Capital Regmt</td>
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<tr>
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<td>Foreign Insurer or Other Regulated w/ Capital Reqmt</td>
<td>Per Local Capital Regmt</td>
<td>Jurisdictional or Sectoral PCR Level Per Local Capital</td>
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<td>Per Local Capital Regmt</td>
<td>Per risk level factor x 3-year avg revenue</td>
<td>Per Local Capital Reqmt</td>
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<td>Non-Financial</td>
<td>Per Local Capital Reqmt</td>
<td>No entry Required</td>
<td>No entry Required - Do not de-stack</td>
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<td>RBC ACL (incl. op risk) x 2</td>
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<tr>
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<td>Per GCC Entity Instructions</td>
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<tr>
<td>Financial w/o Capital Reqmt or Non-Financial</td>
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<td>Per risk level factor x 3-year avg revenue*</td>
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</tr>
<tr>
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<td>Zero</td>
<td>Per GCC Instructions*</td>
<td>Zero</td>
</tr>
</tbody>
</table>
Capital Calculation Adjustments

- **[Inv C Col 3] Investment in Subsidiary** – Enter an adjustment to remove the required capital of the directly owned subsidiary(ies) from Parent’s required capital. The capital requirement to be removed should be the capital requirement carried by the Parent from which the entity is being de-stacked (i.e., the value reported in Column 1 in Inventory C adjusted for ownership percentage). Thus, there will be no adjustment to the Parent’s value in this column for entities that are reported at a capital calculation of zero value by the parent. This is intended to prevent double counting required capital when regulated entities are stacked. [Example: When de-stacking an RBC filer from another RBC filer, the amount entered on the Parent line would be the RBC of the subsidiary. When de-stacking financial entities that are subject to diversification in a capital formula (e.g., RBC) the amount entered on the Parent line is the post-diversified capital requirement as calculated by the preparer (which is also the amount to be reported for the de-stacked entity on the entity’s line).

Generally the capital requirements for Schedule A and BA affiliates and other non-financial affiliates will remain in the capital requirements of the Parent insurer and not entered in this column, except that the capital requirements for any financial entity reported in a Parent’s Schedule A and BA, any financial entity indirectly owned through another Schedule A or BA affiliate listed in Schedule 1 and in this section should be entered in this column in the row of the entity that directly or indirectly owns that Schedule A and BA affiliate so that the parent entity may eliminate double counting of that capital requirement capital which will now be reported by the stand-alone Schedule A or BA affiliate listed in in the inventory.

For indirectly owned Schedule A and BA financial entities, only the capital requirements for that entity will be included in this column and the remaining capital requirement of the downstream BA Parent will remain with the Parent insurer. Similarly, the capital requirement for any U.S. Branch of a foreign insurer that is listed in Schedule 1 and in this section should be entered in this column in the row of the foreign insurer if it is already included in the capital requirement of the foreign insurer so that the parent entity may eliminate double counting of that capital requirement which will now be reported by the stand-alone Branch listed in the inventory. The amounts entered in this column for a Parent must correspond to the capital required by the parent entity which is being de-stacked from that Parent.

Capital calculations for Schedule A and Schedule BA indirectly owned financial entities that are owned by Schedule A or Schedule BA assets are reported in the Inventory Tab and will be adjusted out of the value reported by the U.S. insurer in this column (since the non-financial direct parent Schedule A or BA affiliate is not listed in the Inventory Tab.

In the “Questions and Other Information” tab, a capital requirement should be reported for the value of the indirectly owned insurance of other financial entity based on the insurers Schedule A or Schedule BA charge rather than a charge (which would be zero) attributable to the Schedule A or Schedule BA entity that directly owns the insurance or other financial entity. As indicated earlier, the remaining capital requirement of the entity that directly owns the insurance or other financial entity will remain with the Parent insurer.

- **[Inv C Col 4] Intragroup Capital Instruments** – This column would generally be used if there is potential double-counting of capital requirements (e.g., RBC charges on surplus notes purchased by an affiliated U.S. insurer from a U.S. insurer issuer).
• [Inv C Col 5] Reported Intragroup Guarantees, LOCs and Other – This column would generally be used if there is potential double-counting of capital requirements (e.g., RBC charges on guarantees or LOCs).

• [Inv C Col 6] Other Intragroup Assets – This column is not intended to be used for required capital but is included in case an entity believes it is necessary from reporting an inaccurate required capital figure.
  a. Loans, receivables and arrangements to centralize the management of assets or cash.
  b. Derivative transactions.
  c. Purchase, sale or lease of assets.
  d. Other (describe in “Questions and Other Information” tab).

• [Inv C Col 7] All Other Adjustments – Include a brief explanation in the “Description of ‘Other Adjustments’” in the “Questions and Other Information” tab. Use this column is for adjustments related to required capital that correspond to adjustments in Inventory B, Column 7 and in cases where an entity believes it is necessary to adjust an inaccurate regulatory required capital figure (e.g., the RBC calculation applied as a permitted practice).

  NOTE: Consider whether this column should be used rather than Column 2 for zero value entities.

• [Inv C Col 8] Adjusted Capital Calculation – Stand-alone capital calculation for each entity per the calculation to eliminate double-counting. This value includes the impact of permitted and prescribed practices.

• Inventory D is for “Reference Calculations Checks.” These are calculations that can serve as checks on the reasonability/consistency of entries.
  a. [Inv D Col 1 – 3] Sum of Subsidiaries (Carrying Value) – This automatically generated column calculates the value of the carrying value of the underlying subsidiaries. It is provided for reference when filling out the “Investment in Subsidiary” column. This sum will often, but not always, be equal to the “Investment in Subsidiary” column.
  b. [Inv D Col 4 – 6] Sum of Subsidiaries (Calculated Capital) – Similar to above but for calculated capital.
  c. [Inv D Col 7 – 8] Carrying Value/Adj Calc Cap – This is a capital ratio on the adjusted and unadjusted figures. Double-check entities with abnormally large/small/negative figures to make sure that adjustments were done correctly.

Input 3 – Capital Instruments

69. Provide all relevant information pertaining to paid-up (i.e., any receivables for non-paid-in amounts would not be included for purposes of calculating the allowance) financial instruments issued by the Group (including senior debt issued by a holding company), except for common or ordinary shares and preferred shares. This worksheet aims to capture all financial instruments such as surplus notes, senior debt, hybrid instruments and other subordinated debt. Where a Volunteer Group has issued multiple instruments, the Volunteer Group should not use a single
row to report that information; one instrument per row should be reported (multiple instruments issued under the same terms may be combined on a single line). All qualifying debt should be reported as follows.

70. Debt issued by U.S.-led groups:

- Surplus Notes – Report the outstanding value of all surplus notes in Column 8 whether issued to purchasers within or outside the group. The outstanding value of surplus notes issued to entities outside the group and that is already recognized by state insurance regulators and reported 100% as capital in the carrying value of U.S. insurer issuers in “Inventory B” will not be included in the calculation for an additional capital allowance. Surplus notes issued within the group generally result in double-counting and will not be included in the additional capital allowance. (See instructions below.)

- Subordinated Senior Debt and Hybrid Debt Issued (e.g., debt issuances that receive an amount of equity credit from rating agencies) – The outstanding value will be reported in Column 8. Recognition for structurally subordinated debt will be allowed to increase available capital. For purposes of qualifying for recognition as additional capital, both of the following criteria must be met:
  
a. The instrument has a fixed term (a minimum of five years at the date of issue or refinance, including any call options other than make whole provisions\(^1\)). However, if the instrument is callable within the first five years from the date of issue it may be considered qualifying debt if any such call is at the option of the issuer only (the instrument is not retractable by the holder) AND it is the intent of management to replace the called instrument in full before or at redemption by a new issuance of the same or higher quality instrument.

  b. Supervisory review or approval is required for any ordinary* or extraordinary dividend respectively or distribution from any insurance subsidiary to fund the repurchase or redemption of the instrument. Supervisory approval of ordinary dividends is met if the supervisor has in place direct or indirect supervisory controls over distributions, including the ability for the supervisor to limit, defer and/or disallow the payment of any distributions should it find that the insurer is presently, or may potentially become, financially distressed. There shall be no expectation, either implied or through the terms of the instrument, that such approval will be granted without supervisory review.

*The concept of approval for ordinary dividends is for GCC purposes and is met as described in subparagraph b, above. It is not intended to require explicit regulatory approval or in any way alter current provisions of Model #440 or the Insurance Holding Company System Model Regulation (#450).

- “Other” Debt – The outstanding value will be reported in Column 8 and will be further described in the “Other Information” tab and will be reported in a manner that is

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\(^1\) NAIC staff have been informed that make whole provisions are a form of a call feature that can be exercised by the issuer at any time; that they nonetheless are most frequently utilized near the end of the term of the instrument, generally in connection with refinancing; and that the cost to the issuer to exercise the make whole provision and associated financial reporting impacts, combined with the very low interest rate environment, make it much less likely that such provisions will be triggered, particularly within five years of issuance. Staff will continue their research, and assuming these observations are confirmed, the referenced criteria will continue to scope out make whole provisions.
consistent with Senior Subordinated Debt, as described above. Such debt will not initially be included in the additional capital allowance for the GCC. An additional allowance of this debt as additional capital will be calculated in this tab and reported as a sensitivity analysis in the “Summary” tab, subject to future determination on whether it will become part of the GCC calculation.

- Foreign Debt – Report the outstanding value of Non-U.S. senior debt issued to entities outside the group in Column 8. Debt specifically recognized by statute, regulation or accounting rule as additional capital resources by the lead jurisdiction based on contractual subordination or where a regulatory regime proactively enforces structural subordination through appropriate regulatory/supervisory controls over distributions from insurers in the group will not be included in the calculation of an additional capital allowance if it is already reported as capital in the carrying value of the issuer in “Inventory B”. It will be included in the calculation of an additional capital allowance if recognized by the local jurisdiction and NOT already included in the value of the issuer in “Inventory B”. Cases where the value of debt instruments issued to purchasers outside the group has not been recognized by the legal entity’s insurance or other sectoral supervisor will not be included in the additional capital allowance.

71. Please fill in columns in Section 3A as follows for all capital instruments:

- [Sec 3A Col 1] Name of Issuer – Name of the company that issued the capital financial instrument. Will populate automatically from the “Entity Identifier” column in this subsection.

- [Sec 3A Col 2] Entity Identifier – Provide the reference number that was input in Schedule 1.

- [Sec 3A Col 3] Type of Financial Instrument – Select type from the drop-down menu. Selections include Senior Debt, Surplus Notes (or similar), Hybrid Instruments and “Other” Subordinated Debt.

- [Sec 3A Col 4] Instrument Identifier – Provide a unique security identifier (such as CUSIP). ALL debt instruments must include an internal identifier if not external identifier is available.

- [Sec 3A Col 5] Entity Category – Links automatically to selection made on the “Inventory” tab worksheet.

- [Sec 3A Col 6] Year of Issue – Provide the year in which the financial instrument was issued or refinanced.

- [Sec 3A Col 7] Year of Maturity – Enter the year in which the financial instrument will mature.

- [Sec 3A Col 8] Balance as of Reporting Date – Enter the principal balance outstanding as reported in the general-purpose financial statements of the issuer.
• [Sec 3A Col 9] **Intragroup Issuance** – Select whether the instrument was issued on an intragroup basis (that is, issued to a related entity within the group). This column will be used to remove “double-counting.” This column is a drop-down menu box with options “Y” and “N.”

• [Sec 3A Col 10] **Treatment in Inventory B** – Select option that applies:

  a. **Capital** – This instrument is recognized by the applicable regulator or credited as capital in local regulatory regime and reported as part of the adjusted carrying value of the issuer and was not purchased by an affiliate. This includes the value of qualifying senior and hybrid debt instruments (if recognized as capital) and U.S. surplus notes (or similar local regime instruments) that are issued to entities outside the group and included in the issuing entity’s value in the “Inventory B” tab. The outstanding value of those debt instruments will not be included in the calculation of a proxy allowance for additional capital.

  b. **Liability** – This instrument is reflected by the issuer as a liability in the adjusted carrying value in the “Inventory B” tab and was not purchased by an affiliate. This would apply to all qualifying senior and hybrid debt issued to purchasers outside the group that is not recognized as capital by the local regulator and therefore is not included in the issuing entity’s value in the “Inventory B” tab. The value will be included in the calculation of a proxy allowance for additional capital.

  c. **Liability designation** would also apply to all non-qualifying senior and hybrid instruments and all debt categorized as “Other” issued to purchasers outside the group that is not recognized as capital by the local regulator. The value of these instruments will NOT be included the calculation for the in the calculation of a proxy allowance for additional capital.

  d. **Intragroup** – This would apply to all qualifying instruments purchased by an affiliate within the group. The outstanding value of those debt instruments will not be included in the calculation of a proxy allowance for additional capital. If the financial instrument is recognized or credited as part of the issuer’s available capital in Inventory B, then an adjustment for intragroup capital instruments is made in Inventory B, Column 4 and Inventory C adjustments (if necessary to eliminate an associated capital requirement). If the financial instrument is treated as a liability by the issuer, then no intragroup capital instrument adjustment is required in Inventory B or Inventory C.

  e. The outstanding value of all non-qualifying senior and hybrid instruments and financial instruments categorized as “Other Debt” whether issued to purchasers inside or outside the group will not be included in the calculation of a proxy allowance for additional capital and no other adjustments are required in the template. However, in the unlikely event that the instrument is treated as available capital to the issuer in Inventory B, an adjustment in Inventory B, Column 4 to remove the available capital would be required.

**NOTE:** Additional information on instruments categorized as “Other Debt” in the Type of Financial Instrument Column will require additional information to be provided in the “Questions and Other Information” tab.
For **intragroup surplus notes**, the adjustment will impact the carrying value and associated capital calculation of the purchasing affiliated entity.

- **[Sec 3A Col 11] Intragroup Purchaser Identifier** – Enter the entity identify for the affiliate entity that purchased the instrument.

- **[Sec 3A Col 12] Description of Other Debt Instruments** – Provide a description of instruments designated as “Other.”

- **[Sec 3A Col 13] Call Provisions Criteria** – Respond “Y” or “N” as to whether the instrument is subject to a call provision (other than a make whole provision) in the first five years AND it is management’s intent to replace the called instrument in full before or at redemption by a new issuance of the same or higher quality instrument. Respond “X” if the instrument has a maturity of greater than five years including any call provisions.

- **[Sec 3A Col 14] Potentially Recognized Instrument** – This is an automatic calculation to determine if this is an instrument that has potential to be recognized as additional capital in the GCC and/or in sensitivity analysis. The column will show “Y” if each of the following is true: 1) it is Senior Debt, Hybrid or Other instrument; 2) the instrument is not intragroup; and 3) the instrument is treated as liability on Inventory B. These are calculated using Column 3, Column 9, and Column 10, respectively.

- **[Sec 3A Col 15] Other Criteria Met** – This is an automatic calculation to determine if the instrument qualifies due to criteria beyond those in Column 14. The column will show “Y” if: 1) the instrument has initial maturity of greater than five years including any call provision (i.e., “X” is reported in Column 13); and 2) it meets the “Call provisions criteria” in Column 13 (i.e., “Y” is reported in Column 13).

- **[Sec 3A Col 16] Qualified Debt** – This column is calculated automatically using data from the entries in Column 14 and Column 15. To qualify, an instrument needs a “Y” in both columns. It represents the amount of qualifying debt that will be used in the calculation of an allowance for addition capital under the alternate subordination method and the proxy allowance method. This amount will be carried into Section 3C, Column 1, Line 3.

72. Section 3C will be auto-filled, with the exception of Column 1, Line 2.

- **[Sec 3C Col 1, Line 1] Total Paid-In and Contributed Capital and Surplus** – This is the amount reported on Page 3 of the annual financial statement submitted to regulators by a U.S. insurer.

- **[Sec 3C Col 1, Line 2] Alternate Subordination Calculation** – This manual entry is the excess of qualifying debt issued over liquid assets held by the issuing consolidated holding company as reported in the consolidated financial statements. No entry is expected for a mutual group.

- **[Sec 3C Col 1, Line 4] Downstream Estimate** - The total reported under the alternate subordination approach will be compared to the total amount of gross paid-in or contributed capital and surplus reported by the insurance entities within the group as
reported in Schedule 1. The greater value will be carried into the calculation for an additional capital allowance.

**NOTE:** No more than 100% of the total outstanding value of qualified senior and hybrid debt will be allowed into the calculation.

- **[Sec 3C Col 1, Line 5]** Proxy Calculation for Additional Capital Allowance – A calculation will be made in this tab in Section 3B that will apply 30% of available capital plus the value of all qualifying debt to become part of the proxy allowance for additional capital for qualifying senior subordinated. An additional amount of 15% of available capital plus the value of all qualifying debt will be calculated to become part of a proxy allowance for additional capital be for hybrid debt.

  **Summary Formula:** Proxy Amount = \((30\% \times (\text{Available Capital} + \text{Qualifying Senior and Hybrid Debt})) + (15\% \times (\text{Available Capital} + \text{Qualifying Senior and Hybrid Debt}))\)\text{.}

  **NOTE:** No more than 100% of the total outstanding value of qualified senior and hybrid debt will be allowed into the calculation.

- **[Sec 3C Col 1, Line 6 through Line 8]** – The greater of the proxy calculation or the larger of paid in capital or alternate subordination calculation will be allowed as additional capital in **[Sec 3C Col 6]**. However, an overall limit of no more than 75% of the total adjusted carrying value in Inventory B will be applied in **[Sec 3C Col 7]**. Adjustments to increase available capital will be calculated from data on this page. The summary results of the components of the calculation (paid in capital and surplus, alternate subordination, proxy calculation and limitations) are populated as titled in the calculation columns in this section. The final amount recognized as additional capital is shown in **[Sec 3C Col 8]**.

  The additional capital allowance recognized for capital instruments will be shown as an “on-top” adjustment in the “Summary 1 – Entity Level” tab.

**Summary Calculation for Debt Allowed as Additional Capital:**

Step 1: Calculate the following amounts:
  a) The greater of Total paid-in capital and surplus of U.S. insurers or the alternative subordination calculation (defined above)
  b) A proxy value (defined above)

Step 2: Take the greater of a) or b) from Step 1, and subject that amount to two limitations:
  - First, the total amount to qualify as capital cannot exceed 100% of the total outstanding value of qualified senior and hybrid debt.
  - Second, the total amount to qualify as capital cannot exceed 75% of the total adjusted carrying value in Inventory B.

After applying the two limitations in Step 2, the remaining amount is allowed as additional capital.
73. **Informational calculation to include “Other Subordinated Debt”** – A sensitivity analysis will be applied in [Sec 3C Col 2, Line 1 through Line 8] and carried into the “Summary 2” tab to adjust the amount of additional capital in the proxy calculation by the amount of “Other Debt” reported in [Sec 3C Col 8] issued to purchasers outside the group. This informational sensitivity analysis will include an additional allowance for such debt up to 15% of available capital plus the value of all qualifying debt including qualifying “Other” debt subject to the same limitations noted for the proxy allowance in general.

**Input 4 – Analytics**

74. The entity type information supporting analytics summarized in Summary 3 – Analytics are pulled into this tab from data or information reported in other tabs in the GCC template. That data is exported into summaries in the “Summary 3 – Analytics” tab. Only 2020 data is currently to be populated. However, it is contemplated that going forward, data for prior years will also be populated such that it will provide the Lead State Regulator with metrics to identify trends over time.

**Input 5 – Sensitivity Analysis and Inputs**

75. All sensitivity analysis is ultimately calculated in the “Summary 2” tab. Inputs for Analysis 1, 2, 5, 6, and 7 are not required in this tab. They are populated from other tabs as described below and automatically calculated in the “Summary 2” tab. However certain analysis requires inputs from this tab. Inputs are required in this tab for Analysis 3, Analysis 4, Analysis 8, and Analysis 9. Those inputs are automatically pulled into the calculation in the Summary 2 tab. Sensitivity Analysis are intended to provide the Lead State Regulator additional information that helps them better understand the financial condition of the group. Similar to the sensitivity analysis included in the legal entity RBC, it provides the regulator with additional information and allows them to consider “what-if” scenarios to better understand the impact of such items. The results of these analysis will not impact the GCC ratio.

- **[Analysis 1]: GCC overall sensitivity analysis** – No additional data is needed in the tab. The overall GCC ratio will be presented at 300% x ACL level. This calculation will increase the calculated capital for most entity types by a factor of 1.5. However, entities with existing regulatory capital requirements (e.g., foreign insurers and banks) will be reported at the same level specified in these instructions for both the GCC and the sensitivity analysis (i.e., at 100% of the jurisdictional or sectoral PCR requirements).

- **[Analysis 2]: Excluded non-insurance/non-financial entities without material risk** – No additional data is needed in the tab. The data for entities where exclusion has been requested and the lead state does not agree will be populated based on entries in [Sch 1B Col 3] and data in Inventory B, Column 2 and Inventory C, Column 2. This analysis will be applied and reported in the “Summary 2” tab. It will provide the regulator with the impact of excluding non-agreed-upon entities on the GCC ratio.

- **[Analysis 3 and Analysis 4]: Permitted practices** – This information shows the amount of U.S. permitted practices as described in the Preamble of the *Accounting Practices and
Procedures Manual and the sensitivity analysis allows the state to understand the size of the practices related to the overall group capital position and their impact on the GCC ratio.

- **Prescribed Practices** – This information to be entered on this tab shows the amount of U.S. prescribed and prescribed practices as described in the Preamble of the Accounting Practices and Procedures Manual and the sensitivity analysis allows the state to understand the size of the practices related to the overall group capital position and their impact on the GCC ratio. This analysis will be applied and reported in the “Summary 2” tab.

- **Permitted and Prescribed Practices** – Report values from annual financial statement Note 1 (excluding those pertaining to XXX/AXXX captives):
  a. Entity identifier
  b. Value of permitted practice
  c. Capital Requirement attributable to permitted practice (if any)
  d. Description of permitted practice
  e. Value of prescribed practice
  f. Capital requirement attributable to permitted practice (if any)
  g. Description of prescribed practice

- **[Analysis 5]: Foreign Insurer Capital Requirements Scaled** – No additional data is needed in the tab. This information shows the amount of foreign insurer capital calculations scaled by applying scalars using the Excess Relative Ratio approach at a 200% x ACL RBC calibration level and at 300% x ACL for all non-U.S. jurisdictions where scalar data is available (see Appendix 1). The sensitivity analysis allows the state to understand the impact of this specific scaling method on the GCC ratio. This information is populated from the “Scalar” tab. This analysis will be applied and reported in the “Summary 2” tab.

- **[Analysis 6]: Debt Classified as “Other”** – No additional data is needed in the tab. The analysis data will be populated from the “Capital Instruments” tab and the analysis and will be applied and reported in the “Summary 2” tab.

- **[Analysis 7]: Alternative Capital Calculation for Non-Financial Entities** – No additional data is needed in the tab. The values reported will represent the alternative revenue-based values for capital calculation that is being captured in the template. The data will be populated from Schedule 1 and Inventory B and the analysis will be applied and reported in the “Scaling Non-Insurance” tab (Calc 2).

- **[Analysis 8]** For captives other than XXX/AXXX, all other U.S. captives shall make an asset adjustment as described below;
**Asset Impact**

76. For the asset impact, it is ONLY required for the assets included in a captive or an entity not required to follow the statutory accounting guidance in the *Accounting Practices and Procedures Manual*. It is not required for assets for those groups that retain such business in a non-captive traditional insurance company(ies) already required to follow the *Accounting Practices and Procedures Manual*.

**NOTE**: Variations for state prescribed and permitted practices are captured in the separate sensitivity analysis.

77. The asset impact amount shall be determined based on a valuation that is equivalent to what is required by the *Accounting Practices and Procedures Manual* (SAP). For this purpose, “equivalent” means that, at a minimum the listed adjustments (as follows) be made with the intent of deriving a valuation materially equivalent to what is required by the *Accounting Practices and Procedures Manual*, however, without requiring adjustments that are overly burdensome (e.g., mark-to-market bonds used by some captives under U.S. GAAP versus full SAP that considers NAIC designations). To be more specific, the asset impact shall be developed by accumulating the impact on surplus because of an accumulation of all the following in paragraph 78 and paragraph 79 combined.

**NOTE**: Letters of credit or other financial instruments that operate in a manner like a letter of credit, which are not designated as an asset under either SAP or U.S. GAAP and are required to be adjusted out of the available assets (i.e., the asset reduction is recorded as a negative figure in the template).

78. To achieve the above, accumulate the effect of making the following impact and record as a negative figure in the template, an asset adjustment for all the following explicit assets not allowed to be admitted under SAP:

- **Assets specifically** not allowed under the *Accounting Practices and Procedures Manual* in accordance with paragraph 9 of SSAP No. 97—*Investments in Subsidiary, Controlled and Affiliated Entities*.
- **SSAP No. 6**—*Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due from Agents and Brokers*.
- **SSAP No. 16R**—*Electronic Data Processing Equipment and Software*.
- **SSAP No. 19**—*Furniture, Fixtures, Equipment and Leasehold Improvements*.
- **SSAP No. 20**—*Nonadmitted Assets*.
- **SSAP No. 21**—*Other Admitted Assets* (e.g., collateral loans secured by assets that do not qualify as investments are nonadmitted under SAP).
- **SSAP No. 29**—*Prepaid Expenses*.
- **SSAP No. 105**—*Working Capital Finance Investments*.
- Expense costs that are capitalized in accordance with GAAP but are expensed pursuant to statutory accounting as promulgated by the NAIC in the *Accounting Practices and Procedures Manual* (e.g., deferred policy acquisition costs, pre-operating, development and research costs, etc.).
- Depreciation for certain assets in accordance with the following SSAPs:
  - SSAP No. 16R—Electronic Data Processing Equipment and Software.
  - SSAP No. 19—Furniture, Fixtures, Equipment and Leasehold Improvements.
  - SSAP No. 68—Business Combinations and Goodwill.
- The amount of goodwill of the SCA more than 10% of the audited U.S. GAAP equity of the SCA’s last audited financial statements.
- The amount of the net deferred tax assets (DTAs) of the SCA more than 10% of the audited U.S. GAAP equity of the SCA’s last audited financial statements.
- Any surplus notes held by the SCA issued by the reporting entity.

79. In addition, record as a negative figure, an asset impact for any assets that are not recognized as an admitted asset under the principles of SSAP No. 4—Assets and Nonadmitted Assets, including:

- Letters of credit, or other similar instruments, that operate in a manner like a letter of credit and, therefore, do not meet the definition of “asset” as required under paragraph 2.
- Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets that are unavailable due to encumbrances or other third-party interests, should not be recognized on the balance sheet and are, therefore, considered nonadmitted.
- Assets of an insurance entity pledged or otherwise restricted by the action of a related party, the assets are not under the exclusive control of the insurance entity and are not available to satisfy policyholder obligations due to these encumbrances or other third-party interests. Thus, such assets shall not be recognized as an admitted asset on the balance sheet.

- [Analysis 9]: Other Regulator Discretion – This analysis is designed to reflect other regulator adjustments including for transactions other than XXX/AXXX reinsurance where there are differences in regulatory regimes exist and there is a desire to fully reflect U.S. Statutory Accounting treatment or to reflect the lead state’s view of risk posed by financial entities without specified regulatory capital requirements or risk posed by non-insurance/non-financial entities that have been included in the GCC. This will be a post-submission item completed by the Lead State Regulator. Enter the following information here:
  a. Entity identifier.
  b. Amount of adjustment.
  c. Description of regulatory issue.

NOTE: This column may also be completed by the filer after advance consultation with the Lead State Regulator.
Input 6 – Questions and Other Information

80. This tab provides space for participants to describe or provide greater detail for specified entries in other tabs (as noted in the instructions for the columns in those tabs) or additional relevant information not captured in the template. Examples include; adjustments for intragroup debt, description of permitted practices; and adjustments to available capital or capital calculations that are included in the “other adjustment” column in the “Inventory” tab. Specified items are included in the tab. Other information that the filer believes is relevant should be added freeform in this tab.

Information or Detail for Items Not Captured in the Template

- Intercompany Guarantees – Provide requested information:
  a. Entity identifier issuing the guarantee.
  b. Entity identifier of entity or entities that are covered by the guarantee.
  c. Indicate the notional or fixed value of the guarantee.
  d. Describe the nature of the guarantee.

- Capital Maintenance Agreements – Provide requested information:
  a. Entity identifier obligated under the agreement.
  b. Entity identifier for entity or entities that are covered by the guarantee.
  c. Indicate the notional or fixed value of the agreement.
  d. Describe the nature of the agreement.

- Value of intangible assets included in non-insurance Holding Companies – Provide the requested information for all entities designated in the non-operating holding company entity category.
  a. Entity identifier.
  b. All goodwill.
  c. All intangibles related to health care services acquisitions included in local carrying value column in Inventory B. Examples include, but are not limited to, customer relationships (policy retention, long-term health services contracts) and technology/patents/trade names and provider network contracts.
  d. All other intangible assets included in local carrying value column in Inventory B.
  e. Total of line b, line c and line d.*
  f. A description of each intangible asset included in line d.

* Auto populated.

Further detail on amounts reported for specific intangibles other than goodwill may be requested by the Lead State Regulator during review of the GCC template.

Information or Detail for Items Captured in the Template

- Currency Adjustments – Provide requested information only for entities where the amount reported for an entity in Inventory B, Column 2 is different than the amount in Inventory B, Column 1 due to currency conversion.
a. Entity identifier.
b. Currency type reported in Inventory B, Column 1 and Inventory C, Column 1 (foreign currency).
c. Conversion rate applied.
d. Source of conversion rate applied.

- Intragroup Assets – Description of Adjustments for intragroup assets reported in Inventory B, Column 6 and Inventory C, Column 6. Provide the following information:
  a. Entity identifier.
  b. Amount reported in Inventory B, Column 6.
  c. Description of adjustment.

- Other Adjustments – Description of adjustments reported in Inventory B, Column 7 and Inventory C, Column 7. Provide the following information:
  a. Entity identifier.
  b. Amount reported in Inventory B, Column 7.
  c. Description of adjustment.

- Accounting Adjustments – Provide requested information only for entities where the amount reported for an entity in Inventory B, Column 1 is different than the amount in Inventory B, Column 2 due to differences in accounting basis
  a. Entity identifier.
  b. Value reported in Inventory B, Column 1.*
  c. Value reported in Inventory B, Column 2.*
  d. Total amount of adjustments related to difference in accounting basis.*
  e. Nature of adjustment (e.g., GAAP to SAP).
  * Auto populated.

- Stress Scenario Narrative – Provide a high-level description of the anticipated market conditions or other reasonably likely company specific drivers that would lead to the selected level of stress results (i.e., the percentage adjustments) calculated in the Stress Summary tab. In addition, provide any comments relating to the potential for procyclical GCC ratio results in specific areas of the calculation.

- The tab also includes a listing of all Schedule A and Schedule BA affiliates, along with the following information:
  a. Parent identifier (if available) – This is the same information as is included in Schedule 1 [Sch 1B Col 3] as would be entered for non-Schedule A/Schedule BA affiliates.
  b. Parent Name – Enter the Name of the Parent.
  c. Is Parent a Schedule A or Schedule BA Asset? – This column is only required for financial entities that are Directly owned by a Schedule A or Schedule BA Affiliate. No other downstream affiliates owned by Schedule A or Schedule BA entities need
to be listed. These entities are not normally independently reported in Schedule A and Schedule BA so are extra entries.

d. Financial? (Y/N) – If the entity meets the criteria as being a financial entity, indicate with a “Yes” response. A “No” response is not required for other entities listed. “Yes” entries should correspond to “Yes” entries in Schedule 1 [Sch 1B Col 16].

e. Carrying Value of Immediate Parent – Report the value listed in Schedule A and Schedule BA of the Parent insurer. For those cases where an indirect financial entity is reported use the value used by the direct Parent.

f. Capital Requirement for Immediate Parent – Report the value listed in the RBC report of the Parent insurer (pre-tax where applicable). For those cases where an indirect financial entity is listed, report the value of the capital requirement attributable to the Insurer rather than the direct non-financial Schedule BA Parent. The capital requirement reported in this column for the immediate Schedule BA Parent should be adjusted to deduct the amount moved to Schedule 1 and Inventory C.

Calc 1 – Scaling (Insurance Entities)

81. All entries in this tab are calculation cells populated using data from within the tab or using data from elsewhere in the template. Scaled values for calculated capital will become part of the GCC ratio. The calculated values will be summarized by entity type in the “Summary 1 – Entity Level” tab. The concept of a scalar was first introduced to address the issue of comparability of accounting systems and capital requirements between insurance regulatory jurisdictions. The idea is to scale capital requirements imposed on non-U.S. insurers so as to be comparable to an RBC-based requirement. Two approaches for scaling related to foreign insurers were presented, and others are being explored and will be reviewed. A decision on the scaling methodology to be adopted into the GCC template will be made at the end of the review. In the interim a scalar of 100% of the jurisdictional PCR will be applied to all jurisdictions where a risk-sensitive capital requirement is in place.

82. Information on the Excess Relative Ratio (ERR) scalar methodology will be collected and applied in the “Sensitivity Analysis” tab.

NOTE: See Appendix 1 for more information and examples on how the ERR scalars are calculated.

83. For jurisdictions without risk-sensitive capital requirements a 100% charge will be applied to adjusted carrying value.

Calc 2 – Capital Calculations for Non-insurance Entities

84. All entries in this tab are either calculation cells using data from within the tab or using data populated from elsewhere in the template. Calculated capital for all entities except insurers will be reported in this tab. The calculated values will be summarized by entity type in the “Summary 1 – Entity Level” tab.

85. In addition, one informational option for calculated capital for financial entities without an existing regulatory capital requirement and one informational option for calculated capital for
non-financial entities will be reported in this tab. Those calculation will not be carried into the “Summary 1 – Entity Level” tab and will not be part of the GCC ratio.

86. Only amounts for entities that the filer and the Lead State Regulator agree should not be excluded [Sch 1B Col 2] will be brought into the calculation in this tab and the “Summary 1 – Entity Level” tab. Entities where the Lead State Regulator does not agree with the filer’s request to exclude an entity will be part of the GCC ratio.

**Summary 1 – Entity Level GCC Summary**

87. Summarized results by entity type for the GCC ratio will be reported in this tab. An on top adjustment for debt allowed as additional capital will be added at the bottom of the table. All informational sensitivity analysis will be reported in Summary 2 and will not impact the GCC ratio.

**Summary 2 – Informational Sensitivity Tests**

88. Summary results for each informational sensitivity analysis described in the “Sensitivity Analysis Inputs” tab will be shown here. Each sensitivity analysis will be shown on a stand-alone basis. It is expected that each informational sensitivity analysis will run automatically in the background and the results for each displayed in this tab. The results for the informational sensitivity analysis will not be included in the “Summary 1 – Entity Level” tab.

**Summary 3 – Analytics**

89. Summary results for metrics described in the Analytics Guidance [insert attachment or appendix reference] and utilizing data collected in the “Input 4 – Analytics” tab or other tabs in the GCC will be calculated and presented here.

**Summary 4 – Alternative Grouping Option(s)**

90. One sample alternative structure for grouping by entity type or jurisdiction in the GCC is displayed based on a suggested method. It can be modified, or other suggestions can be accommodated based on combining data from Schedule 1 and the Inventory in defined ways.

This tab is intended to be an additional analytical tool. The tool summarizes the GCC based on how a reporting entity views its organization, and provides regulators that view, to align it with regulatory information, other than what is reported elsewhere in the GCC template, that the reporting entity has submitted such as current filings, communications, etc. In this summary view, entities are organized into like regimes (e.g., RBC filers, foreign insurers, banks, financial, or non-financial entities) and multiple entities may be grouped together, in order to create a view of capital that is easy to review and analyze within each grouping. The intent of this approach is to provide an additional analytical tool designed to enhance dialogue between the Lead State Regulator and the company contemplated by the GCC filing. This view is transparent (no scalers, no adjustments, no de-stacking) so that financial information may be
cross-walked to other financial submissions such as RBC filings. However, it does contain double counting of available and required capital “(i.e., intra-company investments and transactions are not eliminated) and cannot be used to create a GCC ratio.

91. The results are dependent on how the reporting entity populated. Input 1 – Schedule 1, Column 9 Alternative Grouping. For example, if you have a dozen small dental HMO businesses, you may wish to collapse the results to a single line called “Dental HMOs,” by populating Input 1 – Schedule 1, Column 9 Alternative Grouping for each dental HMO as “Dental HMOs.” Then right-click and select “Refresh” to see the results with the “Dental HMOs” combined.

92. For reference, the data for the Summary 4 – Grouping Alternative is from Calc 1 – Scaling (Ins, Bank), which is fed by the inputs made in Input 1 – Schedule 1, Input 2 – Inventory, etc.

**Stress Inputs**

93. All entries in this tab are either calculation cells using data from within the tab or using data populated from elsewhere in the template in a standardized approach. Available capital and calculated capital for all entities using a selected stress level will be reported in this tab. The calculated values will be summarized in the “Stress Summary tab.

94. The filer or the analyst may use the available section in the tab that allows data entry in order to apply stress to additional entity categories not covered in the standardized approach (e.g., foreign insurers subject to scalrs in the sensitivity analysis). The inputted values will be summarized in the “Stress Summary tab.

95. A separate narrative describing potential drivers of the selected stress level should be submitted.

**NOTE:** See Appendix 2 for more detail

**Stress Summary**

96. Summarized results by entity type will be reported in this tab.
Appendix 1 – Explanation of Scalars

93.97. The concept of a scalar is to equate the local capital requirement to an adjusted required capital level that is comparable to U.S. levels. The purpose of a scalar is to address the issue of comparability of accounting systems and capital requirements between jurisdictions. The following provides details on how the scalars were calculated by the NAIC, or how they are to be used when the NAIC has not developed a scalar for a country due to lack of public data.

Excess Relative Ratio Approach

94.98. Included below are various steps to be taken in calculating the excess relative ratio approach to developing jurisdiction-specific scalars. In order to numerically demonstrate how this approach could work, hypothetical capital requirements and financial amounts have been developed for Country A. Based on preliminary research that has been performed by NAIC staff, it appears that the level of conservatism built into accounting and capital requirements within a jurisdiction may differ significantly for life insurers and non-life insurers. Therefore, ideally each jurisdiction would have two different scalars based on the type of business. The example below includes information related to life insurers in the U.S. and Country A.

Step 1: Understand the Jurisdiction’s Capital Requirements and Identify the First Intervention Level

a. The first step in the process is to gain an understanding of the jurisdiction’s capital requirements. This can be done in a variety of ways including reviewing publicly available information on the regulator’s website, reviewing the jurisdiction’s Financial Sector Assessment Program (FSAP) reports and discussions with the regulator.

In Country A, assume that the capital requirements for life insurers are based on a capital ratio, which is calculated as follows:

\[
\text{Capital ratio} = \frac{\text{Total available capital}}{\text{Base required capital (BRC)}}
\]

In the U.S., capital requirements are related to the insurer’s RBC ratio. For purposes of the Relative Ratio Approach, an Anchor RBC ratio is used and calculated as follows:

\[
\text{Anchor RBC ratio} = \frac{\text{Total adjusted capital}}{100\% \text{ Company Action Level RBC}^*}
\]

* 100% Company Action Level RBC is equal to the Total RBC After Covariance before including operational risk, without adjustment or 200% Authorized Control Level RBC.

b. Similar to legal entity RBC requirements in the U.S., Country A utilizes an early intervention approach by establishing target capital levels above the prescribed minimums that provide an early signal so that intervention will be timely and for there to be a reasonable expectation that actions can successfully address difficulties. Presume that this target capital level is similar to the U.S. Company Action Level (CAL) event, both of which can be considered the first intervention level in which some sort of action—either on the part of the insurer or the regulator—is mandated.
A separate sensitivity calculation will be applied in the GCC template using trend test level RBC.

c. For Country A, the target capital level is presumed to be a capital ratio of 150%. That is, the insurer’s ratio of total available capital to its BRC should be above 150% to avoid the first level of regulatory intervention. Again, this is similar to the U.S. CAL event, which is usually represented as an RBC ratio of 200% of Authorized Control Level (ACL) RBC (ignoring the RBC trend test). In the Relative Ratio approach, the Anchor RBC ratio represents the Company Action Level event (or first level of regulatory intervention) as 100% CAL RBC (instead of 200% ACL RBC), because CAL RBC is the reference point that is used to calibrate against other regimes. The Anchor RBC Ratio (Total Adjusted Capital ÷ 100% CAL RBC) tells us how many “multiples of trigger level capital” that the company holds. Conceptualizing the CAL event as 100% CAL RBC allows the consistent definition of local capital ratios that are calibrated against a “multiples of the trigger level” approach, to ensure an “apples-to-apples” comparison.  

Step 2: Obtain Aggregate Industry Financial Data

The next step is to obtain aggregate industry financial data, and many jurisdictions include current aggregate industry data on their websites. Included below are the financial amounts for use in this exercise.

<table>
<thead>
<tr>
<th>U.S. Life Insurers – Aggregate Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Adjusted Capital = $495B</td>
</tr>
<tr>
<td>Authorized Control Level RBC = $51B</td>
</tr>
<tr>
<td>Company Action Level RBC = $102B</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Country A Life Insurers – Aggregate Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Available Capital = $83B</td>
</tr>
<tr>
<td>BRC = $36B</td>
</tr>
</tbody>
</table>

Step 3: Calculate a Jurisdiction’s Industry Average Capital Ratio

To calculate a jurisdiction’s average capital ratio, the aggregate total available capital for the industry would be divided by the minimum or base capital requirement for the industry in computing the applicable capital ratio. In Country A, this would be the BRC. In the U.S., this base or minimum capital requirement is usually seen as the ACL RBC, but because the Relative Ratio Approach is using 100% CAL RBC as a reference point to calibrate other regimes to, the Relative Ratio formula uses 100% CAL RBC as the baseline and the first-intervention level to calculate the Average Capital Ratio and Excess Capital Ratio. As a result, the scaled ratio of a non-U.S. company should inform regulators how many multiples of first-intervention level capital

While it is mathematically equivalent to use 200% ACL RBC as the denominator, the Approach is designed to use the representation of first-intervention level capital levels as the conceptual underpinning of the Relative Ratio Approach, where 100% CAL RBC is the reference point to calibrate against other regimes.
capital the non-U.S. company holds. Included below is the formula to calculate a jurisdiction’s industry average capital ratio:

**Calculation of U.S. Industry Average Capital Ratio – Life Insurers**

\[
\frac{\$495B \text{ (Total Adjusted Capital)}}{\$102B \text{ (CAL RBC)}} = 485\%
\]

**Calculation of Country A Industry Average Capital Ratio – Life Insurers**

\[
\frac{\$83B \text{ (Total Available Capital)}}{\$36B \text{ (BRC)}} = 231\%
\]

**Step 4: Calculate a Jurisdiction’s Excess Capital Ratio**

The next step is to understand the level of capital the industry is holding above the first intervention level. Therefore, to calculate a jurisdiction’s excess capital ratio, one would first need to calculate the amount of the capital ratio carried in excess of the capital ratio required at the first intervention level. This amount would then need to be divided by the capital ratio required at the first intervention level.

**General Excess Capital Ratio Formula**

\[
\frac{\text{Average Capital Ratio} - \text{Capital Ratio at the First Intervention Level}}{\text{Capital Ratio at the First Intervention Level}}
\]

Based on the formula above and information provided in Step 2 and Step 3, included below are how to calculate each jurisdiction’s excess capital ratio.

**NOTE**: The first intervention level in the U.S. is defined in the Relative Ratio Approach as 100% CAL RBC, while the first intervention level in Country A is a capital ratio of 150%.

**Calculation of U.S. Excess Capital Ratio – Life Insurers**

\[
485\% \text{ (Average Capital Ratio)} - 100\% \text{ (Capital Ratio at the First Intervention Level)} = 385\%
\]

**Calculation of Country A Excess Capital Ratio – Life Insurers**

\[
231\% \text{ (Average Capital Ratio)} - 150\% \text{ (Capital Ratio at the First Intervention Level)} = 54\%
\]

---

4 100% CAL RBC translates to an ACL RBC level of 200%, but for conceptual purposes, the Relative Ratio Approach refers to the U.S. first intervention level as 100% CAL RBC, as 100% CAL RBC is the reference point to which the Relative Ratio Approach calibrates other regimes. In other words, 100% CAL RBC ensures that the scaled ratio of Country A results in a ratio that determines how many multiples of first-intervention level capital that the company in Country A is holding.
Step 5: Compare a Jurisdiction’s Excess Capital Ratio to the U.S. Excess Capital Ratio to Develop the Scalar

99.103. Based on the information above, the U.S. excess capital is 385%. In other words, life insurers in the U.S. carry approximately 385% more capital than what is needed over the first intervention level. Country A’s excess capital ratio is 54%. That is, life insurers in Country A carry approximately 54% more capital than what is needed over the first intervention level.

100.104. To calculate the scalar, one would divide a jurisdiction’s excess capital ratio by the U.S. excess capital ratio. Therefore, the calculation of Country A’s scalar for life insurers would be 54% ÷ 385% = 14%. Therefore, Country A’s scalar for life insurers would be 14%.

Step 6: Apply to the Scalar to the Non-U.S. Insurer’s Amounts in the GCC

101.105. In order to demonstrate how the calculation of the scalar works, it would be best to provide a numerical example. For purposes of this memo, assume that a life insurer in Country A reports required capital of $341,866 and total available capital of $1,367,463. (These are the amounts previously used in a hypothetical calculation example that was discussed by the Working Group during its July 20, 2016, conference call.) As noted previously, the above information and calculation suggests that U.S. life insurers carry capital far above the minimum levels, while life insurers in Country A carry capital far closer to the minimum. Therefore, in order to equate the company’s $341,866 of required capital, we must first calibrate the BRC to the first regulatory intervention level by multiplying it by 150%, or Country A’s capital ratio at the first intervention level. The resulting amount of $512,799 is then multiplied by the scalar of 14% to get a scaled minimum required capital of $71,792.

102.106. Further, the above rationale suggests that the available capital might also be overstated (because it does not use the same level of conservatism in the reserves) by the difference between the calibrated required capital of $512,799 and the required capital after scaling of $71,792, or $441,007. Therefore, we should now deduct the $441,007 from the total available capital of $1,367,463 for a new total available capital of $926,456. These two recalculated figures of required capital of $71,792 and total available capital of $926,456 is what would be included in the group’s capital calculation for this insurer. These figures are further demonstrated below.
**Calculation of Scaled Amounts for GCC**

**Amounts as Reported by the Insurer in Country A**

Total available capital = 1,367,463

Minimum required capital (BRC) = 341,866

**Calibration of BRC to 1st Regulatory Intervention Level**

341,866 (BRC) * 150% = 512,799

**Scaling of Calibrated Minimum Required Capital**

512,799 (Calibrated BRC) * 14% (Scalar) = 71,792 (Difference of 441,007)

**Scaled Total Available Capital**

1,367,463 (Total Available Capital) – 441,007 (Difference in scaled required capital) = 926,456

403.107. Given these scaled amounts, one can calculate the numerical effect on the company’s relative capital ratio by using the unscaled and scaled amounts included below.

<table>
<thead>
<tr>
<th></th>
<th>Unscaled Amounts from Table Above</th>
<th>Scaled Amounts from Table Above</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Available Capital (TAC)</td>
<td>1,367,463</td>
<td>926,456</td>
</tr>
<tr>
<td>Base Required Capital (BRC)</td>
<td>341,866</td>
<td>71,792</td>
</tr>
<tr>
<td>Capital Ratio (= TAC ÷ BRC)</td>
<td>400%</td>
<td>1290%</td>
</tr>
</tbody>
</table>

404.108. Considering the fact that life insurers in Country A hold much lower levels of capital over the first intervention level as compared to U.S. life insurers, the change in the capital ratio from 400% (unscaled) to 1290% (scaled) appears reasonable and consistent with the level of conservatism that we understand is built into the U.S. life RBC formula driven primarily from the conservative reserve valuation.

"Note that in the above example, the company has an unscaled ratio (400%) that is above the industry average in Country A (231%) and a scaled ratio (1290%) that is higher than the US life industry average (485%). If the company had unscaled ratio that was lower than the industry average in Country A, its scaled ratio would be lower than the US life industry average. Company with an unscaled ratio equal to its own country’s industry average will have a scaled ratio equal to the anchor RBC ratio."
Appendix 2 – Stress Scenario

105.109. What follows is a proposal for a stress to be applied to the GCC to test how the limits on recognition of capital instruments as capital behave under stress. In designing this stress, an emphasis was placed on simplicity. The proposed scenario requires no input or calculation on the part of volunteers beyond that already necessary for completing the GCC template.

Further scenarios, if any, could follow this same structure:
- (1) A scenario that includes one (or more) stresses to a Group’s financial position
- (2) Specification of how each stress impacts the available capital and calculated capital for each type of legal entity
- (3) Input of the adjusted carrying value and adjusted calculated capital after the impact of the stress(es)
- (4) Re-calculation of the same calculations (e.g., application of limits on debt and scaling) and summary tables (including sensitivity tests)

Proposal

110. Scenario: A group specific loss event that results in a proportional reduction in available capital across the Group’s entire operations. What follows is a description based on a 10% reduction. Other levels of adjustments may be applied by the group. A variation based on a 20% reduction will be tested as well.

106-111. Specification: The scenario should result in X% reduction (10% used in the example below) in the adjusted available capital for all non-holding company entities. For entities where calculated capital is a fixed percentage of available capital (e.g., non-insurance / nonfinancial entities and foreign insurers in jurisdictions without a risk-based capital requirements) and for entities where capital is a fixed percentage of revenue, reductions in calculated capital are assumed to result as well. As an approximation of the impact of the impact of this scenario on revenue, the calculated capital for financial entities with revenue-based exposure should reduce by X% as well.

107-112. Inputs: No direct input needed. Instead, the inputs will be automatically calculated in the new Stress Inputs tab and summarized in the new Stress summary tab as follows:

<table>
<thead>
<tr>
<th>Type of Entity</th>
<th>Impact on Adj Carrying Value</th>
<th>Impact on Adj Calc Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Insurance Entities</td>
<td>10% reduction</td>
<td>No Impact</td>
</tr>
<tr>
<td>Fin (Banking and Other W Cap Req)</td>
<td>10% reduction</td>
<td>No Impact</td>
</tr>
<tr>
<td>Fin (Asset Mgmt and Other W/O Req)</td>
<td>10% reduction</td>
<td>10% reduction based on corresponding reduction in revenue</td>
</tr>
<tr>
<td>Non-US (w/ Risk Based CC)</td>
<td>10% reduction</td>
<td>No Impact on unscaled GCC though XS Relative Ratio factors should be adjusted for sensitivity test</td>
</tr>
<tr>
<td>Non-US (non-Risk Based))</td>
<td>10% reduction</td>
<td>10% reduction based on corresponding reduction in equity value</td>
</tr>
<tr>
<td>HoldCo</td>
<td>No Impact</td>
<td>No Impact</td>
</tr>
<tr>
<td>Other</td>
<td>10% reduction</td>
<td>10% Reduction based on corresponding reduction in equity value</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Capital Instruments</td>
<td>No Impact</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Further adjustments to the calculated capital based on scalars used in the Sensitivity analysis and other selected adjustments to calculated capital can also be considered (see Company Input section). Other potential user driven adjustments may be added to the template using the Optional Inputs section in the Stress Inputs tab. Desired inputs will automatically be brought into in the new Stress Summary tab.

**108.113. Outputs:** The GCC template will be configured to automatically calculate outputs and resulting GCC ratios using the inputs above at varying levels of stress (e.g., 10%, 20% etc.) including the impact on the allowance for qualifying debt. This can be presented on an additive basis (e.g. start with reduction in available capital alone and then add the impact on each entity type’s calculated capital one at a time building to the full scenario outlined in the chart, above.

**Additional Information:**

**114.** Although the impact on adjusted carrying value in this scenario is generic in nature, generic assumptions cannot be prescribed. Assumptions vary by industry and product mix as the underlying cause and the effect on the adjusted carrying value varies group to group. Therefore, each group submitting data should provide a high-level narrative describing the unique assumptions used in conjunction with the corresponding stress level applied to decrease in available capital and calculated capital.

**109.115.** The narrative should be submitted with the completed template.

**Note:** a placeholder has been added to Input 6 in the GCC Template to capture the narrative.
May 10, 2021

Mr. John Rehagen
Chair of the NAIC Group Capital Calculation (“E”) Working Group
301 W. High St., Room 530
Jefferson City, MO 65101
[via e-mail to lfelice@naic.org; ddaveline@naic.org]

Re: Feedback on the Stress/Scenario Proposal for the GCC Trial Implementation (Attachment B)

Dear Mr. Rehagen,

The ACLI appreciates the opportunity to respond to the NAIC Group Capital Calculation (“GCC”) working group’s Stress/Scenario Proposal for the GCC Trial Implementation (Attachment B). ACLI is grateful for the efforts the NAIC has gone to perform a trial implementation period this summer. We believe that an appropriate quantitative analysis on how the limits on capital instruments operate in stress environment may provide insight on whether linking the limits to available capital could generate procyclical effects. Our comments are intended to provide constructive feedback on both the quantitative and qualitative elements of the stress/scenario proposal. If adopted, we believe that our feedback has the potential to strengthen value that regulators receive from the data collected in the quantitative stress analysis and the qualitative narrative. At a high-level, our recommendations include:

- Adding a 30% quantitative stress to simulate a decline from, 400% CAL RBC to 275% CAL RBC.
- Aligning the qualitative narrative with the quantitative stress test by using it to identify other circumstances when elements of the GCC may behave procyclically.

Feedback on the quantitative stress / scenario test – include a 30% stress to better approximate a severe economic stress event

Attachment B proposes a simple quantitative “stress test” to the GCC template. To run the test, the template automatically decreases the amount of available capital in an entity by 10 to 20% to determine how the GCC’s limits on the recognition of capital instruments as capital behave under stress. Some, including ACLI, have expressed concern that tying the limits to available capital could generate a procyclical effect in times of stress. In a stressed environment, a decline in available capital will reduce the level of the

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recognized capital instruments at the same time companies may need to rely on them to weather the market volatility.

We are concerned that a 10-20% decrease may not capture the impact of a stress event. We recommend adding a 30% decrease in available capital into the template because it is more likely to capture the impact of a stressed environment that leads to a significant drop in available capital. A 30% decrease in available capital corresponds more closely with a drop from 400% CAL RBC to 275% CAL RBC.\(^1\) This would put the stress about halfway from 400% to the trend test level of 150% CAL (or 300% ACL RBC). Based on our analysis, we believe that a 30% decrease is more likely to correspond with a real-life economic shock or severe market downturn. We are concerned that the proposed stressors of 10-20% is unlikely to demonstrate how the limits on capital instruments will perform during periods of severe economic stress. Thus, we strongly recommending either resetting the stressed factor to 30%, or at a minimum, adding a 30% decline to the template.

**Recommendations regarding the qualitative narrative**

We recommend the qualitative narrative be used as a vehicle for companies to:

- Expand on the data provided in the quantitative stress analysis, and/or
- Identify any other elements of the GCC that they believe may behave in a procyclical fashion, and provide examples of the circumstances when the procyclicality was likely to occur, as well as any suggested improvements.

We think our approach would provide regulators with more meaningful data, than the current proposal which appears to be requesting companies to provide examples of events/scenarios could cause the company to suffer a symmetrical decline in available capital.

**Conclusion**

Thank you for your time and consideration. As always, we would be happy to discuss our comments with you or your staff, at your convenience.

Sincerely,

Kristin Abbott

Mariana Gomez

\(^1\) 125%/400% = 31\%
The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee met April 27, 2021. The following Working Group members participated: John Rehagen, Chair (MO); Kathy Belfi, Vice Chair (CT); Susan Bernard (CA); Carrie Mears (IA); Kevin Fry (IL); John Turchi and Christopher Joyce (MA); Judy Weaver (MI); Barbara Carey (MN); Jackie Obusek (NC); Justin Schrader (NE); Dave Wolf (NJ); Bob Kasinow (NY); Tim Biler (OH); Greg Lathrop (OR); Melissa Greiner and Kimberly Rankin (PA); Trey Hancock (TN); Mike Boerner (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI).

1. Discussed Comment Letters Received for Edits to the GCC Instructions

Mr. Rehagen stated that three comment letters had been received (Attachment Two-C1) from interested parties, and he asked Lou Felice (NAIC) to first summarize the process for addressing the comments and then the commenters to briefly summarize any remaining concerns. Mr. Felice stated that the letter from Mariana Gomez-Vock (American Council of Life Insurers—ACLI) focused on the ACLI’s continued support for developing scalars for foreign insurers. He stated that Ms. Gomez-Vock will elaborate. The other two letters from America’s Health Insurance Plans (AHIP) and The Travelers Companies Inc. (Travelers) contained some initial general comments and several specific revisions to the existing language in the instructions. Mr. Felice stated that the commenters will elaborate on the general comments, but most of the specific comments were addressed and sent to the commenters for their review, resulting in the version of the instructions that is included in the meeting materials (Attachment Two-C2). One additional requested revision was received from Travelers and will be accepted.

Ms. Gomez-Vock stated that the ACLI letter was to confirm deletion of the opportunity to submit group specific scalars and express support for the NAIC’s activities toward recommending scalars for foreign insurers in both the group capital calculation (GCC) and the Insurance Capital Standard (ICS) – Aggregation Method (AM) being developed by the International Association of Insurance Supervisors (IAIS). Tom Finnell (AHIP) stated that the majority of its specific comments were addressed, but a few remain. With regard to AHIP’s overarching comment, he stated that the instructions should be improved in response to questions from groups participating in the Trial Implementation. He stated that the use of examples would enhance the clarity of the instructions. Mr. Rehagen stated that using input from the Trial participants is a good way to make improvements to the instructions. Mr. Felice agreed that questions could be used to embed examples as the Trial is going on. Mr. Finnell also suggested that the process for getting the comments needs to be set up before the Trial begins. Mr. Felice stated that a question and answer (Q&A) process could be established along the line of the prior GCC Field Test. Ralph Blanchard (Travelers) stated that the Excess Relative Ratio sensitivity analysis may overstate the required capital, and more clarity on the source of Authorized Control Level risk-based capital (RBC) and examples are needed. Ned Tyrrell (NAIC) stated that the examples are forthcoming.

Mr. Rehagen provided an update on the International Insurance Relations (G) Committee’s work on scalars, which was raised in the ACLI letter. He stated that work continues on the development of an appropriate scalar approach for use in the AM ICS and in the GCC. Further evaluation is required, including the review of a recently released paper by the American Academy of Actuaries (Academy) and developments at the IAIS regarding comparability of the AM. Mr. Rehagen noted that it is unlikely that the scalar methodology will be finalized this year; consequently, there is currently nothing to add to the GCC Trial template. The GCC Trial Implementation will continue to be based on an unscaled calculation at 200% of the Authorized Control Level. Sensitivity tests will include the GCC ratio scaled using the Excess Relative Ratio approach at both 200% and 300% of the Authorized Control Level.

Mr. Rehagen asked if there were objections to exposing the latest version of the edited GCC instructions and template until May 10. There were no objections, and NAIC staff were directed to expose the document through the close of business on May 10.

2. Discussed a Proposed Scenario Test in 2021 GCC Trial Implementation

Mr. Rehagen relayed that himself and Ms. Belfi held two calls with several insurance trade groups and some of their members to discuss their concerns and expectations for stress scenarios to be applied in the template to address procyclicality and other
concerns about how the adopted GCC would behave under stressed conditions. During the first call, most of the participants focused on how the allowance for qualifying debt reacts to financial stress, leaving RBC required capital unadjusted, and applying stress scenarios that are not complex and could easily be incorporated into the GCC Trial template prior to the start of the Trial Implementation. As a result, the proposed stress scenario document in the materials (Attachment Two-C3) represents what NAIC staff suggest so far for inclusion in the Trial template, and it was presented during the second call with the expectation that there would be further comments today. Mr. Felice outlined the logic behind adjusting available and calculated capital by a specified percentage in a simplified and standardized approach. He stated that to avoid complexity, specific scenarios that may drive changes in available or calculated capital are not included. Via WebEx, Mr. Tyrrell presented the exhibits to be used in the GCC template to add the stress scenarios. He stated that the percentage of adjustment could be varied, and the necessary data would be populated from other parts of the template with no additional direct data entry required.

Mr. Rehagen asked Ms. Belfi to offer some state insurance regulator comments. She agreed that the work done so far was designed to avoid any additional burden on the groups preparing the template, but it provided little value to state insurance regulators without additional narrative information. She proposed that a high-level narrative would accompany the standardized stress scenario to indicate what each group sees as the potential drivers behind the change in available and calculated capital without requiring additional data. Mr. Blanchard agreed that as set up, the stress scenario would not account for differences in the drivers for adjustments to capital, which vary by group. Ms. Belfi responded that the narrative would address the unique drivers for each group.

Mr. Rehagen asked if there were objections to exposing the stress scenario document and related additions to the GCC template additions concurrently with the instructions until May 10. Mr. Finnell asked if the narrative concept will be included in the exposure, possibly with a later due date for comments on that issue. In response to Mr. Rehagen’s question on whether the narrative could be added to the exposed materials, Mr. Felice stated that several sentences could be added to the proposal document to cover the narrative, and a tentative place to capture the narrative could be added to the template in the next day or two after consulting with Ms. Belfi on the wording for requesting the narrative. Comments could then be submitted on that issue as well. Mr. Rehagen stated that comments on whether the narrative can be shared with the NAIC can be included as well. There were no further comments or objections. NAIC staff were directed to expose the materials through the close of business on May 10.

3. **Discussed Next Steps Toward the Start of the 2021 GCC Trial Implementation**

Mr. Rehagen outlined the steps to get to the start of the Trial. He stated that first, the instructions need to be finalized based on the discussion under agenda item #1, and whether stress scenarios will be included in the Trial template per the discussion under agenda item #2 needs to be determined. He added that currently, 24 volunteers willing to have the state share data on a confidential basis with the NAIC have been identified by state insurance regulators in 12 lead-states thus far. He stated that it needs to be known soon if there are any more volunteers out there. Confidentiality agreement templates will be going out to the lead-states in the next week or so for their review and other edits (e.g., statutory confidentiality provisions). Mr. Rehagen stated that it was previously agreed that the submissions will be due by July 31, and the goal is to have everything in place for the Trial no later than the end of May.

4. **Discussed Other Matters**

Mr. Rehagen stated that the next Working Group call would be held on or about May 17.

Having no other business, the Group Capital Calculation (E) Working Group adjourned.
April 16, 2021

Mr. John Rehagen
Chair of the NAIC Group Capital Calculation (“E”) Working Group
301 W. High St., Room 530
Jefferson City, MO 65101
[via e-mail to lfelice@naic.org]

Re: Clarifying edits to the Group Capital Calculation (“GCC”) instructions and template

Dear Mr. Rehagen,

The ACLI appreciates the opportunity to respond to the NAIC Group Capital Calculation (“GCC”) working group’s proposed edits to the GCC instructions and templates (dated March 22, 2021). ACLI supports the ongoing work by GCC Working Group members and NAIC staff to refine the instructions and template, as well as the Working Group’s decision to perform a quantitative analysis of the GCC methodology during the "trial implementation period."

Our comments are limited to the proposed elimination of the option for companies to report data in the template that would support of the creation of jurisdiction-specific scalars for risk-sensitive regimes (GCC Instructions, section 79, p. 42). The ACLI is writing to express support for the ongoing collaboration of the NAIC “G” Committee and GCC Working Group regarding the development of scalars for as many risk-sensitive insurance regimes, as possible. We encourage the G Committee and GCC Working Group to expose the scalar methodology for comment prior to adoption into the GCC.

ACLI supports the development of scalars for risk-sensitive insurance regimes.

Scalars are a critical component of an aggregated group capital calculation, because they are necessary to equate the local capital requirement to an adjusted capital level that is comparable to U.S. levels. In plain language, jurisdiction-specific scalars are needed to create meaningful results in an aggregation method, like the GCC. The template provides jurisdiction-specific scalars for 7 jurisdictions: Australia; Bermuda; Canada; the European Union (Solvency II); Japan; Switzerland; and the United Kingdom.
(Solvency II). However, some ACLI members have significant insurance operations in risk-sensitive jurisdictions outside of those 7 jurisdictions. Companies with insurance operations in other non-U.S. jurisdictions will enter 1.0 (100%) as a placeholder scalar, which is unlikely to fully reflect differences in accounting, conservatism in reserves, or available capital. The lack of a scalar for these jurisdictions could have a meaningful impact on these companies GCC ratios. As such, ACLI continues to support the development of scalars for all risk-sensitive regimes. If publicly available industry data is not readily available but is necessary to calculate a scalar, then we encourage the NAIC to consider the use of credible, non-public data.

ACLI supports the coordination between the GCC Working Group and G Committee and the exposure of the final selected scalar methodology prior to incorporation into the GCC.

In March 2021, the GCC template was modified to eliminate the option for companies to provide scalar suggestions for risk-sensitive jurisdictions that currently lack a jurisdiction-specific scalar in the GCC template. It is our understanding that the removal of this option to submit data for additional jurisdiction-specific scalars is not intended to foreclose the development of scalars for additional jurisdictions. Instead, the change was made to remove optionality from the template, as well as to clarify that further work on scalars is dependent on the decisions made by the G Committee with respect to scalars incorporated into the U.S. Aggregation Method. The G Committee has partnered with the American Academy of Actuaries to produce a white paper examining the strengths and weaknesses of a variety of different scalar options. ACLI looks forward to hearing the results of the Academy’s research. We strongly encourage the G Committee and GCC Working Group to expose the proposed scalar methodology for review and comment by stakeholders prior to final adoption by the pertinent NAIC Committee. Depending on the methodology selected, we also encourage the NAIC to invite stakeholders to submit recommendations identifying additional jurisdictions with risk-based regimes, that should be considered for scalar development.

Thank you, again for the opportunity to comment on the revisions to the GCC Instructions and Template. As always, we are happy to answer any questions you may about our comments.

Sincerely,

Mariana Gomez-Vock

Cc: Commissioner Gary Anderson, Chair, “G” Committee; Director Bruce Ramge, Vice-Chair, “G” Committee
April 16, 2021

Dan Daveline  
Director, Financial Analysis  
National Association of Insurance Commissioners  
By e-mail to: ddaveline@naic.org

Lou Felice  
Consultant to the National Association of Insurance Commissioners  
By e-mail to: ifelice@naic.org

Re: Revisions to the Instructions and Template for the 2021 GCC Trial Implementation

Gentlemen:

America’s Health Insurance Plans (AHIP) appreciates the opportunity to comment on the draft revisions to the Group Capital Calculation (GCC) Instructions and Template which, when finalized, will be used for the upcoming 2021 “Trial Implementation” exercise.

AHIP’s comments on the proposed revisions to the Instructions are included in “comment bubbles” in the attached version of the document, where they can best be read in the full context of the passages to which they relate. We hope these are self-explanatory, but also emphasize an overarching point: Where possible, the instructions should clearly state where the data needs to reconcile to, or match with, data included in other NAIC-filed documents. In some cases, the instructions do offer that degree of specificity, e.g., for some of the entries described in paragraph 57, as well as the tables shown in paragraphs 60 and 67. However, a similar level of detail is not stated in other cases (for example, also in paragraph 57, are the exact sources and line items for premiums written and “book assets” which are not stated, even in the case of U.S. insurers).

There is another overarching comment that we would like to offer. As you are aware, several of AHIP’s members participated in the prior field test exercise and in closely monitoring the changes to the instructions that were made by the GCC Working Group leading up to the NAIC’s adoption of the GCC late last year. Based on that experience, they observed that the instructions could benefit from a more thorough review and restructuring to better organize the flow of the material presented and to make it easier for all to read and to clearly understand. For an example, organization of the instructions should enable easy cross-reference between the instructions and
the template, with guidance for the source(s) of individual inputs easily referenced (while there are examples where this has been done in the instructions, it has not been consistently followed throughout).

Some members also offer that a documented example/case study populated with anonymized data would be very helpful to illustrate the points that are made in the text.

In contrast, the proposed revisions which are the subject of the current exposure appear to be more “incremental” in nature, addressing the clarity of specific passages in the text; they do not rise to the level of a more comprehensive restructuring as envisioned by our members. That said, it is not pragmatic to attempt such a comprehensive review effort without simultaneously using the instructions to populate the template, e.g., as would occur with the upcoming Trial Implementation exercise. This is consistent with AHIP’s comment to the GCC Working Group on its call of January 28, 2021, i.e., that additional clarity to the instructions should be an additional stated purpose of the 2021 GCC data collection.

Such an effort for a lengthy technical document such as the GCC Instructions would be a huge task for any individual. On the other hand, having all Trial Implementation participants participate in a drafting effort would be unwieldy. Like some other efforts undertaken by the NAIC, it would seem appropriate to identify a smaller subgroup to do the drafting. We suggest a subgroup that is jointly comprised of regulator and industry representatives.

However, for such a subgroup to successfully fulfill its task we would propose there be a process in place as part of the Trial Implementation whereby comments or questions about the clarity or meaning of the instructions, from any participant – whether staff of a participating insurance group or a lead state – and resulting from their attempt to complete, approve, or otherwise use the template and its information, be funneled to a central source, reviewed, and redacted as need be to assure anonymity, and then made available to the subgroup. Drafting would likely occur after the Trial Implementation is completed, but with the objective to have an improved document available for actual implementation based on year-end 2022 reporting.

AHIP suggests that the GCC Working Group consider such a comprehensive re-draft effort and, if a subgroup is appointed, AHIP would be glad to be represented, directly as well as through participation by some of our members.

We hope that you will find our comments constructive as intended and would be glad to address any questions you may have.

Sincerely,

Bob Ridgeway  Tom Finnell
Bridgeway@AHIP.org  ATFinnell@gmail.com
501-333-2621  703-622-9155
April 16, 2021

Mr. John Rehagen, Chairman
Group Capital Calculation (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Exposed revisions to the Draft Group Capital Calculation (GCC) Instructions and Template

Dear Mr. Rehagen:

The Travelers Companies, Inc. (Travelers) appreciates the opportunity to comments on the draft GCC Instructions and Template and thanks the Working Group for their continuing progress in making the GCC an effective tool for analyzing the solvency of an insurance group.

General Comments

When discussing the use of the Company Action Level (CAL), the instructions should clarify that the CAL with the operational risk charge included is being used. RBC filings show two different CAL values, one with and one without the operational risk charge. Additionally, there should be a description as to which “industry” results will be used. The straight sum of industry values for Total Adjusted Capital and Authorized Control Level (ACL) or CAL will include double counting of values for subsidiaries of RBC filers. This will be more of an issue for property & casualty(P&C) companies, as they are more likely to have numerous subsidiaries in their groups. We estimate that the industry RBC ratio for the U.S. P&C industry may be 3.5% to 4% overstated due to this double-counting.

We believe it would be helpful to provide a discussion of the Excess Relative Ratio (ERR) so that both regulators who are reviewing a GCC filing and insurers that are completing the GCC template understand the conceptual intent of the ERR. Our understanding of the ERR is as follows:

- The main assumption is that the amount of capital held in excess of the requirement will be the same for all countries.
• The first step is to adjust the other country’s capital requirement to an equivalent “first level of intervention” stage as the US. (This can be very judgmental, as witnessed by the debate as to whether or not this is the trend test level for the U.S. The first intervention level may be subject to interpretation for both the U.S. and for the other country.)

• From here on, the basic premise is that even though the industry average in all countries is capitalized at the same sufficiency level (as measured by the excess over the requirement), the “requirement” that is being looked at is impacted by differences in local jurisdictional accounting/reporting rules. The assumption is that these differences are a function of risk size and not capital size, i.e., the amount of required capital and held capital is impacted by the same dollar amount by this accounting conservatism for a given risk size. As a result, the ERR calculates a fixed amount to subtract from (or add to) both held capital and required capital so that an average company in the other jurisdiction would have the same RBC ratio as the average in the U.S.

• The actual conservatism may in fact not be a fixed amount for a given risk size but may also vary by the amount of capital.

We don’t believe this concept is intuitive as shown in the instructions and recommend that the instructions illustrate that, if applied to a company with the same ratios as the industry average in the Country A example, the resulting capital ratio after these adjustments would be the same as the U.S. life average.

Detailed Comments

We also offer the following detailed comments on the instructions:

• Paragraph 8 – Please clarify or re-word the following sentence:

  “In general Schedule A and Schedule BA affiliates will otherwise remain as investments of a Parent insurer will be reported as Parent of the value and capital calculation of the Parent insurer.”

• Paragraph 18 – We suggest the following edit for clarification:

  “Risk emanating from a non-insurance/non-financial entity not owned by an insurer but part of the Broader Group that is of a magnitude that could adversely impact the financial stability of the group as a whole such that the ability of insurers within a group to pay policyholder claims or make other policy related payments (e.g., policy loan requests or annuity distributions) may be impacted.”
• Paragraph 22 – We suggest the following edit:

“This is the entity that exercises control directly or indirectly over all entities within the Broader Group.”

• Paragraph 29 – We suggest the following edits:

“Include all entities that meet the definition of an affiliate in Section II above and that fit the criteria…”

• Paragraph 38 – We suggest the following edits:

“Except as noted inon the “Inventory” tab, equity method investments that are…”

• Paragraph 51 – In the Schedule 1 instructions, paragraph 51 refers to the completion of Schedule 1A. However, Schedule 1A does not contain any of the blue-shaded preparer input cells.

• Paragraph 56 [Sch 1B Col 16] “Is Affiliates on Schedule A or Schedule BA” – This paragraph includes the following instruction: “Column is meant to identify an entity with a financial entity identifier in Column 8 that is otherwise reported on Schedule A or Schedule BA but is being moved to this Schedule.” Please clarify the phrase “being moved to this Schedule” (i.e., please explain where these are being moved from).

In addition, the Instructions are not clear as to whether non-financial/non-insurance Schedule A and Schedule BA affiliates should or should not be included in any of the input areas of the GCC template. Paragraph 8 states: “For purposes of the GCC, affiliates will NOT include those affiliates reported on Schedule A or Schedule BA, EXCEPT in cases where there are financial entities reported as or owned indirectly through Schedule A or Schedule BA affiliates.” It would be helpful to include the following general instruction:

“Non-financial/noninsurance Schedule A and Schedule BA affiliated are excluded from the scope of the GCC and are not required to be captured in any of the SCC template tabs.”

However, if that is not the intent, the GCC instructions need to clarify specifically where data pertaining to such entities must be input in the GCC template.

• Paragraph 57 – We do not understand why affiliated assumed and ceded reinsurance needs to be captured in the GCC template, especially if such data does not impact the GCC ratio.

• Paragraph 57 [Sch 1C Col 8] “Gross Paid-in and contributed Capital and Surplus” – As the title of this instruction uses statutory accounting terminology, we assume that...
the column should only be completed for U.S. Insurance entities. Therefore, the GCC instructions should clarify the scope of this column.

- **Paragraph 58 [Sch 1D Col 2] Prior Year Equity or Capital and Surplus** – This paragraph includes the following instruction: “Do not report values for non-insurance/non-financial entities owned directly or indirectly by RBC filers or owned by other financial entities with regulatory capital requirements for which the non-insurance/non-financial entity is included in the capital charges for the Parent entity.” Paragraph 54 states: “Values for, non-insurance/non-financial subsidiaries of U.S. RBC filers may remain with their Parent insurers and will not be de-stacked. Entries for these individual entities in the grouping will be reported in Schedule 1B only as “included.”, but no stand-alone values for each entity would be required.”

One can read the paragraph 54 instruction as requiring entries for non-insurance/non-financial subsidiaries of U.S. RBC in Schedule 1B only, and not required in Schedules 1C or 1D. However, it is confusing to see the above instruction that scopes out these entities in Paragraph 58 [Sch 1D Col 2] but not in other column instructions in paragraph 58. We believe that further clarification is needed as to where in the GCC template data is required for such non-insurance/non-financial subsidiaries.

- **Paragraph 60** – The following sentence appears to contain extraneous words or a grammatical error: “A sensitivity analysis is included to calculate to reflect the impact of excluded entities requested but not approved for exclusion by the lead state.”

- **Paragraph 61 [Inv C Col 2] Entity Required Capital (Local Regime)** - We suggest the following edit for clarification:

  “However, if such an entity has been listed in [Sch1B Col 2] Include/Exclude (Supervisor) column, indicating that the Lead State Regulator agrees that the entity does not pose material risk, then report the capital calculation in accordance with entity instructions (per the “Additional clarification on capital requirements where a formula is required” instructions below), but the ultimate calculation will show the results without the excluded entity’s capital calculation.”

- **Paragraph 74** - For the Sensitivity Analysis tab, it is not clear which entities’ information is required to be entered in this tab. The scope related to this tab should be clarified. Based on the instructions in this section, it appears that data is only needed for entities which have prescribed or permitted practices, as well as captive entities. To avoid confusion and ensure consistency in application, this should be clarified.
• Paragraph 74 - We suggest the following edit for clarification:

“The sensitivity analysis is calculated in the “Summary 2” tab. Most inputs for the analysis are populated from other tabs as described below and carried into the analysis which are reported in the “Summary 2” tab. However certain analysis requires inputs from this tab. Inputs are required in this tab for Analysis 3, Analysis 4, Analysis 8, and Analysis 9 automatic calculations in the “Summary 2” tab.”

• Paragraph 79 – This paragraph includes the following instruction: “The tab also includes a listing of all Schedule A and Schedule BA affiliates, along with the following information…” Paragraph 8 states: “For purposes of the GCC, affiliates will NOT include those affiliates reported on Schedule A or Schedule BA, EXCEPT in cases where there are financial entities reported as or owned indirectly through Schedule A or Schedule BA affiliates.” Therefore, it appears that only Schedule A and Schedule BA entities that are “financial” affiliates are required to be included in this section. Therefore, we recommend the following clarification:

“The tab also includes a listing of all Schedule A and Schedule BA financial affiliates, along with the following information…”

• Paragraph 90 – the first line of paragraph 90 has a “.” after “populated” that should be deleted.

Summary

In summary, we support the Working Group’s effort to complete the GCC Instructions and Template and look forward to the discussion of comments during the Group’s next meeting. If you have any questions or would like to discuss our comments, please feel free to call me at (860) 277-0537.

Sincerely,

D. Keith Bell

cc: Dan Daveline, NAIC staff
NAIC GROUP CAPITAL CALCULATION INSTRUCTIONS

(REVISED March 22, April 27, 2021)
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I. Background

1. In 2015, the ComFrame Development and Analysis (G) Working Group held discussions regarding developing a group capital calculation (GCC) tool. The discussions revealed that developing a GCC was a natural extension of work state insurance regulators had already begun, in part driven by lessons learned from the 2008 financial crisis which include better understanding the risks to insurance groups and their policyholders. While insurance regulators currently have authorities to obtain information regarding the capital positions of non-insurance affiliates, they do not have a consistent analytical framework for evaluating such information. The GCC is designed to address this shortcoming and will serve as an additional financial metric that will assist regulators in identifying risks that may emanate from a holding company system.

2. More specifically, the GCC and related reporting provides more transparency to insurance regulators regarding the insurance group and make risks more identifiable and more easily quantified. In this regard, the tool assists regulators in holistically understanding the financial condition of non-insurance entities, how capital is distributed across an entire group, and whether and to what degree insurance companies may be supporting the operations of non-insurance entities, potentially adversely impacting the insurance company’s financial condition or policyholders. This calculation provides an additional analytical view to regulators so they can begin working with a group to resolve any concerns in a manner that will ensure that policyholders of the insurers in the group will be protected. The GCC is an additional reporting requirement but with important confidentiality protections built into the legal authority. State insurance regulators already have broad authority to take action when an insurer is financially distressed, and the GCC is designed to provide Lead State Regulators with further insights to allow them to reach informed conclusions on the financial condition of the group and the need for further information or discussion.

3. State insurance regulators currently perform group analysis on all U.S. insurance groups, including assessing the risks and financial position of the insurance holding company system based on currently available information; however, they do not have the benefit of a consolidated statutory accounting system and financial statements to assist them in these efforts. It was noted prior to development that a consistent method of calculating group capital for typical group risks would provide a useful tool for state financial regulators to utilize in their group assessment work. It was also noted that a GCC could serve as a baseline quantitative measure to be used by regulators in to compliment the view of group-specific risks and stresses provided by the Own Risk and Solvency Assessment (ORSA) Summary Report filings and in Form F filings that may not be captured in legal entity filings.

4. During the course of several open meetings and exposure periods, the ComFrame Development and Analysis (G) Working Group considered a discussion draft which included three high-level methodologies for the GCC: a risk-based capital (RBC) aggregation approach; a statutory accounting principles (SAP) consolidated approach; and a generally accepted accounting principles (GAAP) consolidated approach. On Sept. 11, 2015, Working Group members unanimously approved a motion to move forward with developing a recommendation for a GCC and directed an appropriate high-level methodology for the recommendation.
5. At a ComFrame Development and Analysis (G) Working Group meeting held Sept. 24, 2015, pros and cons for each methodology were discussed, and a consensus quickly developed in support of using an RBC aggregation approach if a GCC were to be developed. The Executive (EX) Committee and Plenary ultimately adopted the following charge for the Financial Condition (E) Committee:

“Construct a U.S. group capital calculation using an RBC aggregation methodology; liaise as necessary with the ComFrame Development and Analysis (G) Working Group on international capital developments and consider group capital developments by the Federal Reserve Board, both of which may help inform the construction of a U.S. group capital calculation.”

6. The RBC aggregation approach is intended build on existing legal entity capital requirements where they exist rather than developing replacement/additional standards. In selecting this approach, it was recognized as satisfying regulatory needs while at the same time having the advantages of being less burdensome and costly to regulators and industry and respecting other jurisdictions’ existing capital regimes. In order to capture the risks associated with the entire group, including the insurance holding company, RBC calculations would need to be developed in those instances where no RBC calculations currently exist.

7. In early 2016, the Financial Condition (E) Committee appointed the Group Capital Calculation (E) Working Group, which began to address its charge and various details of the items suggested by the ComFrame Development and Analysis (G) Working Group. The instructions included herein represent the data, factors, and approaches that the Working Group believed were appropriate for achieving such an objective. The GCC instructions and template are intended to be modified, improved, and maintained by the NAIC in the future as are the Accounting Practices and Procedures Manual, the Annual Statement Instructions and the Risk-Based Capital Formula and Instructions. This includes, but is not limited to, future disclosure of additional items developed or referred by other NAIC committees, task forces and/or working groups.

8. In December 2020, amendments to NAIC Model Law (#440) and Model Regulation (#450) were adopted to provide States with legislative language to fully implement the GCC as an annual filing. The Model specifies what groups are exempted from the GCC filing requirement and the circumstance under which a limited filing may be submitted. For such information reference should be made not to these instructions, rather to the models and, more specifically, to how they are implemented into laws and regulations of a Lead State.

II. Definitions

8.9. **Affiliate**: As used in Model #440, an “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. For purposes of the GCC, affiliates will NOT include those affiliates reported on Schedule A or Schedule BA, EXCEPT in cases where there are insurers or other financial entities reported as or owned indirectly through Schedule A or Schedule BA affiliates. In general, All other Schedule A and Schedule BA affiliates, investments will otherwise remain as investments of a Parent insurer will be reported as Parent of the value and capital calculation of the Parent insurer. A full list of Schedule A and BA entities will be reported as described in the instructions for Input 6 – Questions and Other Information. Any entities that would otherwise qualify as Schedule BA affiliates as described above but are owned by other entities (e.g., foreign insurers or other type of Parent entity) should be treated in the same way.
9.10. **Broader Group**: The entire set of legal entities that are controlled by the Ultimate Controlling Person of insurers within a corporate group. When considering the use of this term, all entities included in the Broader Group should be included in Schedule 1 and the Inventory, but only those that are denoted as “included” in the Schedule 1 will be considered in the actual GCC.

9.11. **Control**: As used in the Model #440, the term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by Section 4K of Model #440 that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

9.12. **Cross-Support Mechanism**: For purposes of evaluating material risk, depending on the nature of the transaction and the specific circumstances, evaluating material risk. A cross-support mechanism is an agreement or transaction that creates a financial interdependence. Depending on the nature of the transaction and the specific circumstances, these mechanisms may pose material risk. These may include corporate guarantees, capital maintenance agreements (regulatory or ratings based), letters of credit, intercompany indebtedness, bond repurchase agreements, securities lending or other agreements or transactions that create a financial interdependence or link between entities in the group.

9.13. **Entity Not Subject to A Regulatory Capital Requirement**: This is a financial entity other than an entity that is subject to a specified regulatory capital requirement.

9.14. **Financial Entity**: A non-insurance entity that engages in or facilitates financial intermediary operations (e.g., accepting deposits, granting of credits, or making loans, managing, or holding investments, etc.). Such entities may or may not be subject to specified regulatory capital requirements of other sectoral supervisory authorities. For purposes of the GCC, entities that are not regulated by an insurance or banking authority [e.g., the U.S. Securities and Exchange Commission (SEC) or the Financial Industry Regulatory Authority (FINRA)] will be considered as not subject to a specified regulatory capital requirement.

The primary examples of financial entities are commercial banks, intermediation banks, investment banks, saving banks, credit unions, savings and loan institutions, swap dealers, and the portion of special purpose and collective investment entities (e.g., investment companies, private funds, commodity pools, and mutual funds) that represents the Broader Group’s aggregate ownership in such entities, whether or not any member of the Broader Group is involved in that entity’s management responsibilities (e.g., via investment advisory or broker-dealer duties) for those entities.

For purposes of this definition, a subsidiary of an insurance company whose predominant purpose is to manage or hold investments or act as a broker-dealer for those investments on behalf of the insurance company and its affiliated insurance (greater than 90% of all such investment subsidiaries’ assets under management or held are owned by or for the benefit of these insurance affiliates) should NOT be considered a Financial Entity. In the case where an insurer sets up multiple subsidiaries for this purpose, the 90% may be measured in the aggregate for all such entities. Similarly, in the case of collective investment pools (e.g., private funds,
commodity pools, and mutual funds) the 90% may be measured individually, or in the aggregate for each subtype (e.g., private funds, commodity pools, and mutual funds).

In addition, other financial entities without a regulatory capital requirement include those which are predominantly engaged in activities that depending on the nature of the transaction and the specific circumstances, could create financial risks through the offering of products or transactions outside the group such as a mortgage, other credit offering or a derivative.

14.15. **Insurance Group:** For purposes of the GCC, a group that is comprised of two or more entities of which at least one is an insurer, and which includes all insurers in the Broader Group. Another (non-insurance) entity may exercise significant influence on the insurer(s); i.e., a holding company or a mutual holding company; in other cases, such as mutual insurance companies, the mutual insurer itself may be the Ultimate Controlling Person. The exercise of significant influence is determined based on criteria such as (direct or indirect) participation, influence and/or other contractual obligations; interconnectedness; risk exposure; risk concentration; risk transfer; and/or intragroup agreements, transactions and exposures.

An Insurance Group may include entities that facilitate, finance or service the group’s insurance operation, such as holding companies, branches, non-regulated entities, and other regulated financial institutions. An Insurance Group is thus comprised of the head of the Insurance Group and all entities under its direct or indirect control, and includes all members of the Broader Group that exercise significant influence on the insurance entities and/or facilitate, finance or service the insurance operations.

An Insurance Group could be headed by:
- An insurance legal entity;
- A holding company; or
- A mutual holding company.

An Insurance Group may be:
- A subset/part of bank-led or securities-led financial conglomerate; or
- A subset of a wider group.

An Insurance Group is thus comprised of the head of the Insurance Group and all entities under its direct or indirect control.

15.16. **Insurance Subgroup/U.S. Operations:** Refers to all U.S. insurers within a Broader Group where the groupwide supervisor is in a non-U.S. jurisdiction. It includes all the directly and indirectly held subsidiaries of those U.S. insurers. For purposes of subgroup reporting, capital instruments, loans, reinsurance, guarantees would only include those that exist within the U.S. insurers. Amounts included for the U.S. insurers shall include all amounts contained within the financial statements of those entities included in the subgroup reporting, whether those amounts are directly attributable or allocated to a company in the subgroup from an affiliate outside of the U.S. insurers and its direct or indirect subsidiaries.

16.17. **Lead State Regulator:** As defined in the Financial Analysis Handbook; i.e., generally considered to be the one state that “takes the lead” with respect to conducting groupwide supervision within the U.S. solvency system.

17.18. **Limited Group Capital Filing:** Refers to a GCC filing that includes sufficient data or information to complete the “Input 4 Analytics” tab and the “Summary 3 – Analytics” tab of the GCC template. This includes Schedule 1 of the template and may include limited data from other input tabs as deemed necessary for purposes of the analytics.
Material Risk: Risk emanating from a non-insurance/non-financial entity not owned by an insurer in the Insurance Group or is part of the Broader Group that is of a magnitude that could adversely impact the financial stability of the group as a whole such that the ability of insurers within a group to pay policyholder claims or make other policy related payments (e.g., policy loan requests or annuity distributions) may be impacted.

To determine whether an entity within the Broader Group poses material risks to the Insurance Group, the totality of the facts and circumstances must be considered. The determination of whether risk posed by an entity is material requires analysis of various aspects pertaining to the subject entity. A determination that a non-insurance/non-financial entity does not pose material risk allows the filer to request exclusion of that entity from the calculation of the GCC ratio in the “Inventory” tab. A number of items as listed below should be considered in making such a determination, to the extent they apply.

Caution is necessary, however. The fact that one or more of these items may apply does not necessarily indicate risk to the Insurance Group is, or is not, material. The group should be able to support its determination of material risk if requested by the Lead State Regulator. This should not be used as a checklist or as a scorecard. Rather, the list is intended to illuminate relevant facts and circumstances about a subject entity, the risk it poses, how the Insurance Group might be exposed to that risk and means to mitigate that risk.

Primary Considerations:

- Past experience (i.e., the extent to which risk from the entity has impacted the Insurance Group over prior years/cycles).
- The degree to which capital management across the Broader Group has historically relied on funding by the Insurance Group to cover losses of the subject entity.
- The existence of intragroup cross-support mechanisms (as defined below) between the entity and the Insurance Group.
- The means by which risk can be transmitted; i.e., the existence of sufficient capital within the entity itself to absorb losses under stress and/or if adequate capital is designated elsewhere in the Broader Group for that purpose.
- The degree of risk correlation or diversification between the subject entity and the Insurance Group (e.g., where risks of one or more entities outside the Insurance Group are potentially offset (or exacerbated) by risks of other entities) and whether the corporate structure or agreements allow for the benefits of such diversification to protect the Insurance Group.
- The existence and relative strength or effectiveness of structural safeguards that could minimize the transmission of risk to the Insurance Group (e.g., whether the corporate shell can be broken).

Other Considerations (if primary considerations suggest exclusion may be reasonable, these can be used to further support exclusions):

- The location of the entity in relation to the Insurance Group within the Broader Group’s corporate structure and how direct or indirect the linkage, if any, to the Insurance Group may be.
- The activities of the entity and the degree of losses that the entity could pose to the group under the current economic environment or economic outlook.

The guidance above recognizes that there are diverse structures and business models of insurers that make it impracticable to apply a one-size-fits-all checklist that would work for materiality determinations across all groups. Strict or formulaic quantitative measures based on size of the...
entity or its operations of a non-insurance affiliate are an insufficient proxy for materiality of risk to the insurance operations. The GCC Instructions thus consider the unique circumstances of the relevant entity and group and uses an interactive process whereby the group brings forward its suggestions as to entities that should be excluded from the scope of application for a discussion with the lead state, ultimately culminating in an agreement on the scope of application. The guidance in this section helps to facilitate that process and discussion with criteria for cross-support mechanisms that can potentially transmit material risk, as defined, to the Insurance Group as well as safeguards that can mitigate such risk or its transfer.

19.20. **Person:** As used in Model #440, a “person” is an individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert but shall not include any joint venture partnership exclusively engaged in owning, managing, leasing or developing real or tangible personal property.

20.21. **Reciprocal Jurisdiction:** As defined in the Credit for Reinsurance Model Law (#785).

24.22. **Scope of Application:** Refers to the entities that meet the criteria listed herein for inclusion in the GCC ratio. The application of material risk criteria may result in the Scope of Application being the same as, or a subset of, the entities controlled by the Ultimate Controlling Person of the insurer(s).

NOTE: U.S. branches of foreign insurers should be listed as separate entities when they are subject to capital requirements imposed by a U.S. insurance regulator, otherwise in as much as they are already included in a reporting legal entity, they are already in the scope of application and there is no need for any additional reporting.

22.23. **Ultimate Controlling Person:** As used in the Insurance Holding Company System Regulatory Act (#440). This is the entity that exercises control directly or indirectly over all entities within the Broader Group.

III. Exemptions and Determining the Scope of Application

A. **Groups Exempted from the GCC**

23.24. These instructions do not address groups that are exempt from completing the GCC; those matters are addressed instead within proposed changes to Model #440 for guidance on groups that are exempted from filing a GCC. Instead, instructions are provided to ensure Lead State Regulators receive the information necessary to evaluate the Scope of Application.

B. **Scope of the Broader Group and Scope of Application – Legal Entity Inventory**

24.25. When considering the scope of application, preparers of the GCC must first understand the information to be included in Schedule 1 of the template. When developing an initial inventory of all potential entities, the preparers of the GCC shall complete Schedule 1, which, except in the case of an Insurance Subgroup (as defined in Section II), requests data for all of the entities within the Broader Group that are directly or indirectly owned by the Ultimate Controlling Person (including the Ultimate controlling Person) that are listed in the insurer’s most recent Schedule Y or in relevant Holding Company Filings. This will require the preparers of the GCC to provide complete basic information about each such entity in Schedule 1, including its total assets, and total revenue and net income for this specific year identified. Additionally, and the initial filing will require some further the same
information for the prior year (e.g., prior year equity or surplus to policyholders). The primary purpose of the Schedule 1 is to: 1) assist the lead state in making an assessment on the entities within the group that should be included in the Scope of Application; and 2) provide the lead state with valuation information to better understand the group. This valuable information produces various ratios and other financial metrics that will be used in the analysis of the GCC and the group by the lead state for their holding company analysis.

25.26. To assist the Lead State Regulator in assessing the Scope of Application, the Schedule 1 and the “Inventory” tab of the template will be completed by each preparer to provide information and certain financial data on all the entities in the group. Each preparer will also use the include/exclude column in Schedule 1 to request its own set of entities to be excluded from the calculation after applying criteria for material risk (as defined in Section II). The requests for exclusion which will be described by the preparer in the template and evaluated by the Lead State Regulator. A second column will be used by the regulator to reflect entities that the regulator agrees should be excluded.

26.27. Although all entities must be listed in Schedule 1 and in the “Inventory” tab, the preparer is allowed to group data for certain financial entities not subject to a regulatory capital requirement and certain non-insurance and non-financial entities. Thus, while the Schedule 1 would include the full combined financial results/key financial information (for all entities directly or indirectly owned by the Ultimate Controlling Person, such data may be reported based on major groupings of entities to maximize its usefulness, reduce the number of numeric entries, and allow the Lead State Regulator to better understand the group, its structure, and trends at the sub-group as well as group level. Criteria for grouping are further described in Section V, paragraph 55. Prior to completing the GCC annually, the Insurance Group should determine if the proposed grouping is satisfactory to the lead state or if there are certain non-insurance and non-financial entities (such entities are required to be broken out and reported separately) that should be broken out and reported separately.

C. General Process for Determining the Scope of Application

27.28. The starting point for “Scope of Application” (i.e., for purposes of the GCC specifically) is the entire group except in the case of an Insurance Subgroup (as defined in Section II). However, in the case of groups with material diverse non-insurance/non-financial activities isolated from the financial/Insurance Group and without cross-support mechanisms as defined in Section II, the preparer may request a narrower scope starting at the entity that controls all insurance and financial entities within the group [i.e., comprise a subset of, the entities controlled by the Ultimate Controlling Person of the insurer(s) (Broader Group)]. However, the adjustments as to the Scope of Application suggested by the preparer in consultation and in agreement with the Lead State Regulator should include consideration of guidance in paragraph 3129 (“Identify and Include all Financial Entities”) the totality of the facts and circumstances, as described in paragraph 19 (“Definition of material risk”). The rationale and criteria applied in allowing the reduced scope should be documented and made available to non-lead states if requested. The decision on reduced scope should be revisited when changes in the group structure or activities occur.

The fundamental reason for state insurance regulation is to protect American insurance consumers. Therefore, the objective of the GCC is to assess quantitatively the collective risks to, and capital of, the entities within the Scope of Application. This assessment should consider risks that originate within the Insurance Group along with risks that emanate from outside the Insurance Group but within the Broader Group. The overall purpose of this assessment is to better understand the risks that could adversely impact the ability of the entities within the Scope of Application to pay policyholder claims consistent with the primary focus of insurance regulators.
D. Guiding Principles and Steps to Determine the Scope of Application

28. 29. For most groups, the Scope of Application is initially determined by the preparer in a series of steps, listed here and then further explained as necessary in the text that follows:

- Develop a full inventory of potential entities using the Inventory of the Group template (Schedule 1). This should correspond to Annual Statement Schedule Y, Part 1A.

- Denote in Schedule 1 for each non-financial entity whether it is to be “included in or excluded from” the Scope of Application” using the criteria in the “Identify Risks from the Broader Group” subsection below.

- All non-financial entities, whether to be included in or excluded from the Scope of Application are to be reported in the “Inventory” tab of the template. Information to be provided for excluded entities will be limited to Schedule 1B and the corresponding columns in the Inventory tab. See paragraph 55 for additional information on treatment of non-insurance/non-financial subsidiaries of U.S. RBC filers or such subsidiaries owned by other financial entities with regulatory capital requirements for which the non-insurance/non-financial entity is included in the capital charges for the Parent entity.

- Non-financial entities may qualify for grouping on this Inventory tab as described elsewhere in these instructions.

E. Steps for Determining the Scope of Application

29. 30. Identify and list all entities in the Insurance Group or Insurance Subgroup (where required).

Include all entities that meet the definition of an affiliate in Section II, above and that fit the criteria identified in the definition of the Insurance Group or Insurance Subgroup (if applicable), in Section II, above except as modified in paragraph 32 (Identify Risks from the Broader Group), below. All insurance entities and entities owned directly or indirectly by the insurance entities in the group shall be included in the Scope of Application and reported in the Schedule 1 and Inventory of the Group template. Other non-insurance/nonfinancial entities within the Insurance Group may be designated as “exclude” as described in paragraph 30.

30. 31. Identify and include all Financial Entities.

Financial Entities (as defined in Section II) within the Inventory of the Group template shall be included in (i.e., may not be designated as “excluded from”) the Scope of Application, regardless of where they reside within the Broader Group.

As learned from the 2008 financial crisis, U.S. insurers were not materially impacted by their larger group issues; however, materiality of either equity or revenue of an entity might not be an adequate determinant of potential for risk transmission within the group. Furthermore, risks embedded in financial entities are not often mitigated by the activities of the insurers in the group and may amplify their (the insurers’) risks.

Any discretion in evaluating the ultimate risk generated by a defined financial entity that is not subject to a regulatory capital requirement should be applied via review of the material risk definitions/principles included in paragraph 19 to set the level of risk as low, medium or high and not to exclude such entities from the calculation. The rationale should be documented, and all data required in Schedule 1 must be provided for the entity for purposes of analysis and trending.
32. Identify Risks from the Broader Group

An Insurance Group or Insurance Subgroup may be a subset of a Broader Group, such as a larger diversified conglomerate with insurance legal entities, financial entities, and non-financial entities. In considering the risks to which the Insurance Group or Insurance subgroup is exposed, it is important to take account of those material risks (as defined in Section II) to the Insurance Group from the Broader Group within which the Insurance Group operates. All non-insurance/non-financial entities included within the Insurance Group or Insurance Subgroup that pose material risk to the insurers in the group should be included within (i.e., may not be designated as “excluded from”) the Scope of the Application. Similarly, all non-financial entities within the Broader Group but outside the Insurance Group that pose material risks to the Insurance Group should be included within (i.e., may not be designated as “excluded from”) the Scope of Application; non-material non-insurance/non-financial entities within the Broader Group or within the Insurance Group (as both terms are defined in Section II) other than those entities owned by entities subject to a specified regulatory capital requirement should be reported as “excluded.” However, no such entities outside an Insurance Subgroup (as defined in Section II) should be included in the GCC. When determining which non-financial entities from the Broader Group to include in the Scope of Application, the preparer must include any entity that could adversely impact the ability of the entities within the Scope of Application to pay policyholder claims or provide services to policyholders consistent with the primary focus of insurance regulators.

33. Review of Submission

The Lead State Regulator should review the Group template to determine if there are entities excluded by the preparer using the criteria above that the Lead State Regulator agrees do not pose material risk (as defined herein) to its insurance operations. Additional information may be requested by the Lead State Regulator to facilitate this analysis. For entities where the Lead State Regulator agrees with the request to exclude, the GCC may exclude the data for such entities. Ultimately, the decision to include or exclude entities from the GCC will occur based on the Lead State Regulator’s knowledge of the group and related information or filings available to the Lead State and whether they believe an applicable entity would not adversely impact the entities within the Scope of Application to pay policyholder claims.

The template’s sensitivity analysis tab is included to calculate to reflect the impact of excluded entities requested, but not approved for exclusion by the lead state. (see instructions for Input 5 herein).

34. Updating the Scope of Application

The Scope of Application could be re-assessed by the preparer and the Lead State Regulator each successive annual filing of the GCC provided there has been substantial changes in corporate structure or other material changes from the previous year’s filing. Any updates should be driven by the assessment of material risk and changes in group structure as they impact the exclusion or inclusion of entities within the Scope of Application based on material risk considerations.
IV. General Instructions

35.36. The GCC template consists of a number of tabs (sections) within one workbook. The following provides general instructions on each of these tabs.

36.37. **Attestation**: This tab is intended to work similar to the annual financial statement and RBC attestations, which are both intended to give the regulator greater comfort that the company has completed in accordance with its (these) instructions. It will also indicate whether the group consists of predominantly life, P/C, or health insurers and whether the submission is a full or limited group capital filing.

37.38. **Input 1 – Schedule 1**: This tab is intended to provide a full inventory of the group, including the designation by the filer of any non-financial entities to be included in, or excluded from, the Scope of Application and include sufficient data or information on each affiliated entity (see Schedule A and Schedule BA exception as described in paragraph 39) within the group so as to allow for analyzing multiple options for scope, grouping and sensitivity criteria, as well as, allowing the Lead State Regulator to make a determination as to whether the entities to be included in the scope of application or excluded from the scope of application meet the aforementioned criteria. This tab is also used to maximize the value of the calculation by including various information on the entities in the group that allow the lead state to better understand the group as a whole, the risks of the group, capital allocation, and overall strengths and weaknesses of the group.

38.39. **Except as noted, in on the “Inventory” tab, equity method investments reported in the Section 1B in the Inventory tab that are accounted for based on Statement of Statutory Accounting Principles (SSAP) No. 48—Joint Ventures, Partnerships and Limited Liability Companies are not required to be de-stacked (separately listed) in Schedule 1; i.e., their value would be included in amounts reported by the Parent insurer within the calculation. The basis for this approach is predicated on the purpose of the entire GCC, which is to produce an expected level of capital and a corresponding level of available capital that are derived by aggregating the amounts reported of capital of the individual entities under the GCC methodology. The available capital for such joint ventures, partnerships and limited liability companies is already considered in Schedule 1 by its inclusion in its Parent’s financial statements and can thus be excluded from an inventory (not separately listed) because the Parent already receives a corresponding capital charge within its RBC.**

**NOTE**: Data for this tab is required for a Limited Group Capital filing.

39.40. **Input 2 – Inventory**: This tab is intended to be used by the consolidated group to provide information on the value and capital calculation for all the entities in the group before any de-stacking of the entities. While some of this information is designed to “pull” information from Schedule 1, other cells (blue cells) require input from the group. This tab will then apply include the adjustments for investment in subsidiary other than where an exception is described in these instructions and adjust for intragroup arrangements. This tab is set up to subtract those adjustments from capital and therefore should be entered as: 1) a positive figure if the adjustment currently has a positive impact on the available capital or the capital calculation; or 2) a negative figure if the adjustment currently has a negative impact on the available capital or the capital calculation. It will also be used to add relevant insurance or other financial entities included as equity investments in Schedule A and Schedule BA and to aggregate the resulting adjusted values for use in the actual GCC.

**NOTE**: For a Limited Group Capital filing, data will be presented in a summarized format in a limited version of the “Inventory” tab in lieu of completing the full “Inventory” tab (see below).
**Limited Group Capital Filing Only: Input 2 – Inventory:** Manually enter data in Inventory B, Column 8 and Inventory C, Column 8 to report a single aggregated value for each entity category in the group. This will require that eliminations and adjustments normally found in a “full” Inventory B, Column 2 through Column 7 and Inventory C, Column 2 through Column 7 to be addressed offline.

**Input 3 – Capital Instruments:** This tab is intended to be used to gather necessary information to that will be used to calculate an allowance for additional available capital based on the concept of structural subordination applied to senior or other subordinated debt issued by a holding company that is within the scope of application of the GCC filing. It will also provide information on all debt issued by entities within the scope of application of the group.\[TF28\][FL29]

**NOTE:** Data for this tab is NOT required for a Limited Group Capital filing.

**Input 4 – Analytics:** In recognizing a primary purpose of the GCC is to enhance groupwide financial analysis, this tab includes or draws from entity-category-level inputs reported in the tab or elsewhere in the GCC template to be used in GCC analytics. Separate guidance for Lead State Regulators to reference in analysing the data provided in the GCC template (reference applicable location of the guidance; e.g., *Financial Analysis Handbook*).

**NOTE:** Data for this tab is required for a Limited Group Capital filing.

**Input 5 – Sensitivity Analysis and Inputs:** This tab includes inputs and/or describes informational sensitivity analysis for other than XXX/AXXX captives, permitted and prescribed practices, debt designated as “Other,” unscaled foreign insurer values and other designated sensitivity analysis. The inputs are intended to simply be a disclosure, similar to the disclosure required under Note 1 of the statutory financial statements. The analysis will be applied in the “Summary 2” tab.

**NOTE:** Data for this tab is NOT required for a Limited Group Capital filing.

**Input 6 – Questions and Other Information:** This tab will provide space for participants to describe or explain certain entries in other tabs. Examples include the materiality method applied to exclude entities in Schedule 1 and narrative on adjustments for intragroup debt and adjustments to available capital or capital calculations that are included in the “other adjustment” column in the “Inventory” tab.

**NOTE:** Data for this tab is NOT required for a Limited Group Capital filing.

**Calc 1 – Scaling (Ins):** This tab list countries predetermined by NAIC and provides the necessary factors for scaling available and required capital from non-US insurers to a comparable basis relative to the U.S. RBC figures. It also allows for set scaling options (which vary by insurance segment such as life, P/C, and health).

**NOTE:** This tab is NOT required for a Limited Group Capital filing.

**Calc 2 – Scaling (Non-Insurance):** This tab is used to determine calculated capital for non-insurance entities.

**NOTE:** This tab is NOT required for a Limited Group Capital filing.

**Summary 1 – Entity Category Level:** This tab provides a summary of aggregated available capital and calculated capital for each entity category before the application of capital instruments.
NOTE: This tab is NOT required for a Limited Group Capital filing.

47.48. **Summary 2 – Top Level**: This tab calculates various informational GCC ratios resulting from applying “on top” and entity level adjustments to adjusted carrying value and adjusted calculated capital and are described in the “Sensitivity Inputs and Analysis” tab. These “what if” scenario analysis will not be part of the GCC ratio.

NOTE: This tab is NOT required for a Limited Group Capital filing.

48.49. **Summary 3 – Analytics**: Provides a summary of various GCC analytics.

NOTE: This tab is required for a Limited Group Capital filing.

49.50. **Summary 4 – Grouping Alternatives**: This tab currently calculates and displays a selected grouping option for organizing the structure of the group consistent with the way that the entities are managed that was submitted by an interested party. [TF30][FL31]

NOTE: This tab is NOT required for a Limited Group Capital filing.

50.51. All cells in the template are color-coded based on the chart below. Inputs should only be made in blue cells. Do not add/delete rows, columns or cells or change the structure of the template in any way. If there appears to be an error in the formulas in the template, contact the NAIC.

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### The following set of colors is used to identify cells:

<table>
<thead>
<tr>
<th>Colors used</th>
<th>Parameters</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Input cells</td>
</tr>
<tr>
<td></td>
<td>Data from other worksheets</td>
</tr>
<tr>
<td></td>
<td>Local calculations</td>
</tr>
<tr>
<td></td>
<td>Results propagated</td>
</tr>
</tbody>
</table>

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V. **Detailed Instructions** (insert link to template)

**Input 1 – Schedule 1**[TF32]

52. Schedule 1A indicates the version of the template being prepared.

53. is a small table at the top for identification of the filer. Enter the “Name of Group,” name of the person the template is “Completed by,” and the “Date Completed.” Indicate the version number of the template if there are updates or multiple persons completing the template. All figures (in all tabs) should be converted to $'000s. For example, a book value of $123,450 should be entered as “123.45” in the template.[FL33]

54.53. More detailed information on each legal entity should be reported in Schedule 1B through Schedule 1D. The order of the entries in Schedule 1 should match that in the “Inventory” tab. The first entity listed should be the ultimate controlling party.
§§ 54. U.S. branches of foreign insurers should be listed as separate entities when they are subject to capital requirements imposed by a U.S. insurance regulator. They should be reported under the appropriate entity category in [Sch 1B Col 6].

§§ 55. Entries are required for every entity within the scope of the group. However, while recognizing that Lead State Regulator retain the discretion to ask for greater detail, the following simplifications may be applied as long as information for every entity is entity is listed in Schedule 1B:

- A single numerical entry for like Financial Entities would be allowed at the intermediate holding company level, assuming that the like entities are owned by a common Parent that does not own other entity types, all use the same accounting rules (e.g., all GAAP), and are at least consistent with the way the group manages their business. The entity at which the total data is provided must be assigned an “Entity Category” in Schedule 1 that corresponds to the instructed carrying value and capital calculation for which the entry is made (e.g., an entity that would otherwise be categorized as a non-operating holding company but holds asset managers would be categorized as an asset manager). Entries for the remaining individual entities in the grouping will be reported in Schedule 1B only as “included.”

- In addition, a single numerical entry would be allowed for all included non-insurance/non-financial entities at the intermediate holding company level assuming that the intermediate holding company owns only non-insurance/non-financial entities assuming that the entities are owned by a common Parent that does (i.e., does not own other entity types), all use the same accounting rules (e.g., all GAAP), and are at least consistent with the way the group manages their business. This would include any positive residual value of the holding company itself. Entries for all the remaining individual entities in the grouping will be reported in Schedule 1B only as “included.” but no stand-alone values for each entity would be required.

- Values for, non-insurance/non-financial subsidiaries of U.S. RBC filers or such subsidiaries owned by other financial entities with regulatory capital requirements for which the non-insurance/non-financial entity is included in the capital charges for the Parent entity may remain with their Parent insurers and will not be de-stacked. Entries for these individual entities in the grouping will be reported individually in Schedule 1B Columns 1 and 2 only as “included.” along with other required entries in Schedule 1B, but no stand-alone values for each entity would be required in Schedules 1C or 1D.

- Mutual Insurance Groups may use the Total Adjusted Capital and amount of required capital from the top-level Insurer’s RBC Report at 200% x ACL RBC, and further adjusted to de-stack foreign insurers and other financial entities owned directly or indirectly (on a look-through basis) via RBC filing subsidiaries. Such foreign insurance subsidiaries or other financial subsidiaries shall be reported at the carrying values and capital calculations as described later herein.

- Data for U.S. Branches of Foreign insurers may be omitted from Schedule 1 if they are otherwise included in the entries, values, and capital requirements of a foreign insurer.

**NOTE**: These simplifications will be treated in a similar manner in Input 2 – Inventory.

§§ 56. Any insurer or financial entity owned by a Parent insurer and listed in Schedule A or Schedule BA, and any insurance or financial entity that is owned indirectly through a Schedule BA affiliate should be listed in Schedule 1 and in the Inventory and assigned the
appropriated identifying information. (See also the instructions for Part B of the Inventory). These entities will be de-stacked from the values for the Parent insurer. The same treatment for these entities will be afforded when they owned by a foreign insurer or other non-insurance entities.

Schedule 1B contains descriptions of each entity. Make selections from drop-down menu where available.

- **[Sch 1B Col 1] Include/Exclude (Company)** – This column is to select entities where a request is made for exclusion. The filer will indicate which non-insurance/non-financial entities not owned directly or indirectly by an insurer that should be excluded from the GCC as not posing material risk to the group. The filer’s definition of material risk will be reported in the “Other Information” tab.

- **[Sch 1B Col 2] Include/Exclude (Supervisor)** – Column to be filled in by supervisor. These are entities where the Supervisor agrees with the filer’s assessment of material risk and these entities will be excluded from the GCC and may be included in a sensitivity analysis later in the template.

  **NOTE**: This column may also be completed by the filer after advance consultation with the Lead State Regulator.

- **[Sch 1B Col 3] Include/Exclude (Selected)** – Formula to determine treatment of data for later sensitivity analysis. If supervisor has made a determination of include/exclude in the prior column, that will be used. If not, company’s selection will be used.

- **[Sch 1B Col 4] Entity Grouping** – Column denotes whether this is an insurance or non-insurance/non-financial entity and is also automatically populated based on the entry in Column 8.

- **[Sch 1B Col 5] Entity Identifier** – Provide a unique string for each entity. This will be used as a cross-reference to other parts of the template. If possible, use a standardized entity code such as NAIC Company Code (CoCode) or Insurance Services Office (ISO) Legal Entity Identifier. CoCodes should be entered as text and not number (e.g., if CoCode is 01234, then the entry should be “01234” and not “1234”). If there is a different code that is more appropriate (such as a code used for internal purposes), please use that instead. If no code is available, then input a unique string or number in each row in whatever manner is convenient (e.g., A, B, C, D, … or 1, 2, 3, 4…). Do not leave blank.

- **[Sch 1B Col 6] Entity Identifier Type** – Enter the type of code that was entered in the “Entity Identifier” column. Choices include “NAIC Company Code,” “ISO Legal Entity Identifier,” “Volunteer Defined” and “Other.”

- **[Sch 1B Col 7] Entity Name** – Provide the name of the legal entity.
**[Sch 1B Col 8] Entity Category** – Select the entity category that applies to the entity from the following choices (all U.S. life captives shall select the option for “RBC Filing Captive,” complete the calculation using the life RBC formula in accordance with instructions below regarding “Additional clarification on capital requirements where a U.S. formula (RBC) is not required,” regardless of whether the company is required by their captive state to complete the RBC formula. Insurers or financial entities that are de-stacked from an insurer’s Schedule A or Schedule BA should be assigned the corresponding insurer or financial entity category:

<table>
<thead>
<tr>
<th>RBC Filing U.S. Insurer (Life)</th>
<th>UK Solvency II – Life</th>
<th>Colombia</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC Filing U.S. Insurer (P/C)</td>
<td>UK Solvency II – Composite</td>
<td>Indonesia</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td></td>
<td>Thailand</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Other)</td>
<td></td>
<td>Barbados</td>
</tr>
<tr>
<td>U.S. Mortgage Guaranty Insurers</td>
<td></td>
<td>Regime A (Participant Defined)</td>
</tr>
<tr>
<td>U.S. Title Insurers</td>
<td></td>
<td>Regime B (Participant Defined)</td>
</tr>
<tr>
<td>Other Non-RBC Filing U.S. Insurers</td>
<td></td>
<td>Regime C (Participant Defined)</td>
</tr>
<tr>
<td>RBC filing (U.S. Captive)</td>
<td></td>
<td>Regime D (Participant Defined)</td>
</tr>
<tr>
<td>Canada – Life</td>
<td></td>
<td>Regime E (Participant Defined)</td>
</tr>
<tr>
<td>Canadian – P/C</td>
<td>South Africa – Life</td>
<td>Bank (Basel III)</td>
</tr>
<tr>
<td>Bermuda – Other</td>
<td>South Africa – Composite</td>
<td>Bank (Other)</td>
</tr>
<tr>
<td>Bermuda – Commercial Insurers</td>
<td>South Africa – Non-Life</td>
<td>Financial Entity with a Regulatory Capital Requirement</td>
</tr>
<tr>
<td>Japan – Life</td>
<td>Mexico</td>
<td>Asset Manager/Registered Investment Advisor – High Risk</td>
</tr>
<tr>
<td>Japan – Non-Life</td>
<td>China</td>
<td>Asset Manager/Registered Investment Advisor – Medium Risk</td>
</tr>
<tr>
<td>Japan – Health*</td>
<td>South Korea</td>
<td>Other Financial Entity without a Regulatory Capital Requirement – High Risk</td>
</tr>
<tr>
<td>Solvency II – Life</td>
<td>Malaysia</td>
<td>Other Financial Entity without a Regulatory Capital Requirement – Medium Risk</td>
</tr>
<tr>
<td>Solvency II – Composite</td>
<td>Chile</td>
<td>Other Financial Entity without a Regulatory Capital Requirement – Low Risk</td>
</tr>
<tr>
<td>Solvency II – Non-Life</td>
<td>India</td>
<td>Other Non-Ins/Non-Fin with Material Risk</td>
</tr>
<tr>
<td>Solvency II – Non-Life</td>
<td>Brazil</td>
<td>Other Non-Ins/Non-Fin without Material Risk</td>
</tr>
<tr>
<td>UK Solvency II – Non-Life</td>
<td>Argentina</td>
<td>Non-Operating Holding Co.</td>
</tr>
</tbody>
</table>
* If the GCC group’s Japanese insurer health business (referred to as “Third Sector”) is greater than 60% of total life business (referred to as “First Sector”) and health business combined, as reflected by annualized premium for the year reported, then that group may elect to use the Japan health scalar set rather than the life scalar set.

NOTE: All U.S. captives are required to complete the applicable RBC formula template. In addition, any insurer, other than U.S. captive, that submits an RBC filing to either the state of domicile or the NAIC will be considered an RBC filer.

- **[Sch 1B Col 9] Alternative Grouping** – This is an optional input field. This field should be used if you wish to show similar entities aggregated into a single line in Summary 4-Alternative Grouping on the “Grouping Alternative Exhibit.” For example, if you have a dozen small dental HMO businesses, you may wish to show them as a single line called “Dental HMOs,” as opposed to listing each entity separately. This is a level of granularity below “Entity Category” but above individual entities. No entity should be put in the same “Alternative Grouping” as its Parent. It is acceptable to put only one entity in a grouping. If any entries are left blank then, in Column 17, the “Entity Name” will be selected as the grouping. This will not impact the order of the entities for which data is entered in Schedule 1 or the “Inventory” tab.

- **[Sch 1B Col 10] Parent Identifier** – Provide the Entity Identifier of the immediate Parent legal entity for each entity, as applicable. If there are multiple Parents, select the Parent entity with the largest ownership percentage. Only include one entry. For the top holding company, enter “N/A.”

- **[Sch 1B Col 11] Parent Name** – This will be populated by a formula, so input is not required.

- **[Sch 1B Col 12] % Owned by Parent** – Enter the percentage of the entity that is owned by the Parent identified earlier in the worksheet. Percentages of ownership should be based on the percentage of voting class securities (unless ownership is maintained other than by control of voting securities) consistent with what is reported pursuant to state holding company regulation filings (Form B or equivalent).

- **[Sch 1B Col 13] % Owned within Group Structure** – Enter the percentage of the entity that is owned in the aggregate by any/all affiliate entities within the Group structure.

- **[Sch 1B Col 14] State/Country of Domicile** – Enter state of domicile for U.S. insurance entities and country of domicile for all other entities. (Use references that are consistent with those use on Schedule Y, where available.)

- **[Sch 1B Col 15] Zero Valued and Not Admitted Entities – Report for U.S. Insurers Only**. Select the treatment of the entity from following options: “Zero Valued for RBC” or “Nonadmitted for Accounting and RBC (Direct or Indirect).”

Zero Valued for RBC are affiliated insurance and financial entities that are otherwise reported in the RBC filer’s annual financial statement at their accounting value (i.e., per SAP) but are reported at zero value and zero capital requirements for RBC purposes. Examples include non-Canadian foreign insurers directly owned by U.S. life RBC filers. The carrying value and capital calculation specified in these instructions for the specific insurance or financial entity type should be reported in Inventory B, Column 2 and Inventory C, Column 2, respectively.

NOTE: Do not report zero values in Column 2 of Inventory B and Inventory C for these affiliates. Only RBC filing entities with this type of affiliate will report in this column.
Nonadmitted for Accounting and RBC (Direct or Indirect) are insurance or other financial affiliates that owned directly indirectly by an RBC filer via a downstream non-financial entity or holding companies that are reported at zero value per SAP and are also reported at zero value and zero capital requirements for RBC purposes. Examples include U.S. insurers indirectly owned by a U.S. RBC filer through a nonadmitted holding company that has not been subject to an independent audit. The carrying values and capital calculations specified herein associated with the specific insurance or financial indirectly owned entity type should be reported Inventory B, Column 2 and Inventory C, Column 2, respectively.

**NOTE:** Do not report zero values in Column 2 of Inventory B and Inventory C for these affiliates. Only RBC filing entities with this type of affiliate will report in this column. The excess value in the nonadmitted Parent entity may be reported at zero value.

No entry is required in this column for any nonadmitted directly or indirectly owned non-insurance/non-financial subsidiary. Report zero for these affiliates in Column 2 of Inventory B and Inventory C.

- **[Sch 1B Col 16]** Is Affiliate on Schedule A or Schedule BA an Insurer or Other Financial Entity? – Column is meant to identify an entity with an insurer or financial entity identifier in Column 8 that is otherwise-reported on Schedule A or Schedule BA but is being de-stacked and also reported on the Inventory tab moved to this Schedule.[FL46]

  Provide a “Y” response where that is applicable. Otherwise leave blank.

- **[Sch 1B Col 17]** Selected Alternative Grouping – This will be populated by a formula, so input is not required. If there are any blank entries in Column 9 (Alternative Grouping), this column will set them equal to the name of the entity.

50.58. Schedule 1C contains financials for each entity:

- **[Sch 1C Col 1]** Basis of Accounting – Enter basis of accounting used for the entity’s financial reporting.


- **[Sch 1C Col 4]** Reinsurance Assumed from Affiliates – Report for all U.S. and non-U.S. insurers. Use applicable entity annual financial statement data source for U.S. insurers (assumed premiums from P/C Schedule F, Part 1 and life and health Schedule S, Part 1, Section 1, and Section 2). Use equivalent local source for non-U.S. insurers or company records when available.[FL47]

- **[Sch 1C Col 5]** Reinsurance Ceded to Affiliates – Report for all U.S. and non-U.S. insurers. Use applicable entity annual financial statement data source for U.S. insurers (assumed premiums from P/C Schedule F, Part 3 and life and health Schedule S, Part 3, Section 1, and Section 2). Use equivalent local source for non-U.S. insurers or company records when available.[FL48][FL49]

- **[Sch 1C Col 6]** Book Assets – This should be valued based on the applicable basis of accounting reported under the entity’s local regime and represents the total assets as reported in the basic financial statements before eliminations (because that is presumed to be less burdensome on the insurance holding company). Other financial data should
similarly be prepared using financial data before eliminations. However, insurance holding companies are allowed to present such figures after eliminations if they do so for all figures and consistently for all years.

- **[Sch 1C Col 7] Book Liabilities** – This should be valued based on the applicable basis of accounting reported under the entity’s local regime and represents the total liabilities as reported in the basic financial statements.

- **[Sch 1C Col 8] Gross Paid-in and contributed Capital and Surplus (U.S. Insurers Only)** – For U.S. insurers, report the current year end amounts from annual financial statement Page 3 as follows:
  a. Life Insurers: lines 29, 30 and 33.
  b. P/C Insurers: lines 30, 31 and 34.
  c. Health Insurers: lines 26, 27 and 28. [FL51]

Generally, Schedule 1D will include entries from regulatory filings or entity specific GAAP financial statements as of the reporting date. The amounts reported should be the entity value on a stand-alone (fully de-stacked) or grouped basis (where applicable). This may require use of company records in certain cases. The amounts should be reported at 100% for the entity listed. Any required adjustments for percentage of ownership will be applied later, if necessary, to calculate a capital charge.

- **[Sch 1D Col 1] Prior Year Entity Identifier** – Report the Legal Entity Identifier, NAIC company code or other identifier used for the entity in the prior year GCC filing for the prior calendar year.

- **[Sch 1D Col 2] Prior Year Equity or Capital and Surplus** – Report the value based on net equity reported in the entity stand-alone balance sheet. This will generally be the same as what is reported in the current year column in the prior year GCC filing. Where grouping is permitted, the balance reported may be on a grouped basis. Do not report values for non-insurance/non-financial entities owned directly or indirectly by RBC filers, or owned by other financial entities with regulatory capital requirements for which the non-insurance/non-financial entity is included in the capital charges for the Parent entity. [FL52]

- **[Sch 1D Col 3] Net Income** – The final reported income figure from the income statement, and therefore is the figure reported after interest, taxes, extraordinary items, etc. For entities with accounting and reporting requirements that specify that dividends paid or received will be part of “net income,” report the dividends received in this column. Report dividends to policyholders here as a reduction to net income if required by local accounting or reporting requirements.

- **[Sch 1D Col 4] Dividends Paid and Received (Net)** – All entity types report the net amount of dividends paid and received in reporting year to/from and affiliate, a Parent shareholder, public shareholders, or policyholders (if not required to be a reduction/increase in net income by local accounting or reporting requirements). All entity types that are subject to accounting and reporting requirements that specify that dividends paid or received will be reported as a surplus adjustment, will report dividends received in reporting year from affiliates in this column.
- **[Sch 1D Col 5] Capital and Surplus Contributions Received from Affiliates** – All entity types. Report sum of capital contribution (other than via surplus notes) during the reporting year received from any affiliated entity.

- **[Sch 1D Col 6] All Other Changes in Capital and Surplus** – Include total for all adjustments not listed above. This would include any investment income not already reported in Column 3 or Column 5. Also, report all stock repurchases or redemptions in this column.

  **NOTE**: Greater detail may be made available upon request.

- **[Sch 1D Col 7] Current Year Equity or Capital and Surplus** – Report the value based on net equity reported in the entity stand-alone Balance Sheet for the current year. This will generally be the same as what is reported for the entity in the Inventory B, Column 2. Where grouping is permitted, the balance reported may be on a grouped basis. Do not report values for non insurance/non financial entities owned directly or indirectly by RBC-filers or owned by other financial entities with regulatory capital requirements for which the non insurance/non financial entity is included in the capital charges for the Parent entity.

- **[Sch 1D Col 8] Capital and Surplus Contributions Paid to Affiliates** – All entity types report the total of capital contributions (other than via surplus notes) during the reporting year paid to any affiliated entity.

- **[Sch 1D Col 9] Dividends Declared and Unpaid** – For all applicable entities report the amount of dividends declared or approved but not yet distributed.

- **[Sch 1D Col 10] Dividends Received and Not Retained** – All holding companies, insurers and financial entities with regulatory capital requirements indicate by “Y” or “N” if part or all of dividends received reported in Column 5 have been paid (passed through) to a Parent company, to public shareholders, or used to repurchase or redeem shares of stock.
Input 2 – Inventory

Columns in Inventory A are being pulled from Schedule 1:

- [Column 1] Insurance/Non-Insurance
- [Column 2] Entity Identifier
- [Column 3] Entity Identifier Type
- [Column 4] Entity Name
- [Column 5] Entity Category
- [Column 6] Parent Identifier
- [Column 7] Parent Name
- [Column 8] Basis of Accounting

Columns Requiring Input

Enter information on adjustments to carrying value. Considerations specific to different types of entities are located at the end of this subsection.

- **[Inv B Col 1] Carrying Value (Immediate Parent Regime)** – This column is included to accommodate participants with either a U.S. or a non-U.S. based Parent company. In general, carrying values utilized should represent: 1) the subsidiary valuation required by the insurance or other sectoral regulator if the Parent is a regulated entity; or 2) in the case where the Parent is not subject to insurance or other sectoral regulatory valuation, then a subsidiary valuation based U.S. GAAP or other International GAAP as used in the ordinary course of business by the ultimate controlling party in their financial statements. **No entry is required for the Ultimate Controlling Person (UCP)**

  The value in this column will include a zero value for entities not admitted per SAP or other jurisdictional regulatory rules. A single entry for all entities that qualify under the grouping criteria described in **Input 1**, herein may be made in lieu of individual entries on the line for the affiliate that holds the qualifying entities. This column will include double-counting.

  The values recorded for all subsidiaries should be the full value of the subsidiary regardless of percentage of ownership by entities within the group. Where entities are owned partially by entities outside of the group, then report the full value of the subsidiary adjusted to reflect total percentage of ownership within the group.

- **[Inv B Col 2] Carrying Value (Local Regime)** – Record the carrying value recognized by the legal entity’s jurisdictional insurance or other sectoral supervisor. This will include the value of capital instruments (e.g., U.S. insurer issued surplus notes) that are specifically recognized by statute, regulation or accounting rule and included in the carrying value of the entity. In the case where the entity is not subject to insurance or other sectoral regulatory valuation, then U.S. GAAP equity (including OCI) or other International GAAP as used in the ordinary course of business by the ultimate controlling party in their financial statements. If an agreed-upon change in local carrying value should become effective by 2021, Volunteer Groups are expected to report on that basis.

  If the group is comprised entirely of U.S.-based entities under a U.S.-based Parent company, the entries in this column will be the same as in Column 1 except in cases where the Parent owns not admitted (or otherwise zero valued financial affiliates that would be reported as not admitted in the Parent Regime column but fully admitted (per SAP valuation) in the Local Regime column). (See instructions for **[Sch 1B Col 15]**.) However, if such an entity has been listed in the **[Sch 1B Col 2] Include/Exclude**
(Supervisor) column, indicating that the Lead State Regulator agrees that the entity does not pose material risk, then a value will be reported here, but the ultimate calculation will show the results without the excluded entity’s value. The carrying value for affiliates that are U.S. RBC filers, the value will be the amount reported TAC on entity’s RBC report. This column will include double-counting. The values recorded for all subsidiaries should be the full value of the subsidiary regardless of percentage of ownership by entities within the group. Where entities are owned partially by entities outside of the group, then report the full value of the subsidiary adjusted to reflect total percentage of ownership within the group. The entry here should generally be the same as the value reported in Inventory B, Column 1, except where TAC for RBC filers differs from their BACV. A single entry for all entities that qualify under the grouping exceptions criteria described exceptions described herein under Input 1, above may be made in the line for the affiliate that holds the qualifying entities in lieu of individual entries.

A sensitivity analysis is included to calculate to reflect in the impact of excluded entities requested but not approved for exclusion by the lead state.

<table>
<thead>
<tr>
<th>Parent Entity Line</th>
<th>Entity</th>
<th>Inv B, Column 1</th>
<th>Inv B, Column 2</th>
<th>Parent Entity Line</th>
<th>Inv C, Column 3</th>
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</thead>
<tbody>
<tr>
<td>U.S. RBC filer</td>
<td>U.S. RBC filer</td>
<td>BACV Per Statutory Accounting</td>
<td>RBC TAC</td>
<td>BACV Per Statutory Accounting</td>
<td></td>
</tr>
<tr>
<td>U.S. RBC filer</td>
<td>Other U.S. Insurer</td>
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<td>BACV Per Statutory Accounting</td>
<td>BACV Per Statutory Accounting</td>
<td></td>
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<tr>
<td>U.S. RBC filer</td>
<td>Foreign Insurer or Other Regulated w/ Capital Reqmt</td>
<td>BACV Per Statutory Accounting</td>
<td>Per Local Regulatory Accounting</td>
<td>BACV Per Statutory Accounting</td>
<td></td>
</tr>
<tr>
<td>U.S. RBC filer</td>
<td>Financial w/o Capital Reqmt</td>
<td>BACV Per Statutory Accounting</td>
<td>BACV Per Statutory Accounting</td>
<td>BACV Per Statutory Accounting</td>
<td></td>
</tr>
<tr>
<td>Other U.S. Insurer</td>
<td>Non-Financial</td>
<td>BACV Per Statutory Accounting</td>
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<td>No entry Required – Do not de-stack</td>
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<td>Other U.S. Insurer</td>
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<td>RBC TAC</td>
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<td>Any Other Entity Type</td>
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<td>BACV Per Statutory Accounting</td>
<td>BACV Per Statutory Accounting</td>
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<tr>
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<td>Per Local Regulatory Accounting</td>
<td>RBC TAC</td>
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<tr>
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<td>Per Local Regulatory Accounting</td>
<td>BACV Per Statutory Accounting</td>
<td>Per Local Regulatory Accounting</td>
<td></td>
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<tr>
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<td>Foreign Insurer or Other Regulated w/ Capital Reqmt</td>
<td>Per Local Regulatory Accounting</td>
<td>Per Local Regulatory Accounting</td>
<td>Per Local Regulatory Accounting</td>
<td></td>
</tr>
<tr>
<td>Foreign Insurer or Other Regulated w/ Capital Reqmt</td>
<td>Financial w/o Capital Reqmt</td>
<td>Per Local Regulatory Accounting</td>
<td>Per risk level factor x 3-year avg revenue</td>
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<td>Per Local Regulatory Accounting</td>
<td>No entry Required</td>
<td>No entry Required – Do not de-stack</td>
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<tr>
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<td>Per Local Public Accounting</td>
<td>RBC TAC</td>
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<td>Per Local Public Accounting</td>
<td>BACV Per Statutory Accounting</td>
<td>Per Local Public Accounting</td>
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<tr>
<td>Financial w/o Capital Reqmt or Non-Financial</td>
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<td>Per Local Public Accounting</td>
<td>Per Local Regulatory Accounting</td>
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<tr>
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<td>Financial w/o Capital Reqmt</td>
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<td>Per Local Regulatory Accounting*</td>
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<td>Per Local Public Accounting*</td>
<td>Per Local Public Accounting*</td>
<td>Per Local Public Accounting</td>
<td></td>
</tr>
</tbody>
</table>

*Subject to Grouping

In cases where a U.S. life RBC filer owns a foreign insurer and the BACV value reported for the foreign insurer in the Parent U.S. insurers financial statement is adjusted to zero for RBC purposes, then report zero in Inventory B, Column 1 and Column 3 for that foreign insurance entity.
• **[Inv B Col 3] Investment in Subsidiary** – Enter an adjustment to remove the investment carrying value of any directly owned subsidiary(ies) from Parent’s carrying value. This is intended to prevent double-counting of available capital when regulated entities are stacked. The carrying value to be removed should be the investment value carried by the Parent from which the entity is being de-stacked (i.e., the value in Column 1 in Inventory B adjusted for ownership percentage). Thus, there will be no adjustment to the Parent’s value in this column for entities that are reported at zero value by the Parent. Where entities are owned partially by entities outside of the group, then the Parent’s percentage of ownership will be calculated based on the value owned within the group.

Generally, for all non-financial affiliates, Schedule A and Schedule BA assets will remain in the value of the Parent insurer and not entered in this column. However, if the Schedule A or Schedule BA asset is an insurance or financial entity, then the exceptions as described herein, the value of that entity will be included in this column. For indirectly owned Schedule A or Schedule BA insurance or financial entities, only the value of that entity will be included in this column and the remaining value of the downstream Schedule BA Parent will remain with the Parent insurer. Similarly, the carrying value of U.S. branch of a foreign insurer that is listed in Schedule 1 and in this section should be entered in this column in the row of the foreign insurer if it is already included in the value of the foreign insurer so that the Parent entity may eliminate double-counting of that available capital which will now be reported by the stand-alone Branch listed in the inventory.

**NOTE:** The “Sum of Subsidiaries” column may provide a useful check against this entry, but it will not necessarily be equal.

When utilizing public accounting (e.g., GAAP) equity values that differ from regulatory values (e.g., SAP), it is the **GAAP equity** of the insurers must be eliminated from the GAAP Parent in this column, not the SAP (regulated capital). This is necessary in order to allow the calculation to appropriately represent SAP capital of regulated entities and GAAP equity of non-regulated entities. Data on the accounting differences between Parent and Local carrying values will be collected in **[Inventory B, Column 9]** and further detail provided in the “Questions and Other Information” tab.

**NOTE:** Values for Schedule A and Schedule BA affiliates that are required to be reported in the “Inventory” tab will be adjusted out of the value reported by the U.S. insurer in this column.

• **[Inv B Col 4] Intragroup Capital Instruments** – This column is automatically calculated from inputs to the “Capital Instruments” tab. It reflects an adjustment to remove carrying value for intragroup financial instruments that are treated as capital by the issuer and consequently create additional capital within the group upon issuance (most notably U.S. surplus notes). Example for surplus notes: In both intragroup and unaffiliated transactions, treat the assets transferred to the issuer of the surplus note as available capital. If the purchaser is an affiliate, eliminate the investment value from the affiliated purchaser of the surplus note in this column. If the purchaser is an insurer or other regulated entity, eliminate the purchaser’s capital charge (e.g., RBC charge) on the surplus note investment in the corresponding adjustment column for the capital calculation. No adjustments are made for any intragroup capital instrument that is treated as a liability by the issuer.
• [Inv B Col 5] Reported Intragroup Guarantees, LOCs and Other – Enter an adjustment to reflect the notional value weighted for expected utilization for reported intragroup guarantees (including solvency insurance and capital maintenance agreements). Enter the notional value for letters of credit, or other intragroup financial support mechanisms. Explain each intragroup arrangement in the “Questions and Other Information” tab.

• [Inv B Col 6] Other Intragroup Assets – Enter the amounts to adjust for and to remove double-counting of carrying value for other intragroup assets, which could include intercompany balances, such as (provide an explanation of each entry in the “Questions and Other Information” tab):
   a. Loans, receivables and arrangements to centralize the management of assets or cash;
   b. Derivative transactions;
   c. Purchase, sale or lease of assets; and
   d. Other (describe).

• [Inv B Col 7] All Other Adjustments – Include a brief explanation in the “Description of ‘Other Adjustments’” in the “Other Information” tab.

• [Inv B Col 8] Adjusted Carrying Value – Stand-alone value of each entity per the calculation to eliminate double-counting. This value includes permitted and prescribed practices.

• [Inv B Col 9] Accounting Adjustments (e.g., GAAP to SAP) – Report the total difference between the carrying value reported in Column 1 (and Column 3) and the value reported in Column 2. This column will apply to regulated entities where the stand-alone carrying value is based on regulatory accounting (e.g., SAP) while the value reported for that entity by the Parent is carried at a financial accounting (e.g., GAAP) value. Further detail is reported in the “Questions and Other Information” tab.

• [Inv B Col 10] Gross Revenue 2nd Prior Year (Financial Entities without Regulatory Capital Requirements and Non-financial Entities) – Report gross revenue (excluding dividends from subsidiaries and affiliates).


• [Inv B Col 13] Average Revenue over 3-years (Financial Entities without Regulatory Capital Requirements and Non-Financial Entities) – This column is populated from data in Column 10, Column 11 and Column 12. This column will support the capital calculation for asset managers, broker-dealers and other Financial Entities without Regulatory Capital Requirements.

“Adjusted Capital Calculation” is reported in a similar manner to the “Adjusted Carrying Value” above. The columns are in the same order, although it is likely that fewer entries will be needed for Column 4 through Column 7. Further guidance is below.
[Inv C Col 1] Entity Required Capital (Immediate Parent Regime) – This column is included to accommodate participants with either a U.S. or a non-U.S. based Parent company. No entry is required for the Ultimate Controlling Person. In general, entity required capital should represent the capital requirements of the Parent’s insurance or other sectoral regulator:

a. For subsidiaries of foreign insurers or other non-U.S. financial entities, the unscaled capital required by the Parent’s regulator of the regulated entity based on the equivalent of a Prescribed Capital Requirement (PCR) level.

b. For subsidiaries, including applicable Schedule A and Schedule BA subsidiaries, of U.S. insurance entities that are subject to RBC, except where the subsidiary is also an RBC filer, the entry should be equivalent of what would be required in the Parent’s RBC, adjusted for covariance where applicable (calculated by the preparer) reported at company action level (or two times authorized control level RBC) for that entity. Where the subsidiary is also an RBC filer, then the amount reported will be at company action level RBC (or two times authorized control level RBC) after covariance.

c. For subsidiaries of U.S. insurers that do not file RBC, report the actual amount of capital required in the Parent’s capital requirement (if any) for the subsidiary entity.

d. In the case where the Parent is not subject to insurance or other sectoral regulatory valuation, then use zero where applicable. This column will include double-counting. The values recorded for all subsidiaries should be the 100% of the specified capital requirements regardless of percentage of ownership by entities within the group. Where entities are owned partially by entities outside of the group, then report the capital requirements of the subsidiary adjusted to reflect total percentage of ownership within the group. A single entry for all entities that qualify under the grouping exceptions described in Section V, herein may be made on the line for the affiliate that holds the qualifying entities in lieu of individual entries.

[Inv C Col 2] Entity Required Capital (Local Regime) – Enter required capital for each de-stacked entity, as applicable entity description below. For U.S. RBC filing subsidiaries under a U.S. RBC filing Parent the amounts will be the same in both the Parent and Local Regime columns, except where the RBC filing subsidiary is subject to an operational risk charge. In such cases the amount reported in this column for the subsidiary will include the operational risk charge while the amount reported in Column 1 will exclude the subsidiary’s operational risk charge. However, for some entity types his will result in entries for the entities under a U.S.-based insurance Parent to be different from what U.S. RBC would dictate. In addition, where a U.S. insurer directly or indirectly owns not admitted (or otherwise zero valued) financial affiliates, those affiliates would be reported with zero value in the Parent Regime column but at the specified regulatory value described below for that financial entity type in this column. However, if such an entity has been listed in [Sch1B Col 2] Include/Exclude (Supervisor) column, indicating that the Lead State Regulator agrees that the entity does not pose material risk, then report the capital calculation in accordance with entity instructions below but the ultimate calculation will show the results without the excluded entity’s capital calculation. Directly or indirectly owned non-financial entities that were not admitted or otherwise carried at a zero value in the Parent Regime, may be carried at zero value in this column. A single entry for all entities that qualify under the grouping exceptions described herein may be made in the line for the affiliate that holds the qualifying entities in lieu of individual entries. This column will include double-counting. The values recorded for all subsidiaries should be the 100% of the
capital requirements regardless of percentage of ownership by entities within the group. Where entities are owned partially by entities outside of the group, then report the capital requirements of the subsidiary adjusted to reflect total percentage of ownership within the group.

64. For financial entities without a regulatory capital requirement and for non-insurance/non-financial entity types, where additional options are noted below, the options are shown here for informational purposes only, and the calculations are described in the tab where the relevant data and calculations reside.

65. Additional clarification on capital requirements where a formula is required:

- **U.S. RBC filing Insurers**: Report RBC at Company Action Level excluding operational risk (200% x ACL)\(^{[FL57]}\)

- **Foreign Insurance Entities**: The local capital requirement as specified below for each jurisdiction should be reported, by legal entity, at a Prescribed Capital Requirement (PCR) level. This treatment is different than what U.S. RBC would require and recognizes other regulators’ view of adequate capital for insurers within another jurisdiction. It is more reflective of risk within the group context. A sensitivity analysis will be included in the “Sensitivity Analysis” tab using the jurisdictional PCR scaled per the Excess Relative Ratio method (see Appendix 1) for insurers in foreign jurisdictions that are subject to scaling.

- **European Union subsidiaries**: Use the Solvency II Solo Solvency Capital Requirement (SCR) as the PCR.

- **U.S. RBC filing subsidiaries**: The RBC Company Action Level including operational risk of each insurer should be reported.

- **Australia subsidiaries**: The PCR is the target capital as set by the insurer/group in accordance with APRA requirements. Effectively, this would be “Target capital under ICAAP.” PCR is not a set multiple of MCR.

- **Bermuda subsidiaries**: The Legal Entity PCR in Bermuda for medium and large commercial insurers is called the “Enhanced Capital Requirement” (ECR) and is calibrated to Tail VaR at 99% confidence level over a one-year time horizon.

- **Hong Kong subsidiaries**: Under the current rule-based capital regime, if applied similar to the concept of PCR, the regime’s PCR would be 150% of MCR for life insurers and 200% of MCR for non-life insurers.

- **Japan subsidiaries**: The PCR is the solvency margin ratio of 200%.

- **Korea subsidiaries**: The PCR is 100% of risk-based solvency margin ratio.

- **Singapore subsidiaries**: The PCR is 120% of total risk requirement (i.e., capital requirement).

- **China Taipei subsidiaries**: The PCR is 200% of RBC ratio.

- **Canada life entities**: The baseline PCR should be stated to be “100% of the LICAT Base Solvency Buffer.” The carrying value should include surplus allowances and eligible deposits.
- **Canada P/C entities**: The PCR should be the MCT capital requirement at the target level.
- **South Africa subsidiaries**: The PCR is 100% of the SAM SCR.
- For any entities that cannot be mapped to the above categories, scaling will be at 100%

66.64. Additional clarification on capital requirements where a U.S. formula (RBC) is not required:

- For those U.S. insurers that do not have an RBC formula, the minimum capital per state law should be used as the basis for what is used for that insurer in the GCC. This may differ from what U.S. RBC would require. It is more reflective of the regulatory view of risk in the group context. The following requirements should be used in other specified situations where an RBC does not exist:
  - **Mortgage Guaranty Insurers**: The minimum capital requirement shall be based on the NAIC’s requirements set forth in the Mortgage Guaranty Insurance Model Act (#630).
  - **Financial Guaranty Insurers**: The minimum capital requirement shall be based on the NAIC’s requirements set forth in the Financial Guaranty Insurance Guideline (#1626), specifically considering Section 2B (minimum capital requirements) and Section 3 (Contingency, Loss and Unearned Premium Reserves) and the other requirements of that guideline that impact capital (e.g., specific limits).
  - **Title Companies**: The minimum capital requirement shall represent 200% of the required level of reserves carried by the insurance company.
  - **Other Companies**: A selected basis for minimum capital requirements derived from a review of state laws. Where there is a one-off treatment of a certain type of insurer that otherwise would file RBC (e.g., HMOs domiciled in California), the minimum capital required by their respective regulator could be considered in lieu of requiring the entity to complete an RBC blank.
  - **Captives**: U.S. insurers that have captives should complete the applicable RBC formula regardless of whether the captive is required to complete it in their captive state. The amounts input into RBC by the captive shall be based on the actual assets and liabilities utilized in the regulatory reporting used by the captive. Captives used exclusively for self-insurance (either by U.S. life insurers or any other type of insurer) or insurance provided exclusively to its own employees and/or its affiliates, should not complete an RBC calculation and the entire entity should be treated as non-insurers and receive the same charge as a non-regulated entity.

67.65. Non-insurance financial entities subject to a specified regulatory capital requirement:

- All banks and other depository institutions – The unscaled minimum required by their regulator. For U.S. banks, that is the Office of the Comptroller of the Currency (OCC) Tier 1 or other applicable capital requirement. This is understood to be consistent with how the Federal Reserve Board would apply its Building Block Approach.
- Any other financial entity that is determined to be subject to a specified regulatory capital requirement will bring that requirement in the GCC at the first level of regulator intervention (if applicable).
• This differs from what U.S. RBC would require. It recognizes the sectoral regulator’s view of risk for a particular financial entity type. It is more reflective of risk in the group context.

68.66. Non-insurance financial entities NOT subject to a specified regulatory capital requirement:

• All asset managers and registered investment advisors and all other financial entities as defined in Section II: Use the capital calculation specified below based the level of risk assigned to the entity by applying the material risk principles defined in Section II. However, asset managers and investment affiliates (not qualifying to be treated as non-financial entities per paragraph 9) will be reported at either medium or high risk. In certain cases, these entities may be subject to a layer of regulation (e.g., SEC or FINRA) but are not generally subject to a specified capital requirement.

High Risk: 10% x 3-year average revenue

NOTE: A Basel Charge of 15% will be used for the IAIS ICS.

Medium Risk: 5.0% x 3-year average revenue.

Low Risk: 2.5% x 3-year average revenue

NOTE: Medium risk could be used as a starting point while the stratified methodology is further developed.

69.67. Other non-insurance, non-financial entities with material risk:

• Non-insurance, non-financial entities may not be as risky as financial entities. For non-insurance, non-financial entities not owned by RBC filers or other such entities where there is not a regulatory capital charge for the entity in the capital formula, use an equity charge of 10.5% (post tax) for predominantly life Insurance Groups 9.5% for predominantly P/C Insurance Groups and 3.5% for predominantly health Insurance Groups x BACV. If the entity is not subject to a capital charge or is included in the capital charge of another financial entity, then enter zero in Column 1 and the charge specified in this paragraph in Column 2. These factors are based on average after covariance RBC charges for the respective insurer types and are calibrated at 200% x ACL RBC. This is meant to be consistent with how the entity would be treated if owned by an RBC filer while recognizing that the entity may be excluded from the GCC if it does not pose material risk to the insurers in the group.

Non-insurance/non-financial entities owned by RBC filing insurers (or owned by other entities where a regulatory capital charge applied to the non-insurance/non-financial affiliate) will remain in the Parent’s capital charge and reported at that value in Column 1 but will be reported as zero in Column 2. These non-financial entities may not be excluded from the GCC.

One additional informational capital calculation for all non-financial entities will be applied in the Sensitivity Analysis tab using current year gross revenue from Inventory B, Column 12 with the calculation occurring and results available in the “Calc 2” tab as follows: 5% of reporting year gross revenue based on a medium level risk for a financial entity.

70.68. Non-operating holding companies:
Non-operating holding companies will be treated the same as other non-insurance/non-financial entities with material risk. Unless reported on a grouped basis (see paragraph 5.24), for purposes of applying the capital calculation, the carrying value of stand-alone positive valued and negative valued non-operating holding companies will be netted. If the net value is zero or less (floored at zero for purposes of applying a charge), the charge applied will be zero. If the filer chooses to designate the non-operating holding company as a non-insurance/non-financial entity without material risk and requests exclusion, then no allowance for debt issued by that holding company may be included in the calculation.

**Capital Calculation Adjustments**

- **[Inv C Col 3] Investment in Subsidiary** – Enter an adjustment to remove the required capital of the directly owned subsidiary(ies) from Parent’s required capital. The capital requirement to be removed should be the capital requirement carried by the Parent from which the entity is being de-stacked (i.e., the value reported in Column 1 in Inventory C adjusted for ownership percentage). Thus, there will be no adjustment to the Parent’s value in this column for entities that are reported at a capital calculation of at zero value by the parent. This is intended to prevent double counting required capital when regulated entities are stacked. [Example: When de-stacking an RBC filer from another RBC filer, the amount entered on the Parent line would be the RBC of the subsidiary. When de-stacking financial entities that are subject to diversification in a capital formula (e.g., RBC) the amount entered on the Parent line is the post-diversified capital requirement as calculated by the preparer, which is also the amount to be reported for the de-stacked entity on the entity’s line.

<table>
<thead>
<tr>
<th>Parent Entity Line</th>
<th>Parent Entity</th>
<th>Entity</th>
<th>Inv CR, Column 1</th>
<th>Inv CR, Column 2</th>
<th>Parent Entity Line</th>
<th>Inv C, Column 3</th>
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<tr>
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<td>RBC ACL (incl. op Risk) x 2</td>
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<td>RBC ACL (excl. op Risk) x 2</td>
</tr>
<tr>
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<td>RBC ACL (excl. op Risk) x 2</td>
<td>Per GCC Entity Instructions</td>
<td>U.S. RBC filer</td>
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<td>RBC ACL (excl. op Risk) x 2</td>
<td>Jurisdictional or Sectoral PCR Level Capital Reqmt</td>
<td>U.S. RBC filer</td>
<td>RBC ACL (excl. op Risk) x 2</td>
<td></td>
</tr>
<tr>
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<td>Per risk level factor x 3-year avg revenue</td>
<td>U.S. RBC filer</td>
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<td>No entry Required - Do not de-stack</td>
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<tr>
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<td>Foreign Insurer or Other Regulated w/ Capital Reqmt</td>
<td>Per Local Capital Reqmt</td>
<td>Per risk level factor x 3-year avg revenue</td>
<td>U.S. RBC filer</td>
<td>Per Local Capital Reqmt</td>
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<td>Per Local Capital Reqmt</td>
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<td>U.S. RBC filer</td>
<td>No entry Required - Do not de-stack</td>
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<tr>
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<tr>
<td>Financial w/o Capital Reqmt or Non-Financial</td>
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<td>Per GCC Entity Instructions</td>
<td>U.S. RBC filer</td>
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<tr>
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<td>Zero</td>
<td>Jurisdictional or Sectoral PCR Level Capital Reqmt</td>
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<td>Financial w/o Capital Reqmt or Non-Financial</td>
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<td>Zero</td>
<td>Per risk level factor x 3-year avg revenue</td>
<td>U.S. RBC filer</td>
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<tr>
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<td>Zero</td>
<td>Per GCC Instructions</td>
<td>U.S. RBC filer</td>
<td>Zero</td>
<td></td>
</tr>
</tbody>
</table>
Generally the capital requirements for Schedule A and BA affiliates and other non-financial affiliates will remain in the capital requirements of the Parent insurer and not entered in this column, except that the capital requirements for any financial entity reported in a Parent’s Schedule A and BA, any financial entity indirectly owned through another Schedule A or BA affiliate listed in Schedule 1 and in this section should be entered in this column in the row of the entity that directly or indirectly owns that Schedule A and BA affiliate so that the parent entity may eliminate double counting of that capital requirement capital which will now be reported by the stand-alone Schedule A or BA affiliate listed in in the inventory.

For indirectly owned Schedule A and BA financial entities, only the capital requirements for that entity will be included in this column and the remaining capital requirement of the downstream BA Parent will remain with the Parent insurer. Similarly, the capital requirement for any U.S. Branch of a foreign insurer that is listed in Schedule 1 and in this section should be entered in this column in the row of the foreign insurer if it is already included in the capital requirement of the foreign insurer so that the parent entity may eliminate double counting of that capital requirement which will now be reported by the stand-alone Branch listed in the inventory. The amounts entered in this column for a Parent must correspond to the capital required by the parent entity which is being de-stacked from that Parent.

Capital calculations for Schedule A and Schedule BA indirectly owned financial entities that are owned by Schedule A or Schedule BA assets are reported in the Inventory Tab and will be adjusted out of the value reported by the U.S. insurer in this column (since the non-financial direct parent Schedule A or BA affiliate is not listed in the Inventory Tab.

In the “Questions and Other Information” tab, a capital requirement should be reported for the value of the indirectly owned insurance of other financial entity based on the insurers Schedule A or Schedule BA charge rather than a charge (which would be zero) attributable to the Schedule A or Schedule BA entity that directly owns the insurance or other financial entity. As indicated earlier, the remaining capital requirement of the entity that directly owns the insurance or other financial entity will remain with the Parent insurer.

- **[Inv C Col 4] Intragroup Capital Instruments** – This column would generally be used if there is potential double-counting of capital requirements (e.g., RBC charges on surplus notes purchased by an affiliated U.S. insurer from a U.S. insurer issuer).

- **[Inv C Col 5] Reported Intragroup Guarantees, LOCs and Other** – This column would generally be used if there is potential double-counting of capital requirements (e.g., RBC charges on guarantees or LOCs).

- **[Inv C Col 6] Other Intragroup Assets** – This column is not intended to be used for required capital but is included in case an entity believes it is necessary from reporting an inaccurate required capital figure.
  a. Loans, receivables and arrangements to centralize the management of assets or cash.
  b. Derivative transactions.
  c. Purchase, sale or lease of assets.
  d. Other (describe in “Questions and Other Information” tab).

- **[Inv C Col 7] All Other Adjustments** – Include a brief explanation in the “Description of ‘Other Adjustments’” in the “Questions and Other Information” tab. Use this column is for adjustments related to required capital that correspond to adjustments in Inventory B, Column 7 and in cases where an entity believes it is necessary to adjust an inaccurate regulatory required capital figure (e.g., the RBC calculation applied as a permitted practice).
NOTE: Consider whether this column should be used rather than Column 2 for zero value entities.

- **[Inv C Col 8] Adjusted Capital Calculation** – Stand-alone capital calculation for each entity per the calculation to eliminate double-counting. This value includes the impact of permitted and prescribed practices.

- Inventory D is for “Reference Calculations Checks.” These are calculations that can serve as checks on the reasonability/consistency of entries.
  
  a. **[Inv D Col 1 – 3] Sum of Subsidiaries (Carrying Value)** – This automatically generated column calculates the value of the carrying value of the underlying subsidiaries. It is provided for reference when filling out the “Investment in Subsidiary” column. This sum will often, but not always, be equal to the “Investment in Subsidiary” column.

  b. **[Inv D Col 4 – 6] Sum of Subsidiaries (Calculated Capital)** – Similar to above but for calculated capital.

  c. **[Inv D Col 7 – 8] Carrying Value/Adj Calc Cap** – This is a capital ratio on the adjusted and unadjusted figures. Double-check entities with abnormally large/small/negative figures to make sure that adjustments were done correctly.

### Input 3 – Capital Instruments

21.69. Provide all relevant information pertaining to paid-up (i.e., any receivables for non-paid-in amounts would not be included for purposes of calculating the allowance) financial instruments issued by the Group (including senior debt issued by a holding company), except for common or ordinary shares and preferred shares. This worksheet aims to capture all financial instruments such as surplus notes, senior debt, hybrid instruments and other subordinated debt. Where a Volunteer Group has issued multiple instruments, the Volunteer Group should not use a single row to report that information; one instrument per row should be reported (multiple instruments issued under the same terms may be combined on a single line). All qualifying debt should be reported as follows.

22.70. Debt issued by U.S.-led groups:

- Surplus Notes – Report the outstanding value of all surplus notes in Column 8 whether issued to purchasers within or outside the group. The outstanding value of surplus notes issued to entities outside the group and that is already recognized by state insurance regulators and reported 100% as capital in the carrying value of U.S. insurer issuers in “Inventory B” and will not be included in the calculation for an additional capital allowance. Surplus notes issued within the group generally result in double-counting and will not be included in the additional capital allowance. (See instructions below.)

- Subordinated Senior Debt and Hybrid Debt Issued (e.g., debt issuances that receive an amount of equity credit from rating agencies) – The outstanding value will be reported in Column 8. Recognition for structurally subordinated debt will be allowed to increase available capital. For purposes of qualifying for recognition as additional capital, both of the following criteria must be met:
a. The instrument has a fixed term (a minimum of five years at the date of issue or refinance, including any call options other than make whole provisions\(^1\)). However, if the instrument is callable within the first five years from the date of issue it may be considered qualifying debt if any such call is at the option of the issuer only (the instrument is not retractable by the holder) AND it is the intent of management to replace the called instrument in full before or at redemption by a new issuance of the same or higher quality instrument.

b. Supervisory review or approval is required for any ordinary* or extraordinary dividend respectively or distribution from any insurance subsidiary to fund the repurchase or redemption of the instrument. Supervisory approval of ordinary dividends is met if the supervisor has in place direct or indirect supervisory controls over distributions, including the ability for the supervisor to limit, defer and/or disallow the payment of any distributions should it find that the insurer is presently, or may potentially become, financially distressed. There shall be no expectation, either implied or through the terms of the instrument, that such approval will be granted without supervisory review.

\*The concept of approval for ordinary dividends is for GCC purposes and is met as described in subparagraph b, above. It is not intended to require explicit regulatory approval or in any way alter current provisions of Model #440 or the Insurance Holding Company System Model Regulation (#450).

- “Other” Debt – The outstanding value will be reported in Column 8 and will be further described in the “Other Information” tab and will be reported in a manner that is consistent with Senior Subordinated Debt, as described above. Such debt will not initially be included in the additional capital allowance for the GCC. An additional allowance of this debt as additional capital will be calculated in this tab and reported as a sensitivity analysis in the “Summary” tab, subject to future determination on whether it will become part of the GCC calculation.

- Foreign Debt – Report the outstanding value of Non-U.S. senior debt issued to entities outside the group in Column 8. Debt specifically recognized by statute, regulation or accounting rule as additional capital resources by the lead jurisdiction based on contractual subordination or where a regulatory regime proactively enforces structural subordination through appropriate regulatory/supervisory controls over distributions from insurers in the group will not be included in the calculation of an additional capital allowance if it is already reported as capital in the carrying value of the issuer in “Inventory B”. It will be included in the calculation of an additional capital allowance if recognized by the local jurisdiction and NOT already included in the value of the issuer in “Inventory B”. Cases where the value of debt instruments issued to purchasers outside the group has not been recognized by the legal entity’s insurance or other sectoral supervisor will not be included in the additional capital allowance.

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\(^1\) NAIC staff have been informed that make whole provisions are a form of a call feature that can be exercised by the issuer at any time; that they nonetheless are most frequently utilized near the end of the term of the instrument, generally in connection with refinancing; and that the cost to the issuer to exercise the make whole provision and associated financial reporting impacts, combined with the very low interest rate environment, make it much less likely that such provisions will be triggered, particularly within five years of issuance. Staff will continue their research, and assuming these observations are confirmed, the referenced criteria will continue to scope out make whole provisions.
Please fill in columns in Section 3A as follows for all capital instruments:

- **[Sec 3A Col 1] Name of Issuer** – Name of the company that issued the capital financial instrument. Will populate automatically from the “Entity Identifier” column in this subsection.

- **[Sec 3A Col 2] Entity Identifier** – Provide the reference number that was input in Schedule 1.

- **[Sec 3A Col 3] Type of Financial Instrument** – Select type from the drop-down menu. Selections include Senior Debt, Surplus Notes (or similar), Hybrid Instruments and “Other” Subordinated Debt.

- **[Sec 3A Col 4] Instrument Identifier** – Provide a unique security identifier (such as CUSIP). ALL debt instruments must include an internal identifier if not external identifier is available.

- **[Sec 3A Col 5] Entity Category** – Links automatically to selection made on the “Inventory” tab worksheet.

- **[Sec 3A Col 6] Year of Issue** – Provide the year in which the financial instrument was issued or refinanced.

- **[Sec 3A Col 7] Year of Maturity** – Enter the year in which the financial instrument will mature.

- **[Sec 3A Col 8] Balance as of Reporting Date** – Enter the principal balance outstanding as reported in the general-purpose financial statements of the issuer.

- **[Sec 3A Col 9] Intragroup Issuance** – Select whether the instrument was issued on an intragroup basis (that is, issued to a related entity within the group). This column will be used to remove “double-counting.” This column is a drop-down menu box with options “Y” and “N.”

- **[Sec 3A Col 10] Treatment in Inventory B** – Select option that applies:
  a. **Capital** – This instrument is recognized by the applicable regulator or credited as capital in local regulatory regime and reported as part of the adjusted carrying value of the issuer and was not purchased by an affiliate. This includes the value of qualifying senior and hybrid debt instruments (if recognized as capital) and U.S. surplus notes (or similar local regime instruments) that are issued to entities outside the group and included in the issuing entity’s value recognized in the “Inventory B” tab. The outstanding value of those debt instruments will not be included in the calculation of a proxy allowance for additional capital.

  b. **Liability** – This instrument is reflected as the liability of the issuer in the adjusted carrying value in the “Inventory B” tab and was not purchased by an affiliate. This would apply to all qualifying senior and hybrid debt issued to purchasers outside the group that is not recognized as capital by the local regulator and therefore is not included in the issuing entity’s value recognized in the “Inventory B” tab. The value will be included in the calculation of a proxy allowance for additional capital.
c. **Liability designation** would also apply to all non-qualifying senior and hybrid instruments and all debt categorized as “Other” issued to purchasers outside the group that is not recognized as capital by the local regulator. The value of these instruments will NOT be included the calculation for the in the calculation of a proxy allowance for additional capital.

d. **Intragroup** – This would apply to all qualifying instruments purchased by an affiliate within the group. The outstanding value of those debt instruments will not be included in the calculation of a proxy allowance for additional capital. If the financial instrument is recognized or credited as part of the issuer’s available capital in Inventory B, then an adjustment for intragroup capital instruments is made in Inventory B, Column 4 and Inventory C adjustments (if necessary to eliminate an associated capital requirement). If the financial instrument is treated as a liability by the issuer, then no intragroup capital instrument adjustment is required in Inventory B or Inventory C.

e. The outstanding value of all non-qualifying senior and hybrid instruments and financial instruments categorized as “Other Debt” whether issued to purchasers inside or outside the group will not be included in the calculation of a proxy allowance for additional capital and no other adjustments are required in the template. However, in the unlikely event that the instrument is treated as available capital to the issuer in Inventory B, an adjustment in Inventory B, Column 4 to remove the available capital would be required.

**NOTE**: Additional information on instruments categorized as “Other Debt” in the Type of Financial Instrument Column will require additional information to be provided in the “Questions and Other Information” tab.

For **intragroup surplus notes**, the adjustment will impact the carrying value and associated capital calculation of the purchasing affiliated entity.

- **[Sec 3A Col 11] Intragroup Purchaser Identifier** – Enter the entity identify for the affiliate entity that purchased the instrument.

- **[Sec 3A Col 12] Description of Other Debt Instruments** – Provide a description of instruments designated as “Other.”

- **[Sec 3A Col 13] Call Provisions Criteria** – Respond “Y” or “N” as to whether the instrument is subject to a call provision (other than a make whole provision) in the first five years AND it is management’s intent to replace the called instrument in full before or at redemption by a new issuance of the same or higher quality instrument. Respond “X” if the instrument has a maturity of greater than five years including any call provisions.

- **[Sec 3A Col 14] Potentially Recognized Instrument** – This is an automatic calculation to determine if this is instrument that has potential to be recognized as additional capital in the GCC and/or in sensitivity analysis. The column will show “Y” if each of the following is true: 1) it is Senior Debt, Hybrid or Other instrument; 2) the instrument is not intragroup; and 3) the instrument is treated as liability on Inventory B. These are calculated using Column 3, Column 9, and Column 10, respectively.

- **[Sec 3A Col 15] Other Criteria Met** – This is an automatic calculation to determine if instrument qualifies due to criteria beyond those in Column 14. The column will show “Y” if: 1) the instrument has initial maturity of greater than five years including any call
provision (i.e., “X” is reported in Column 13); and 2) it meets the “Call provisions criteria” in Column 13 (i.e., “Y” is reported in Column 13).

• [Sec 3A Col 16] Qualified Debt – This column is calculated automatically using data from the entries in Column 14 and Column 15. To qualify, an instrument needs a “Y” in both columns. It represents the amount of qualifying debt that will be used in the calculation of an allowance for addition capital under the alternate subordination method and the proxy allowance method. This amount will be carried into Section 3C, Column 1, Line 3.

Section 3C will be auto-filled, with the exception of Column 1, Line 2.

• [Sec 3C Col 1, Line 1] Total Paid-In and Contributed Capital and Surplus – This is the amount reported on Page 3 of the annual financial statement submitted to regulators by a U.S. insurer.

• [Sec 3C Col 1, Line 2] Alternate Subordination Calculation – This manual entry is the excess of qualifying debt issued over liquid assets held by the issuing consolidated holding company as reported in the consolidated financial statements. No entry is expected for a mutual group.

• [Sec 3C Col 1, Line 4] Downstream Estimate - The total reported under the alternate subordination approach will be compared to the total amount of gross paid-in or contributed capital and surplus reported by the insurance entities within the group as reported in Schedule 1. The greater value will be carried into the calculation for an additional capital allowance.

NOTE: No more than 100% of the total outstanding value of qualified senior and hybrid debt will be allowed into the calculation.

• [Sec 3C Col 1, Line 5] Proxy Calculation for Additional Capital Allowance – A calculation will be made in this tab in Section 3B that will apply 30% of available capital plus the value of all qualifying debt to become part of the proxy allowance for additional capital for qualifying senior subordinated. An additional amount of 15% of available capital plus the value of all qualifying debt will be calculated to become part of a proxy allowance for additional capital to be for hybrid debt.

Summary Formula: Proxy Amount = (30% x (Available Capital + Qualifying Senior and Hybrid Debt)) + (15% x (Available Capital + Qualifying Senior and Hybrid Debt)).

NOTE: No more than 100% of the total outstanding value of qualified senior and hybrid debt will be allowed into the calculation.
• [Sec 3C Col 1, Line 6 through Line 8] – The greater of the proxy calculation or the larger of paid in capital or alternate subordination calculation will be allowed as additional capital in [Sec 3C Col 6]. However, an overall limit of no more than 75% of the total adjusted carrying value in Inventory B will be applied in [Sec 3C Col 7]. Adjustments to increase available capital will be calculated from data on this page. The summary results of the components of the calculation (paid in capital and surplus, alternate subordination, proxy calculation and limitations) are populated as titled in the calculation columns in this section. The final amount recognized as additional capital is shown in [Sec 3C Col 8].

• The additional capital allowance recognized for capital instruments will be shown as an “on-top” adjustment in the “Summary 1 – Entity Level” tab.

Summary Calculation for Debt Allowed as Additional Capital:

Step 1: Calculate the following amounts:
   a) The greater of Total paid-in capital and surplus of U.S. insurers or the alternative subordination calculation (defined above)
   b) A proxy value (defined above)

Step 2: Take the greater of a) or b) from Step 1, and subject that amount to two limitations:
   • First, the total amount to qualify as capital cannot exceed 100% of the total outstanding value of qualified senior and hybrid debt.
   • Second, the total amount to qualify as capital cannot exceed 75% of the total adjusted carrying value in Inventory B.

After applying the two limitations in Step 2, the remaining amount is allowed as additional capital.

25.73. Informational calculation to include “Other Subordinated Debt” – A sensitivity analysis will be applied in [Sec 3C Col 2, Line 1 through Line 8] and carried into the “Summary 2” tab to adjust the amount of additional capital in the proxy calculation by the amount of “Other Debt” reported in [Sec 3C Col 8] issued to purchasers outside the group. This informational sensitivity analysis will include an additional allowance for such debt up to 15% of available capital plus the value of all qualifying debt including qualifying “Other” debt subject to the same limitations noted for the proxy allowance in general.
Input 4 – Analytics

26.74. The entity type information supporting analytics summarized in Summary 3 – Analytics are pulled into this tab from data or information reported in other tabs in the GCC template. That data is exported into summaries in the “Summary 3 – Analytics” tab. Only 2020 data is currently to be populated. However, it is contemplated that going forward, data for prior years will also be populated such that it will provide the Lead State Regulator with metrics to identify trends over time.

Input 5 – Sensitivity Analysis and Inputs

27.75. All The sensitivity analysis is ultimately calculated in the “Summary 2” tab. Most inputs for the Analysis 1, 2, 5, 6, and 7 are not required in this tab. They are populated from other tabs as described below and automatically calculated into the analysis which are reported in the “Summary 2” tab. However, certain analysis requires inputs from this tab. Inputs are required in this tab for Analysis 3, Analysis 4, Analysis 8, and Analysis 9. Those inputs are automatically pulled into the calculation in the Summary 2 tab. Sensitivity Analysis are intended to provide the Lead State Regulator additional information that helps them better understand the financial condition of the group. Similar to the sensitivity analysis included in the legal entity RBC, it provides the regulator with additional information and allows them to consider “what-if” scenarios to better understand the impact of such items. The results of these analysis will not impact the GCC ratio.

- **[Analysis 1]: GCC overall sensitivity analysis** – No additional data is needed in the tab. The overall GCC ratio will be presented at 300% x ACL level. This calculation will increase the calculated capital for most entity types by a factor of 1.5. However, entities with existing regulatory capital requirements (e.g., foreign insurers and banks) will be reported at the same level specified in these instructions for both the GCC and the sensitivity analysis (i.e., at 100% of the jurisdictional or sectoral PCR requirements).

- **[Analysis 2]: Excluded non-insurance/non-financial entities without material risk** – No additional data is needed in the tab. The data for entities where exclusion has been requested and the lead state does not agree will be populated based on entries in [Sch 1B Col 3] and data in Inventory B, Column 2 and Inventory C, Column 2. This analysis will be applied and reported in the “Summary 2” tab. It will provide the regulator with the impact of excluding non-agreed-upon entities on the GCC ratio.

- **[Analysis 3 and Analysis 4]: Permitted practices** – This information shows the amount of U.S. permitted practices as described in the Preamble of the Accounting Practices and Procedures Manual and the sensitivity analysis allows the state to understand the size of the practices related to the overall group capital position and their impact on the GCC ratio.
  - **Prescribed Practices** – This information to be entered on this tab shows the amount of U.S. prescribed and prescribed practices as described in the Preamble of the Accounting Practices and Procedures Manual and the sensitivity analysis allows the state to understand the size of the practices related to the overall group capital position and their impact on the GCC ratio. This analysis will be applied and reported in the “Summary 2” tab.
Permitted and Prescribed Practices – Report values from annual financial statement Note 1 (excluding those pertaining to XXX/AXXX captives):

a. Entity identifier
b. Value of permitted practice
c. Capital Requirement attributable to permitted practice (if any)
d. Description of permitted practice
e. Value of prescribed practice
f. Capital requirement attributable to permitted practice (if any)
g. Description of prescribed practice

- [Analysis 5]: Foreign Insurer Capital Requirements Scaled – No additional data is needed in the tab. This information shows the amount of foreign insurer capital calculations scaled by applying scalars using the Excess Relative Ratio approach at a 200% x ACL RBC calibration level and at 300% x ACL for all non-U.S. jurisdictions where scalar data is available (see Appendix 1). The sensitivity analysis allows the state to understand the impact of this specific scaling method on the GCC ratio. This information is populated from the “Scalar” tab. This analysis will be applied and reported in the “Summary 2” tab.

- [Analysis 6]: Debt Classified as “Other” – No additional data is needed in the tab. The analysis data will be populated from the “Capital Instruments” tab and the analysis and will be applied and reported in the “Summary 2” tab.

- [Analysis 7]: Alternative Capital Calculation for Non-Financial Entities – No additional data is needed in the tab. The values reported will represent the alternative revenue-based values for capital calculation that is being captured in the template. The data will be populated from Schedule 1 and Inventory B and the analysis will be applied and reported in the “Scaling Non-Insurance” tab (Calc 2).

- [Analysis 8] For captives other than XXX/AXXX, all other U.S. captives shall make an asset adjustment as described below;

Asset Impact

For the asset impact, it is ONLY required for the assets included in a captive or an entity not required to follow the statutory accounting guidance in the Accounting Practices and Procedures Manual. It is not required for assets for those groups that retain such business in a non-captive traditional insurance company(ies) already required to follow the Accounting Practices and Procedures Manual.

NOTE: Variations for state prescribed and permitted practices are captured in the separate sensitivity analysis.
79. The asset impact amount shall be determined based on a valuation that is equivalent to what is required by the Accounting Practices and Procedures Manual (SAP). For this purpose, “equivalent” means that, at a minimum the listed adjustments (as follows) be made with the intent of deriving a valuation materially equivalent to what is required by the Accounting Practices and Procedures Manual, however, without requiring adjustments that are overly burdensome (e.g., mark-to market bonds used by some captives under U.S. GAAP versus full SAP that considers NAIC designations). To be more specific, the asset impact shall be developed by accumulating the impact on surplus because of an accumulation of all the following in paragraph 78 and paragraph 79 combined.

NOTE: Letters of credit or other financial instruments that operate in a manner like a letter of credit, which are not designated as an asset under either SAP or U.S. GAAP and are required to be adjusted out of the available assets (i.e., the asset reduction is recorded as a negative figure in the template).

80. To achieve the above, accumulate the effect of making the following impact and record as a negative figure in the template, an asset adjustment for all the following explicit assets not allowed to be admitted under SAP:

- Assets specifically not allowed under the Accounting Practices and Procedures Manual in accordance with paragraph 9 of SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities.
- SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due from Agents and Brokers.
- SSAP No. 16R—Electronic Data Processing Equipment and Software.
- SSAP No. 19—Furniture, Fixtures, Equipment and Leasehold Improvements.
- SSAP No. 20—Nonadmitted Assets.
- SSAP No. 21—Other Admitted Assets (e.g., collateral loans secured by assets that do not qualify as investments are nonadmitted under SAP).
- SSAP No. 29—Prepaid Expenses.
- Expense costs that are capitalized in accordance with GAAP but are expensed pursuant to statutory accounting as promulgated by the NAIC in the Accounting Practices and Procedures Manual (e.g., deferred policy acquisition costs, pre-operating, development and research costs, etc.).
- Depreciation for certain assets in accordance with the following SSAPs:
  o SSAP No. 16R—Electronic Data Processing Equipment and Software.
  o SSAP No. 19—Furniture, Fixtures, Equipment and Leasehold Improvements.
  o SSAP No. 68—Business Combinations and Goodwill.
- The amount of goodwill of the SCA more than 10% of the audited U.S. GAAP equity of the SCA’s last audited financial statements.
- The amount of the net deferred tax assets (DTAs) of the SCA more than 10% of the audited U.S. GAAP equity of the SCA’s last audited financial statements.
- Any surplus notes held by the SCA issued by the reporting entity.
In addition, record as a negative figure, an asset impact for any assets that are not recognized as an admitted asset under the principles of SSAP No. 4—Assets and Nonadmitted Assets, including:

- Letters of credit, or other similar instruments, that operate in a manner like a letter of credit and, therefore, do not meet the definition of “asset” as required under paragraph 2.
- Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets that are unavailable due to encumbrances or other third-party interests, should not be recognized on the balance sheet and are, therefore, considered nonadmitted.
- Assets of an insurance entity pledged or otherwise restricted by the action of a related party, the assets are not under the exclusive control of the insurance entity and are not available to satisfy policyholder obligations due to these encumbrances or other third-party interests. Thus, such assets shall not be recognized as an admitted asset on the balance sheet.

[Analysis 9]: Other Regulator Discretion – This analysis is designed to reflect other regulator adjustments including for transactions other than XXX/AXXX reinsurance where there are differences in regulatory regimes exist and there is a desire to fully reflect U.S. Statutory Accounting treatment or to reflect the lead state’s view of risk posed by financial entities without specified regulatory capital requirements or risk posed by non-insurance/non-financial entities that have been included in the GCC. This will be a post-submission item completed by the Lead State Regulator. Enter the following information here:

a. Entity identifier.
b. Amount of adjustment.
c. Description of regulatory issue.

NOTE: This column may also be completed by the filer after advance consultation with the Lead State Regulator.

Input 6 – Questions and Other Information

This tab provides space for participants to describe or provide greater detail for specified entries in other tabs (as noted in the instructions for the columns in those tabs) or additional relevant information not captured in the template. Examples include:

- the materiality method applied to exclude entities in Schedule 1,
- adjustments for intragroup debt, description of permitted practices,
- scalars proposed, supporting information for jurisdiction without a prescribed scalar,
- and adjustments to available capital or capital calculations that are included in the “other adjustment” column in the “Inventory” tab. Specified items are included in the tab. Other information that the filer believes is relevant should be added freeform in this tab.

Information or Detail for Items Not Captured in the Template

- Intercompany Guarantees – Provide requested information:

  a. Entity identifier issuing the guarantee.
  b. Entity identifier of entity or entities that are covered by the guarantee.
  c. Indicate the notional or fixed value of the guarantee.
  d. Describe the nature of the guarantee.
• Capital Maintenance Agreements – Provide requested information:
  a. Entity identifier obligated under the agreement.
  b. Entity identifier for entity or entities that are covered by the guarantee.
  c. Indicate the notional or fixed value of the agreement.
  d. Describe the nature of the agreement.

Information or Detail for Items Captured in the Template

• Value of intangible assets included in non-insurance Holding Companies – Provide the requested information for all entities designated in the non-operating holding company entity category.
  a. Entity identifier.
  b. All goodwill.
  c. All intangibles related to health care services acquisitions included in local carrying value column in Inventory B. Examples include, but are not limited to, customer relationships (policy retention, long-term health services contracts) and technology/patents/trade names and provider network contracts.
  d. All other intangible assets included in local carrying value column in Inventory B.
  e. Total of line b, line c and line d.*
  f. A description of each intangible asset included in line d.

* Auto populated.

Further detail on amounts reported for specific intangibles other than goodwill may be requested by the Lead State Regulator during review of the GCC template.

Information or Detail for Items Captured in the Template

• Currency Adjustments – Provide requested information only for entities where the amount reported for an entity in Inventory B, Column 2 is different than the amount in Inventory B, Column 1 due to currency conversion.
  a. Entity identifier.
  b. Currency type reported in Inventory B, Column 1 and Inventory C, Column 1 (foreign currency).
  c. Conversion rate applied.
  d. Source of conversion rate applied.

• Intragroup Assets – Description of Adjustments for intragroup assets reported in Inventory B, Column 6 and Inventory C, Column 6. Provide the following information:
  a. Entity identifier.
  b. Amount reported in Inventory B, Column 6.
  c. Description of adjustment.

• Other Adjustments – Description of adjustments reported in Inventory B, Column 7 and Inventory C, Column 7. Provide the following information:
  a. Entity identifier.
  b. Amount reported in Inventory B, Column 7.
  c. Description of adjustment.
• Accounting Adjustments – Provide requested information only for entities where the amount reported for an entity in Inventory B, Column 1 is different than the amount in Inventory B, Column 2 due to differences in accounting basis
  a. Entity identifier.
  b. Value reported in Inventory B, Column 1.*
  c. Value reported in Inventory B, Column 2.*
  d. Total amount of adjustments related to difference in accounting basis.*
  e. Nature of adjustment (e.g., GAAP to SAP).
  * Auto populated.

• The tab also includes a listing of all Schedule A and Schedule BA affiliates, along with the following information:
  a. Parent identifier (if available) – This is the same information as is included in Schedule 1 [Sch 1B Col 3] as would be entered for non-Schedule A/Schedule BA affiliates.
  b. Parent Name – Enter the Name of the Parent.
  c. Is Parent a Schedule A or Schedule BA Asset? – This column is only required for financial entities that are Directly owned by a Schedule A or Schedule BA Affiliate. No other downstream affiliates owned by Schedule A or Schedule BA entities need to be listed. These entities are not normally independently reported in Schedule A and Schedule BA so are extra entries.
  d. Financial? (Y/N) – If the entity meets the criteria as being a financial entity, indicate with a “Yes” response. A “No” response is not required for other entities listed. “Yes” entries should correspond to “Yes” entries in Schedule 1 [Sch 1B Col 16].
  e. Carrying Value of Immediate Parent – Report the value listed in Schedule A and Schedule BA of the Parent insurer. For those cases where an indirect financial entity is reported use the value used by the direct Parent.
  f. Capital Requirement for Immediate Parent – Report the value listed in the RBC report of the Parent insurer (pre-tax where applicable). For those cases where an indirect financial entity is listed, report the value of the capital requirement attributable to the Insurer rather than the direct non-financial Schedule BA Parent. The capital requirement reported in this column for the immediate Schedule BA Parent should be adjusted to deduct the amount moved to Schedule 1 and Inventory C.
Calc 1 – Scaling (Insurance Entities)

83.81. All entries in this tab are calculation cells populated using data from within the tab or using data from elsewhere in the template. Scaled values for calculated capital will become part of the GCC ratio. The calculated values will be summarized by entity type in the “Summary 1 – Entity Level” tab. The concept of a scalar was first introduced to address the issue of comparability of accounting systems and capital requirements between insurance regulatory jurisdictions. The idea is to scale capital requirements imposed on non-U.S. insurers so as to be comparable to an RBC-based requirement. Two approaches for scaling related to foreign insurers were presented, and others are being explored and will be reviewed. A decision on the scaling methodology to be adopted into the GCC template will be made at the end of the review. In the interim a scalar of 100% of the jurisdictional PCR will be applied to all jurisdictions where a risk-sensitive capital requirement is in place.

84.82. Information on the Excess Relative Ratio (ERR) scalar methodology will be collected and applied in the “Sensitivity Analysis” tab.

NOTE: See Appendix 1 for more information and examples on how the ERR scalars are calculated.

85.83. For jurisdictions without risk-sensitive capital requirements a 100% charge will be applied to adjusted carrying value.

Calc 2 – Capital Calculations for Non-insurance Entities

86.84. All entries in this tab are either calculation cells using data from within the tab or using data populated from elsewhere in the template. Calculated capital for all entities except insurers will be reported in this tab. The calculated values will be summarized by entity type in the “Summary 1 – Entity Level” tab.

87.85. In addition, one informational option for calculated capital for financial entities without an existing regulatory capital requirement and one informational option for calculated capital for non-financial entities will be reported in this tab. Those calculation will not be carried into the “Summary 1 – Entity Level” tab and will not be part of the GCC ratio.

88.86. Only amounts for entities that the filer and the Lead State Regulator agree should **not** be excluded [Sch 1B Col 2] will be brought into the calculation in this tab and the “Summary 1 – Entity Level” tab. Entities where the Lead State Regulator does not agree with the filer’s request to exclude an entity will be part of the GCC ratio.

Summary 1 – Entity Level GCC Summary

89.87. Summarized results by entity type for the GCC ratio will be reported in this tab. An on top adjustment for debt allowed as additional capital will be added at the bottom of the table. All informational sensitivity analysis will be reported in Summary 2 and will not impact the GCC ratio.
Summary 2 – Informational Sensitivity Tests

90.88. Summary results for each informational sensitivity analysis described in the “Sensitivity Analysis Inputs” tab will be shown here. Each sensitivity analysis will be shown on a stand-alone basis. It is expected that each informational sensitivity analysis will run automatically in the background and the results for each displayed in this tab. The results for the informational sensitivity analysis will not be included in the “Summary 1 – Entity Level” tab.

Summary 3 – Analytics

91.89. Summary results for metrics described in the Analytics Guidance [insert attachment or appendix reference] and utilizing data collected in the “Input 4 – Analytics” tab or other tabs in the GCC will be calculated and presented here.

Summary 4 – Alternative Grouping Option(s) (aka “Cigna Illustration”)

92.90. One sample alternative structure for grouping by entity type or jurisdiction in the GCC is displayed based on a suggested method. It can be modified, or other suggestions can be accommodated based on combining data from Schedule 1 and the Inventory in defined ways.

This tab is intended to be an additional analytical tool. The tool summarizes the GCC based on how a reporting entity views its organization, and provides regulators that view, to align it with regulatory information, other than what is reported elsewhere in the GCC template, that the reporting entity has submitted such as current filings, communications, etc. In this summary view, entities are organized into like regimes (e.g., RBC filers, foreign insurers, banks, financial, or non-financial entities) and multiple entities may be grouped together, in order to create a view of capital that is easy to review and analyze within each grouping. The intent of this approach is to provide an additional analytical tool designed to enhance dialogue between the Lead State Regulator and the company contemplated by the GCC filing. This view is transparent (no scalers, no adjustments, no de-stacking) so that financial information may be crosswalked to other financial submissions such as RBC filings. However, it does contain double counting of available and required capital (i.e., intra-company investments and transactions are not eliminated) and cannot be used to create a GCC ratio.

93.91. The results are dependent on how the reporting entity populated. Input 1 – Schedule 1, Column 9 Alternative Grouping. For example, if you have a dozen small dental HMO businesses, you may wish to collapse the results to a single line called “Dental HMOs,” by populating Input 1 – Schedule 1, Column 9 Alternative Grouping for each dental HMO as “Dental HMOs.” Then right-click and select “Refresh” to see the results with the “Dental HMOs” combined.

94.92. For reference, the data for the Summary 4 – Grouping Alternative is from Calc 1 – Scaling (Ins, Bank), which is fed by the inputs made in Input 1 – Schedule 1, Input 2 – Inventory, etc.
Appendix 1 – Explanation of Scalars

95.93 The concept of a scalar is to equate the local capital requirement to an adjusted required capital level that is comparable to U.S. levels. The purpose of a scalar is to address the issue of comparability of accounting systems and capital requirements between jurisdictions. The following provides details on how the scalars were calculated by the NAIC, or how they are to be used when the NAIC has not developed a scalar for a country due to lack of public data.

Excess Relative Ratio Approach

96.94 Included below are various steps to be taken in calculating the excess relative ratio approach to developing jurisdiction-specific scalars. In order to numerically demonstrate how this approach could work, hypothetical capital requirements and financial amounts have been developed for Country A. Based on preliminary research that has been performed by NAIC staff, it appears that the level of conservatism built into accounting and capital requirements within a jurisdiction may differ significantly for life insurers and non-life insurers. Therefore, ideally each jurisdiction would have two different scalars based on the type of business. The example below includes information related to life insurers in the U.S. and Country A.

Step 1: Understand the Jurisdiction’s Capital Requirements and Identify the First Intervention Level

a. The first step in the process is to gain an understanding of the jurisdiction’s capital requirements. This can be done in a variety of ways including reviewing publicly available information on the regulator’s website, reviewing the jurisdiction’s Financial Sector Assessment Program (FSAP) reports and discussions with the regulator.

In Country A, assume that the capital requirements for life insurers are based on a capital ratio, which is calculated as follows:

\[
\text{Capital ratio} = \frac{\text{Total available capital}}{\text{Base required capital (BRC)}}
\]

In the U.S., capital requirements are related to the insurer’s RBC ratio. For purposes of the Relative Ratio Approach, an Anchor RBC ratio is used and calculated as follows:

\[
\text{Anchor RBC ratio} = \frac{\text{Total adjusted capital}}{100\% \text{ Company Action Level RBC}^*}
\]

* 100% Company Action Level RBC is equal to the Total RBC After Covariance before operational risk, without adjustment or 200% Authorized Control Level RBC.

b. Similar to legal entity RBC requirements in the U.S., Country A utilizes an early intervention approach by establishing target capital levels above the prescribed minimums that provide an early signal so that intervention will be timely and for there to be a reasonable expectation that actions can successfully address difficulties. Presume that this target capital level is similar to the U.S. Company Action Level (CAL) event, both of which can be considered the first intervention level in which some sort of action—either on the part of the insurer or the regulator—is mandated. A separate sensitivity calculation will be applied in the GCC template using trend test level RBC.
c. For Country A, the target capital level is presumed to be a capital ratio of 150%. That is, the insurer’s ratio of total available capital to its BRC should be above 150% to avoid the first level of regulatory intervention. Again, this is similar to the U.S. CAL event, which is usually represented as an RBC ratio of 200% of Authorized Control Level (ACL) RBC (ignoring the RBC trend test). In the Relative Ratio approach, the Anchor RBC ratio represents the Company Action Level event (or first level of regulatory intervention) as 100% CAL RBC (instead of 200% ACL RBC), because CAL RBC is the reference point that is used to calibrate against other regimes. The Anchor RBC Ratio (Total Adjusted Capital ÷ 100% CAL RBC) tells us how many “multiples of trigger level capital” that the company holds. Conceptualizing the CAL event as 100% CAL RBC allows the consistent definition of local capital ratios that are calibrated against a “multiples of the trigger level” approach, to ensure an “apples-to-apples” comparison.3

Step 2: Obtain Aggregate Industry Financial Data

92.95. The next step is to obtain aggregate industry financial data, and many jurisdictions include current aggregate industry data on their websites. Included below are the financial amounts for use in this exercise.

<table>
<thead>
<tr>
<th>U.S. Life Insurers – Aggregate Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Adjusted Capital = $495B</td>
</tr>
<tr>
<td>Authorized Control Level RBC = $51B</td>
</tr>
<tr>
<td>Company Action Level RBC = $102B</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Country A Life Insurers – Aggregate Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Available Capital = $83B</td>
</tr>
<tr>
<td>BRC = $36B</td>
</tr>
</tbody>
</table>

Step 3: Calculate a Jurisdiction’s Industry Average Capital Ratio

98.96. To calculate a jurisdiction’s average capital ratio, the aggregate total available capital for the industry would be divided by the minimum or base capital requirement for the industry in computing the applicable capital ratio. In Country A, this would be the BRC. In the U.S., this base or minimum capital requirement is usually seen as the ACL RBC, but because the Relative Ratio Approach is using 100% CAL RBC as a reference point to calibrate other regimes to, the Relative Ratio formula uses 100% CAL RBC as the baseline and the first-intervention level to calculate the Average Capital Ratio and Excess Capital Ratio. As a result, the scaled ratio of a non-U.S. company should inform regulators how many multiples of first-intervention level capital the non-U.S. company holds. Included below is the formula to calculate a jurisdiction’s industry average capital ratio:

While it is mathematically equivalent to use 200% ACL RBC as the denominator, the Approach is designed to use the representation of first-intervention level capital levels as the conceptual underpinning of the Relative Ratio Approach, where 100% CAL RBC is the reference point to calibrate against other regimes.
### Calculation of U.S. Industry Average Capital Ratio – Life Insurers

<table>
<thead>
<tr>
<th>Total Adjusted Capital</th>
<th>CAL RBC</th>
<th>Capital Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>$495B</td>
<td>$102B</td>
<td>485%</td>
</tr>
</tbody>
</table>

### Calculation of Country A Industry Average Capital Ratio – Life Insurers

<table>
<thead>
<tr>
<th>Total Available Capital</th>
<th>BRC</th>
<th>Capital Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>$83B</td>
<td>$36B</td>
<td>231%</td>
</tr>
</tbody>
</table>

### Step 4: Calculate a Jurisdiction’s Excess Capital Ratio

The next step is to understand the level of capital the industry is holding above the first intervention level. Therefore, to calculate a jurisdiction’s excess capital ratio, one would first need to calculate the amount of the capital ratio carried in excess of the capital ratio required at the first intervention level. This amount would then need to be divided by the capital ratio required at the first intervention level.

**General Excess Capital Ratio Formula**

\[
\text{Excess Capital Ratio} = \frac{\text{Average Capital Ratio} - \text{Capital Ratio at the First Intervention Level}}{\text{Capital Ratio at the First Intervention Level}} \times 100\%
\]

### Calculation of U.S. Excess Capital Ratio – Life Insurers

\[
\frac{485\% \text{ (Average Capital Ratio)} - 100\% \text{ (Capital Ratio at the First Intervention Level)}}{100\% \text{ (Capital Ratio at the First Intervention Level)}} = 385\%
\]

### Calculation of Country A Excess Capital Ratio – Life Insurers

\[
\frac{231\% \text{ (Average Capital Ratio)} - 150\% \text{ (Capital Ratio at the First Intervention Level)}}{150\% \text{ (Capital Ratio at the First Intervention Level)}} = 54\%
\]

4 100% CAL RBC translates to an ACL RBC level of 200%, but for conceptual purposes, the Relative Ratio Approach refers to the U.S. first intervention level as 100% CAL RBC, while 100% CAL RBC is the reference point to which the Relative Ratio Approach calibrates other regimes. In other words, 100% CAL RBC ensures that the scaled ratio of Country A results in a ratio that determines how many multiples of first-intervention level capital that the company in Country A is holding.
Step 5: Compare a Jurisdiction’s Excess Capital Ratio to the U.S. Excess Capital Ratio to Develop the Scalar

101.99. Based on the information above, the U.S. excess capital is 385%. In other words, life insurers in the U.S. carry approximately 385% more capital than what is needed over the first intervention level. Country A’s excess capital ratio is 54%. That is, life insurers in Country A carry approximately 54% more capital than what is needed over the first intervention level.

102.100. To calculate the scalar, one would divide a jurisdiction’s excess capital ratio by the U.S. excess capital ratio. Therefore, the calculation of Country A’s scalar for life insurers would be 54% ÷ 385% = 14%. Therefore, Country A’s scalar for life insurers would be 14%.

Step 6: Apply to the Scalar to the Non-U.S. Insurer’s Amounts in the GCC

103.101. In order to demonstrate how the calculation of the scalar works, it would be best to provide a numerical example. For purposes of this memo, assume that a life insurer in Country A reports required capital of $341,866 and total available capital of $1,367,463. (These are the amounts previously used in a hypothetical calculation example that was discussed by the Working Group during its July 20, 2016, conference call.) As noted previously, the above information and calculation suggests that U.S. life insurers carry capital far above the minimum levels, while life insurers in Country A carry capital far closer to the minimum. Therefore, in order to equate the company’s $341,866 of required capital, we must first calibrate the BRC to the first regulatory intervention level by multiplying it by 150%, or Country A’s capital ratio at the first intervention level. The resulting amount of $512,799 is then multiplied by the scalar of 14% to get a scaled minimum required capital of $71,792.

104.102. Further, the above rationale suggests that the available capital might also be overstated (because it does not use the same level of conservatism in the reserves) by the difference between the calibrated required capital of $512,799 and the required capital after scaling of $71,792, or $441,007. Therefore, we should now deduct the $441,007 from the total available capital of $1,367,463 for a new total available capital of $926,456. These two recalculated figures of required capital of $71,792 and total available capital of $926,456 is what would be included in the group’s capital calculation for this insurer. These figures are further demonstrated below.

<table>
<thead>
<tr>
<th>Calculation of Scaled Amounts for GCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amounts as Reported by the Insurer in Country A</td>
</tr>
<tr>
<td>Total available capital = 1,367,463</td>
</tr>
<tr>
<td>Minimum required capital (BRC) = 341,866</td>
</tr>
<tr>
<td>Calibration of BRC to 1st Regulatory Intervention Level</td>
</tr>
<tr>
<td>341,866 (BRC) * 150% = 512,799</td>
</tr>
<tr>
<td>Scaling of Calibrated Minimum Required Capital</td>
</tr>
<tr>
<td>512,799 (Calibrated BRC) * 14% (Scalar) = 71,792 (Difference of 441,007)</td>
</tr>
<tr>
<td>Scaled Total Available Capital</td>
</tr>
<tr>
<td>1,367,463 (Total Available Capital) – 441,007 (Difference in scaled required capital) = 926,456</td>
</tr>
</tbody>
</table>

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105.103. Given these scaled amounts, one can calculate the numerical effect on the company’s relative capital ratio by using the unscaled and scaled amounts included below.

<table>
<thead>
<tr>
<th></th>
<th>Unscaled Amounts from Table Above</th>
<th>Scaled Amounts from Table Above</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Available Capital (TAC)</td>
<td>1,367,463</td>
<td>926,456</td>
</tr>
<tr>
<td>Base Required Capital (BRC)</td>
<td>341,866</td>
<td>71,792</td>
</tr>
<tr>
<td>Capital Ratio (= TAC ÷ BRC)</td>
<td>400%</td>
<td>1290%</td>
</tr>
</tbody>
</table>

106.104. Considering the fact that life insurers in Country A hold much lower levels of capital over the first intervention level as compared to U.S. life insurers, the change in the capital ratio from 400% (unscaled) to 1290% (scaled) appears reasonable and consistent with the level of conservatism that we understand is built into the U.S. life RBC formula driven primarily from the conservative reserve valuation.
Stress / Scenario Proposal for GCC Trial Implementation

What follows is a proposal for a stress to be applied to the GCC to test how the limits on recognition of capital instruments as capital behave under stress. In designing this stress, an emphasis was placed on simplicity. The proposed scenario requires no input or calculation on the part of volunteers beyond that already necessary for completing the GCC template. Further scenarios, if any, could follow this same structure:

- (1) A scenario that includes one (or more) stresses to a Group’s financial position
- (2) Specification of how each stress impacts the available capital and calculated capital for each type of legal entity
- (3) Input of the adjusted carrying value and adjusted calculated capital after the impact of the stress(es)
- (4) Re-calculation of the same calculations (e.g. application of limits on debt and scaling) and summary tables (including sensitivity tests)

Proposal

Scenario: A generic loss event that results in a proportional reduction in available capital across the Group’s entire operations. What follows is a description based on a 10% reduction. A variation based on a 20% reduction will be tested as well.

Specification: The scenario should result in X% reduction (10% used in the example below) in the adjusted available capital for all non-holding company entities. For entities where calculated capital is a fixed percentage of available capital, there should be also reduction in calculated capital as well. As an approximation of the impact of the impact of this scenario on revenue, the calculated capital for financial entities with revenue-based exposure should reduce by X% as well.

Inputs: No direct input needed from Volunteers. Instead the inputs will be automatically calculated as follows—

<table>
<thead>
<tr>
<th>Type of Entity</th>
<th>Impact on Adj Carrying Value</th>
<th>Impact on Adj Calc Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Insurance Entities</td>
<td>10% reduction</td>
<td>No Impact</td>
</tr>
<tr>
<td>Fin (Banking and Other W Cap Req)</td>
<td>10% reduction</td>
<td>No Impact</td>
</tr>
<tr>
<td>Fin (Asset Mgmt and Other W/O Req)</td>
<td>10% reduction</td>
<td>10% reduction based on corresponding reduction in revenue</td>
</tr>
<tr>
<td>Non-US (w/ Risk Based CC)</td>
<td>10% reduction</td>
<td>No Impact on unscaled GCC though XS Relative Ratio factors should be adjusted for sensitivity test</td>
</tr>
<tr>
<td>Non-US (non-Risk Based))</td>
<td>10% reduction</td>
<td>10% reduction based on corresponding reduction in equity value</td>
</tr>
<tr>
<td>HoldCo</td>
<td>No Impact</td>
<td>No Impact</td>
</tr>
<tr>
<td>Other</td>
<td>10% reduction</td>
<td>10% Reduction based on corresponding reduction in equity value</td>
</tr>
<tr>
<td>Capital Instruments</td>
<td>No Impact</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Outputs: The GCC template will be configured to automatically calculate outputs using the inputs above. This can be presented on an additive basis (e.g. start with reduction in available capital alone and then add the impact on each entity type’s calculated capital one at a time building to the full scenario outlined in the chart, above.

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Group Solvency Issues (E) Working Group
Virtual Meeting (in lieu of meeting at the 2021 Summer National Meeting)
August 4, 2021

The Group Solvency Issues (E) Working Group met Aug. 4, 2021. The following Working Group members participated: Justin Schrader, Chair (NE); Jamie Walker, Vice Chair (TX); Kim Hudson (CA); Kathy Belfi (CT); Charles Santana (DE); Virginia Christy (FL); Kim Cross (IA); Cindy Andersen, Susan Berry and Eric Moser (IL); Roy Eft (IN); John Turchi (MA); Judy Weaver (MI); Shannon Schmoeger (MO); Diana Sherman (NJ); Margot Small (NY); Dale Bruggeman (OH); Doug Stolte (VA); and Amy Malm (WI).


Mr. Schrader stated that the primary purpose of the meeting is to discuss comments received on the public exposure of proposed revisions to the NAIC’s Financial Analysis Handbook (Handbook), which were developed by the ComFrame Financial Analysis Drafting Group. The proposed revisions are intended to incorporate elements of the International Association of Insurance Supervisors’ (IAIS’) Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) deemed appropriate for the U.S. system of solvency regulation.

Mr. Schrader stated that the proposed revisions were exposed for a 60-day public comment period and that five comment letters were received during the exposure. Mr. Schrader stated that the focus of the meeting will be to discuss the comments received at a high level, before asking the Drafting Group to consider the development of a revised draft in response to the comments received.

Robert Neill (American Council of Life Insurers—ACLI) provided an overview of the topics covered in the ACLI comment letter, which included concerns related to the scope of insurers that proposed procedures could be applied to, the appropriateness of placing guidance on determining the head of an internationally active insurance group (IAIG) in the Handbook, and concerns regarding references to IAIS Insurance Core Principles (ICPs) and application papers within the Handbook. In addition, Mr. Neill recommended that the Handbook language allow for more flexibility in approaches to governance, control, and risk management functions and expressed concerns over language referencing the IAIS’ insurance capital standard (ICS).

In response to the scoping issue, Mr. Schrader stated that the Drafting Group thinks that the newly proposed procedures should not restrict the existing ability of state insurance regulators to conduct holding company analysis and examination procedures as they see fit in accordance with a risk-focused approach to financial surveillance. Therefore, while they are primarily intended for use in conducting analysis of IAIGs, the proposed language states that analysts can use judgment in determining whether the procedures should be applied to a broader range of insurance groups. Mr. Schrader also stated that the Drafting Group is likely open to working on some additional clarifying language in this area.

Mr. Schrader stated that the intent of the Drafting Group behind including guidance on determining the head of the IAIG in the Handbook was to encourage state insurance regulators to consider applying the ComFrame considerations at a level below the ultimate controlling person, when appropriate. Mr. Schrader stated that the requirements and oversight outlined in the Insurance Holding Company System Regulatory Act (#440) generally apply at the ultimate controlling person or holding company registrant level. However, there may be situations in a conglomerate group where the insurance operations are overseen at a subsidiary or intermediate holding company level. Therefore, providing guidance to assist state insurance regulators in using discretion in determining the level of the group to focus on in conducting analysis procedures was deemed appropriate for inclusion in the Handbook.

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Mr. Schrader stated his agreement with the need to allow for flexibility in approaches to governance, control, and risk management functions within the Handbook guidance and believes that this was the intent of the Drafting Group. However, he stated that the Drafting Group can consider some additional clarifying language in that area. Mr. Schrader stated that the Drafting Group’s intent behind including references to the ICS in the Handbook was not to expect or require ICS reporting by IAIGs, but rather to encourage group-wide supervisor review and consideration if ICS reporting is being prepared on a voluntary basis by certain IAIGs during the monitoring period. Mr. Schrader stated that given the key role that the ICS plays within ComFrame guidance and the ongoing implementation in other jurisdictions, that Handbook guidance would be incomplete without some background information on ICS.

Steve Broadie (American Property Casualty Insurance Association—APCIA) stated that APCIA members endorse the comments made by the ACLI in this area and oppose references to the ICS in the Handbook as a tool for group capital assessment because it is developed for a different system of evaluating group solvency and based on a different accounting system. Mr. Schrader stated that as several IAIGs are currently filing an ICS with their group-wide supervisor during the monitoring period, those supervisors would be expected to review the filing, and the Handbook guidance should so indicate. Ms. Weaver stated that it may also be helpful for other state insurance regulators who are involved in supervising non-U.S.-based IAIGs to have some background information on the ICS so that they can understand how it is being used in other jurisdictions. Keith Bell (Travelers) stated that part of the issue here is that the ICS is currently in a monitoring period and not really a regulatory standard for anyone yet. As such, the Handbook should only address the ICS when and if it becomes a regulatory requirement for U.S.-based groups. Mr. Schrader stated that it is obvious that various interested parties have strong feelings on this topic and encouraged the Drafting Group to review and consider the comments received.

Bob Ridgeway (America’s Health Insurance Plans—AHIP) provided an overview of the comment in the AHIP letter, which focused on the scope of companies that the proposed procedures could be applied to. He stated that the new guidance cites Section 7.1 of Model #440 as the authority to conduct the procedures, and that section of the act relates specifically to the group-wide supervision of IAIGs. Therefore, the law does not grant state insurance regulators to apply these measures to non-IAIG groups. Mr. Schrader stated that Section 7.1 is primarily focused on the identification of IAIGs and outlining the role of a group-wide supervisor but does highlight certain areas of group governance and risk exposures that should be assessed by the group-wide supervisor. However, Mr. Schrader said he does not interpret that to mean that these same areas cannot be reviewed for other groups, just that they are required to be reviewed for IAIGs. Ms. Belfi stated that other sections of Model #440, including Section 6 on examinations, provide broad authority to conduct procedures as deemed appropriate for all insurance holding company systems. Therefore, Ms. Belfi stated that such authority would allow such procedures to be performed on a broader range of insurers. Mr. Schrader asked NAIC staff to seek the opinion of its legal division on the regulatory authority outlined in Model #440 to conduct monitoring procedures for holding company groups and to return and report the results to the Working Group.

Mr. Broadie provided an overview of the APCIA letter and stated that it covers many of the same topics that were already discussed by the ACLI. Mr. Broadie stated that he will cover three topics from the letter that have not yet been discussed. First, he stated that APCIA members are opposed to including references to the IAIS ICPs and Application Papers within the Handbook as this could be seen as incorporating all IAIS standards by reference, which would not be appropriate for the U.S. system. Second, Mr. Broadie stated that proposed language in the Handbook appears to expect a group-wide Corporate Governance Annual Statement or Own Risk and Solvency Assessment (ORSA) Summary Report to be filed by IAIGs, which could exceed the authority granted by the existing legislation in those areas. Finally, Mr. Broadie stated that several areas in the proposed Handbook guidance appear to expect IAIGs to have group-wide processes or functions that are too prescriptive and would not allow appropriate flexibility for various types of corporate structures.

Mr. Schrader stated that the intent behind placing references to IAIS ICPs and Application Papers in the Handbook was to highlight additional background information and reference material to analysts and was not an attempt to incorporate by reference. Mr. Schrader stated that the Drafting Group should develop language to clarify the intent in this regard. Regarding the second comment, Mr. Schrader stated that it will be necessary for the supervisor to obtain information on group practices in certain areas to conduct the assessments outlined in ComFrame. As such, the Handbook guidance states that logical sources
for this information would be the Corporate Governance Annual Disclosure and the ORSA Summary Report, if they are
provided at the head of the IAIG level. However, the Handbook cannot and does not require filings to be made at that level, so
it will be up to the group-wide supervisor to determine the best way to obtain the necessary information. Mr. Schrader also
stated that this topic will likely be addressed in more detail as drafting work moves forward on the ORSA Guidance Manual,
which will be discussed later in the agenda. Regarding the third comment, Mr. Schrader stated that the Drafting Group’s intent
was to provide flexibility in approaches to group governance and processes, but that additional language can be considered to
make expectations clearer in this regard.

Joe Zolecki (Blue Cross and Blue Shield Association—BCBSA) stated his support for the comments made in the other letters
and focused his comments on the scope issue. Mr. Zolecki stated that his members would encourage the deletion of language
stating that the new procedures added to the Handbook could be performed in non-IAIG group analysis. However, if the
Drafting Group’s intent is to prepare companies that are approaching the IAIG threshold for that additional level of regulation,
then the BCBSA comment letter has some specific language recommendations to address this issue. Mr. Schrader stated that
the Drafting Group would review and consider this language in developing an updated draft.

Ms. Cross stated that Iowa had no additional comments to make on their letter. Mr. Schrader thanked the Iowa Department of
Insurance (DOI) for its comments and stated that the Drafting Group will consider them in developing an updated draft.

2. Received an Update on Other Drafting Efforts

Mr. Schrader stated that two other drafting groups have begun meeting to develop proposed revisions to the NAIC’s Financial
Condition Examiners Handbook and ORSA Guidance Manual to incorporate ComFrame elements as deemed appropriate for
the U.S. system of insurance regulation. Mr. Schrader stated that the intent of the Working Group will be to adopt the proposed
ComFrame revisions to all three NAIC publications together as a package later this year once they have all been fully developed
and vetted.

3. Discussed IAIS Consultation

Mr. Schrader stated the IAIS has released a revised Application Paper on Supervisory Colleges for public consultation.
Feedback on this Application Paper is due to the IAIS by Aug. 24. This paper has been updated to reflect subsequent
developments of IAIS supervisory materials, in particular revisions to ICP 3 (Information Sharing and Confidentiality
Requirements) and ICP 25 (Supervisory Cooperation and Coordination), and the adoption of ComFrame.

Mr. Schrader encouraged Working Group members to review the revised Application Paper and provide comments to the
International Insurance Relations (G) Committee for submission to the IAIS. Interested parties were also encouraged to review
the revised Application Paper and submit their own comments to the IAIS.

Having no further business, the Group Solvency Issues (E) Working Group adjourned.
The Group Solvency Issues (E) Working Group met May 19, 2021. The following Working Group members participated: Justin Schrader, Chair (NE); Jamie Walker, Vice Chair (TX); Susan Bernard and Kim Hudson (CA); Kathy Belfi (CT); Charles Santana (DE); Robert Ridenour (FL); Kim Cross (IA); Cindy Andersen, Susan Berry and Eric Moser (IL); Roy Eft (IN); Judy Weaver (MI); Shannon Schmoeger (MO); Diana Sherman (NJ); Margot Small (NY); Dale Bruggeman and Tim Biler (OH); Kimberly Rankin and Melissa Greiner (PA); Doug Stolte (VA); and Amy Malm (WI).

1. **Discussed Proposed Revisions to the Financial Analysis Handbook**

Mr. Schrader stated that the primary purpose of the meeting is to discuss proposed revisions to the NAIC’s *Financial Analysis Handbook*, which have been developed by the ComFrame Financial Analysis Drafting Group. He stated that the Working Group met in July 2020 and decided to form three separate drafting groups to develop revisions to the *Financial Analysis Handbook*, *Financial Condition Examiners Handbook*, and *NAIC Own Risk and Solvency Assessment Guidance Manual* (ORSA Guidance Manual) to incorporate elements of the International Association of Insurance Supervisors’ (IAIS’s) Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) deemed appropriate for the U.S. system of solvency regulation.

Several states volunteered to participate in the drafting groups, and an initial organizational call of volunteers was held in September 2020. During that call, the volunteers determined that the Drafting Group should proceed first in the development of its proposed revisions, as the *Financial Analysis Handbook* is expected to house many of the ComFrame elements deemed appropriate for the U.S. system.

Mr. Schrader stated that the Drafting Group, consisting of state insurance regulators from Illinois, Michigan, Missouri and Nebraska met eight times to work through discussions on various ComFrame elements. As a result of these discussions, an extensive set of edits were developed for the group-wide supervision section of the *Financial Analysis Handbook*, spanning almost 100 pages of guidance. Mr. Schrader stated that in addition to revisions, the Drafting Group developed a memorandum to describe the changes and map them to specific ComFrame elements.

Bruce Jenson (NAIC) provided an overview of the proposed edits, noting that the only sections of Chapter VI. Group-Wide Supervision that did not receive any proposed edits included Section VI.G. Form F – Enterprise Risk Report Procedures and Section VI.H. Periodic Meeting with Company Procedures. He also stated that the new guidance makes it clear that ComFrame additions are not intended to only apply to internationally active insurance groups (IAIGs), but they should also be considered for other large insurance groups that do not yet meet the IAIG criteria. He also stated that new guidance encourages the consideration of a team-based approach to IAIG supervision, recommending the integration of financial analysts, financial examiners, department supervisors and specialists into a cohesive unit that facilitates the ongoing supervision of an IAIG. As such, he stated that the proposed guidance addresses a similar recommendation received by the Working Group in response to the 2019/2020 Financial Sector Assessment Program (FSAP).

Ms. Weaver stated that Drafting Group members consisted of experienced state insurance regulators that participate as both home and host supervisors of IAIGs, which enabled the Drafting Group to incorporate practical experiences in determining the elements of ComFrame appropriate for the U.S. system of solvency regulation. She also stated that the proposed revisions will require judgment and customization in applying them to insurance groups, and they should not be seen as a set of prescriptive procedures to be performed for every group.

Robert Neill (American Council of Life Insurers—ACLI) thanked the Drafting Group for its efforts and for the overview of the proposed revisions, and he stated that interested parties are looking forward to reviewing and offering comments. Tom Finnell (America’s Health Insurance Plans—AHIP) asked whether the Working Group would consider exposing the proposed revisions for a 60-day public comment period to allow sufficient time to review the extensive revisions. Mr. Schrader, Mr. Jenson and Ms. Weaver stated that a 60-day public comment period should still allow the proposed revisions to be finalized and adopted ahead of the Fall National Meeting, which is the cutoff for adopting revisions for publication in next year’s *Financial Analysis Handbook*. 

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Ms. Berry made a motion, seconded by Ms. Rankin, to expose the proposed revisions to the Financial Analysis Handbook for a 60-day public comment period. The motion passed unanimously.

Having no further business, the Group Solvency Issues (E) Working Group adjourned.
Mortgage Guaranty Insurance (E) Working Group
Virtual Meeting
May 18, 2021

The Mortgage Guaranty Insurance (E) Working Group of the Financial Condition (E) Committee met May 18, 2021. The following Working Group members participated: Kevin Conley, Chair, Jackie Obusek and Richard Kohan (NC); Kurt Regner (AZ); Monica Macaluso (CA); Robert Ballard (FL); Jay Buschmann (MO); Michael Campanelli (NY); Melissa Greiner (PA); Chris Miller (TX); and Amy Malm (WI).

1. **Heard an Update on the State Regulatory Mortgage Insurance Capital Standard Model (SRMICS)**

Mr. Conley commented that the mortgage insurers will be required to file the SRMICS on a direct basis and tabulate it within the schedules of the mortgage guaranty annual supplement (supplement), which will be available to all state insurance regulators as a monitoring tool. He indicated that SRMICS would not provide the ability to take regulatory action, similar to risk-based capital (RBC). Mr. Conley commented that the plan is to leave all the Milliman risk-based components in place. He commented that in the fall of 2019, when the mortgage insurers were asked to run the SRMICS against their 2018 data, the output did not create a high enough standard, which would necessitate state insurance regulators to default to the 25:1 risk-to-capital rule. Mr. Conley indicated that he used 10 years of data from his domestics to run stress scenarios to determine a change in the base rate. As a result of the stress testing, the base rate changed from 0.55 to 1.1. He indicated the Milliman was agnostic about the base rate as it knew it would require calibration to get it just right.

Mr. Conley stated that North Carolina is proposing to remove the 1% expense margin. Further, he indicated that SRMICS will follow the Private Mortgage Insurer Eligibility Requirements (PMIERS) by removing explicit premium credits and scaling down the seasoning factors. He commented that seasoning factors are required as reserves are booked and the mortgage insurer recognizes potential losses as the book years age. Mr. Conley commented that the economic factors require input from Moody’s Investors Service regarding the home price index and from the U.S. Bureau of Labor Statistics (BLS) for the consumer price index. He stated that he updated all the economic factors for each state and quarter for 2019 and 2020. Mr. Conley commented that William Meers (Arch Mortgage Insurance) confirmed the economic factors. Mr. Conley indicated that the updated SRMICS factors would be emailed to the mortgage insurers by the end of the week. The mortgage insurers would complete SRMICS based on 2020 data. Further, he indicated there would be no need to complete the premium credit triangle. Mr. Conley indicated that the goal is to put in place a capital standard that is less stringent than PMIERS.

The mortgage insurers agreed on returning the completed SRMICS to the Working Group by June 30. Tony Shore (Essent Guaranty) commented that the vintage earned premium table remains in the supplement. However, he said it is not being used in SRMICS. Mr. Conley commented that the Supplement will require the mortgage insurers to tabulate earned premiums on a book year basis historically for 20 years. He commented further that because the two-year premium credit is being removed, state insurance regulators would have access to premium growth and can project ultimate premium in order to tabulate future inflows. Mr. Shore commented that a non-historical aggregate value would serve the same purpose.

Since SRMICS will be used as a tool to assess capital, rather than integrating it into RBC, Ed Hartman (Genworth Financial) questioned how state insurance regulators would use SRMICS. Mr. Conley commented that there was discussion on relaxing the contingency reserve requirements with the reliance on SRMICS. Further, he commented that this is not being proposed now; it may be considered once state insurance regulators are more comfortable with the results of SRMICS. Mr. Conley commented that once the SRMICS filings are received and reviewed, he will provide the next steps to the Working Group.

Having no further business, the Mortgage Guaranty Insurance (E) Working Group adjourned.
The Mortgage Guaranty Insurance (E) Working Group of the Financial Condition (E) Committee conducted an e-vote that concluded April 9, 2021. The following Working Group members participated: Kevin Conley, Chair (NC); Kurt Regner (AZ); Monica Macaluso (CA); Robert Ballard (FL); John Rehagen (MO); Margot Small (NY); Melissa Greiner (PA); Chris Miller (TX); and Amy Malm (WI).

1. **Adopted the Mortgage Guaranty Insurance Exhibit and Instructions**

The Working Group conducted an e-vote to consider adoption of the 2020 Mortgage Guaranty Insurance Exhibit and Instructions *(see NAIC Proceedings – Spring 2021, Financial Condition (E) Committee, Attachment Four-B)*. The motion passed, with a majority of Working Group members voting in favor of adopting the document.

Having no further business, the Mortgage Guaranty Insurance (E) Working Group adjourned.
The Mutual Recognition of Jurisdictions (E) Working Group of the Financial Condition (E) Committee met in a joint session with the Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee July 20, 2021. The following Mutual Recognition of Jurisdictions (E) Working Group members participated: Robert Wake, Chair (ME); Monica Macaluso, Vice Chair (CA); Kathy Belfi (CT); Virginia Christy (FL); Tom Travis (LA); Shelley Woods and John Rehagen (MO); Lindsay Crawford (NE); Diana Sherman (NJ); Michael Campanelli (NY); Kimberly Rankin (PA); and Amy Garcia (TX). The following Group Capital Calculation (E) Working Group members participated: John Rehagen, Chair (MO); Kathy Belfi, Vice Chair (CT); Susan Bernard (CA); Philip Barlow (DC); Ray Spudeck (FL); Carrie Mears (IA); Kevin Fry (IL); Gary D. Anderson (MA); Judy Weaver (MI); Kathleen Orth (MN); Jackie Obusek (NC); Justin Schrader (NE); David Wolf (NJ); Bob Kasinow (NY); Dale Bruggeman (OH); Kimberly Rankin (PA); Trey Hancock (TN); Jamie Walker (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI).

1. Discussed the Draft of the Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation

Mr. Wake stated that the Mutual Recognition of Jurisdictions (E) Working Group received a charge to prepare a list of foreign jurisdictions that recognize and accept the group capital calculation (GCC). Dan Schelp (NAIC) stated that the meeting materials contain a draft of the Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation (GCC Process) (Attachment Six-A) and the Appendix: Letter Templates (Attachment Six-B). He provided the background and an overview of the GCC Process document, and he recommended that the Mutual Recognition of Jurisdictions (E) Working Group expose the documents for a 30-day public comment period. Mr. Rehagen asked for clarification on when a letter must be sent to the International Association of Insurance Supervisors (IAIS). Mr. Schelp stated that in order to satisfy the requirements of Sections 21D(1)(b) and 21D(2) of the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450), the competent regulatory authority of a non-U.S. jurisdiction in which no U.S. insurance groups operate shall provide the NAIC with a written letter, and a copy must be submitted to the IAIS.

Mr. Rehagen made a motion, seconded by Mr. Travis, for the Mutual Recognition of Jurisdictions (E) Working Group to expose the draft of the Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation with the Appendix: Letter Templates for a 30-day public comment period ending Aug. 20. The motion passed unanimously.

Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation

Mutual Recognition of Jurisdictions (E) Working Group
Process for Evaluating Jurisdictions that Recognize and Accept
the Group Capital Calculation

1. **Group Capital Calculation.** On December 9, 2020, the NAIC adopted revisions to the NAIC Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). These revisions implement the Group Capital Calculation (GCC) filing requirements for insurance groups at the level of the ultimate controlling person for the purposes of evaluating solvency at the group level. The revisions specifically provide that the requirement to file the NAIC’s GCC applies to U.S.-based groups, while a group headquartered outside the U.S. is exempt from the GCC (subject to limited exceptions)\(^1\) if its group-wide supervisor “recognizes and accepts” the GCC for U.S. groups doing business in that jurisdiction. Likewise, a U.S. group subject to a group capital calculation specified by the Federal Reserve Board is exempt from the GCC. This process codifies the concepts of mutual recognition and one group/one group-wide supervisor.

2. **NAIC Listing Process.** Section 4L(2) of Model #440 provides two ways a non-U.S. jurisdiction may meet the standards for its insurance groups to be exempt from the GCC:

- If the jurisdiction has been determined to be a Reciprocal Jurisdiction for purposes of credit for reinsurance, which includes a requirement that the jurisdiction “recognizes the U.S. state regulatory approach to group supervision and group capital”;\(^2\) or

- If the jurisdiction has otherwise been determined to recognize and accept the GCC by procedures specified in regulation.

Jurisdictions meeting either of these criteria will be referred to informally as “‘Recognize and Accept’ Jurisdictions.” Sections 21D and 21E of Model #450 provide a general framework for how the process to identify “Recognize and Accept” Jurisdictions will work and specifically contemplates the development of a list of such jurisdictions through the NAIC Committee Process. The purpose of this document is to provide a documented evaluation process for creating and maintaining this list of jurisdictions that recognize and accept the GCC.

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\(^1\) Under Section 4L(2)(e) of Model #440, if the worldwide insurance operations of a non-U.S. group are exempt from the GCC, the group’s U.S. Lead State Commissioner may nevertheless require a GCC that is limited to the group’s U.S. operations if: “after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace.” A group’s exemption is also contingent on the group providing sufficient information to the lead state, directly or through the group-wide supervisor, sufficient to enable the lead state to comply with the group supervision approach set forth in the *NAIC Financial Analysis Handbook*.

\(^2\) Model #440, § 4L(2)(c).
3. **Covered Agreements.** The GCC and the “recognize and accept” process are intended to comply with the requirements under the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance”, which was signed on September 22, 2017. On December 18, 2018, a similar Covered Agreement was signed with the United Kingdom (UK) (collectively “Covered Agreements”). The Covered Agreements require the elimination of reinsurance collateral requirements for certain reinsurers licensed and domiciled in participating jurisdictions, and limit the worldwide application of prudential group insurance measures on insurance groups based in participating jurisdictions. Specifically, the Covered Agreements provide that U.S. insurers and reinsurers can operate in the EU and UK without subjecting the U.S. parent to the host jurisdiction’s group-level governance, solvency and capital, and reporting requirements, and also provide the same protections for EU and UK insurers and reinsurers operating in the U.S. However, the Covered Agreements only exempt U.S., EU and UK insurance groups from each other’s worldwide group capital requirements if the home supervisor performs worldwide group capital assessments on its own insurance groups and has the authority to impose preventive and corrective measures.

4. **Reciprocal Jurisdictions.** In response to the Covered Agreements, the NAIC also amended the *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786) to provide that jurisdictions that are subject to in-force covered agreements are considered to be “Reciprocal Jurisdictions,” and large, financially strong reinsurers that are based in those jurisdictions are not required to post reinsurance collateral. In addition, a “Qualified Jurisdiction” under Section 2E of Model #785 may become a Reciprocal Jurisdiction if, among other requirements, it “recognizes the U.S. state regulatory approach to group supervision and group capital.” By the terms of the Covered Agreements, insurance groups based in EU Member States and the UK are entitled to exemption from the extraterritorial application of the U.S. GCC, and Section 4L(2)(c) of Model #440 recognizes that other Reciprocal Jurisdictions, which have made the same commitment, are entitled to the same treatment.

5. **Other Jurisdictions that Recognize and Accept.** In addition, because most of the requirements for Reciprocal Jurisdiction status are not relevant to group capital and group supervision, Section 4(L)(2)(d) of Model #440 provides an alternative pathway for the exemption. The ultimate controlling person of an insurance holding company system whose non-U.S. group-wide supervisor is not in a Reciprocal Jurisdiction is exempted from filing the GCC as long as the jurisdiction of its group-wide supervisor “recognizes and accepts” the GCC, as specified by the commissioner in regulation. Section 21D of Model #450 provides that a non-U.S. jurisdiction is considered to “recognize and accept” the GCC if it satisfies the following criteria:

(a) The non-U.S. jurisdiction recognizes the U.S. state regulatory approach to group supervision and group capital, by providing confirmation by a competent regulatory authority, in such
jurisdiction, that insurers and insurance groups whose lead state is accredited by the NAIC under the NAIC Accreditation Program shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction;

(b) Where no U.S. insurance groups operate in the non-U.S. jurisdiction, that non-U.S. jurisdiction indicates formally in writing to the lead state with a copy to the International Association of Insurance Supervisors that the group capital calculation is an acceptable international capital standard. This will serve as the documentation otherwise required in Section 21D(1)(a);

(c) The non-U.S. jurisdiction provides confirmation by a competent regulatory authority in such jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the lead state commissioner in accordance with a memorandum of understanding or similar document between the commissioner and such jurisdiction, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC. The commissioner shall determine, in consultation with the NAIC Committee Process, if the requirements of the information sharing agreements are in force;

(d) Notwithstanding these exemptions, Section 4L(2)(e) of Model #440 provides that a lead state commissioner shall require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system from a Reciprocal Jurisdiction or “Recognize and Accept” Jurisdiction where, after any necessary consultation with other supervisors or officials, it is deemed appropriate by the commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace. Section 21E(1) of Model #450 then provides that to assist with a determination under Section 4L(2)(e) of Model #440, the list will also identify whether a jurisdiction that is exempted under either Sections 4L(2)(c) and 4L(2)(d) requires a group capital filing for any U.S.-based insurance group’s operations in that non-U.S. jurisdiction.

6. Mutual Recognition of Jurisdictions (E) Working Group. On March 8, 2021, the Financial Condition (E) Committee repositioned the Qualified Jurisdiction (E) Working Group to report directly to the Committee and revised the name of the group to the Mutual Recognition of Jurisdictions (E) Working Group. The Working Group received the additional charge of developing a process for evaluating jurisdictions that meet the NAIC requirements for recognizing and accepting the GCC ("Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation," or
“Recognize and Accept” Process). A separate process exists for evaluating Qualified and Reciprocal Jurisdictions (“Process for Evaluating Qualified and Reciprocal Jurisdictions”), and it is intended that the “Recognize and Accept” Process will closely mirror this process. The Committee charged this Working Group with developing and implementing the “Recognize and Accept” Process due to this Working Group’s experience and expertise in evaluating the insurance regulatory systems of non-U.S. jurisdictions and their recognition of U.S. group-wide supervision.

7. **List of Jurisdictions that Recognize and Accept the GCC.** The Mutual Recognition of Jurisdictions (E) Working Group will evaluate non-U.S. jurisdictions in accordance with this “Recognize and Accept” Process. A list of “Recognize and Accept” Jurisdictions is published through the NAIC committee process (“NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation”; “Recognize and Accept’ List”; or “List”). The creation of the List does not constitute a delegation of regulatory authority to the NAIC. Although a state must consider this List under Section 21E(3) of Model #450 in its determination of whether a non-U.S. insurance group is exempt from filing an annual GCC, the List is not binding and the ultimate authority to designate a “Recognize and Accept” Jurisdiction resides solely in each state.

(a) The List will include all Reciprocal Jurisdictions that recognize the U.S. state regulatory approach to group supervision and group capital. [See discussion in paragraph 9].

(b) The evaluation of non-U.S. jurisdictions that are non-Reciprocal Jurisdictions as “Recognize and Accept” Jurisdictions will be conducted in accordance with the provisions of Section 4L(2) of Model #440 and Section 21 of Model #450, and any other relevant guidance developed by the NAIC. [see discussion in paragraphs 10 and 11].

(c) As specified in Section 21E(1) of Model #450, the List will also identify which “Recognize and Accept” Jurisdictions require a group capital filing for a U.S.-based insurance group’s operations in that jurisdiction. [See discussion of Subgroup Capital Calculation in paragraph 12].

(d) Upon final inclusion of a jurisdiction on the List, any confidential documents reviewed by the Mutual Recognition of Jurisdictions (E) Working Group in its evaluation of the jurisdiction will be made available to individual U.S. state insurance regulators upon request and confirmation that the information contained therein will remain confidential. The NAIC will maintain the List on its public website and in other appropriate NAIC publications.

(e) If a non-US group’s lead state exempts the group from the GCC, and the group-wide supervisor is based in a jurisdiction that is not on the “Recognize and Accept” List, the state must thoroughly document the justification for the exemption.
8. **Procedure for Evaluation of Non-U.S. Jurisdictions.** In undertaking the evaluation of a non-U.S. Jurisdiction for inclusion on the “Recognize and Accept” List, the Mutual Recognition of Jurisdictions (E) Working Group shall utilize similar processes and procedures to those outlined in the *Process for Evaluating Qualified and Reciprocal Jurisdictions*. Specifically, the Working Group will undertake the following procedure in making its evaluation:

(a) **Initiation of Evaluation.** Formal notification of the Mutual Recognition of Jurisdictions (E) Working Group’s intent to initiate the evaluation process will be sent by the NAIC to the supervisory authority in the jurisdiction selected. The process of evaluation and all related documentation are private and confidential matters between the NAIC and the applicant jurisdiction, unless otherwise provided in this document. Upon receipt of confirmation by a competent regulatory authority of the non-U.S. jurisdiction, the Mutual Recognition of Jurisdictions (E) Working Group:

   i. Will review the materials received from the jurisdiction.

   ii. Will issue public notice on the NAIC website inviting public comments with respect to consideration of the jurisdiction as a “Recognize and Accept” Jurisdiction.

   iii. Will consider public comments from state regulators, U.S. insurance groups, and any other interested parties.

   iv. May review other public materials deemed relevant to making a determination.

   v. Will invite each non-U.S. jurisdiction, or its designee, to provide any additional information it deems relevant to making a determination.

   vi. Relevant U.S. state and federal authorities will be notified of the Mutual Recognition of Jurisdictions (E) Working Group’s decision to evaluate a jurisdiction.

(b) **Preliminary Evaluation Report.** NAIC staff will prepare a Preliminary Evaluation Report for review by the Mutual Recognition of Jurisdictions (E) Working Group. The report will contain a recommendation as to whether the NAIC should recognize the jurisdiction as a “Recognize and Accept” Jurisdiction. Upon review by the Working Group, the results of the Preliminary Evaluation Report will be immediately communicated in written form to the supervisory authority of the jurisdiction under review. At that time, a copy of the Preliminary Evaluation Report will also be shared with the Group Capital Calculation (E) Working Group in regulator-to-regulator session. The Group Capital Calculation (E) Working Group will also be kept advised of any new developments in the evaluation of this jurisdiction.

(c) **Final Evaluation Report.** Upon receipt of the Preliminary Evaluation Report, the
supervisory authority will have an opportunity to respond to the initial findings and determination. The Mutual Recognition of Jurisdictions (E) Working Group will consider any response, and will proceed to prepare its Final Evaluation Report. The Working Group will consider the Final Evaluation Report for approval in regulator-to-regulator session.

(d) **Summary of Findings and Determination.** Upon approval of the Final Evaluation Report, the Mutual Recognition of Jurisdictions (E) Working Group will issue a public statement and a summary of its findings with respect to its determination. At this time, the Working Group will release the Summary of Findings and Determination for public comment. Once the Working Group has finally adopted the Summary of Findings and Determination in open session after opportunity for public comment, it will submit the summary of its findings and its recommendation to the Financial Condition (E) Committee at an open meeting. Upon approval by the Committee, the summary and recommendation will be submitted to the Executive (EX) Committee and Plenary, as well as to the Federal Insurance Office (FIO), United States Trade Representative (USTR) and other relevant federal authorities for consultation purposes. Upon approval as a “Recognize and Accept” Jurisdiction by the Executive (EX) Committee and Plenary, the jurisdiction will be added to the NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation.

9. **Evaluation of Reciprocal Jurisdictions.** Under Section 4L(2)(c) of Model #440, Reciprocal Jurisdictions that recognize the U.S. state regulatory approach to group supervision and group capital are exempt from the GCC. Because a “recognize and accept” evaluation by the Mutual Recognition of Jurisdictions (E) Working Group is already part of the Reciprocal Jurisdiction review process, all Reciprocal Jurisdictions designated by the NAIC through that review process are also automatically designated as “Recognize and Accept” Jurisdictions. Likewise, in accordance with the terms of the EU and UK Covered Agreements, all EU States and the UK are automatically designated “Recognize and Accept” Jurisdictions. If there is a material change to the terms of either Covered Agreement, or the United States enters into a new covered agreement with one or more non-U.S. jurisdictions, the Mutual Recognition of Jurisdictions (E) Working Group will rely upon its review and evaluation of the applicable covered agreement, in consultation with FIO and USTR, to determine whether automatic “Recognize and Accept” status is appropriate, or whether it is necessary to conduct a case-by-case review of the jurisdiction or jurisdictions in accordance with Paragraph 10 below.

10. **Evaluation of Non-Reciprocal Jurisdictions with U.S. Insurance Group Operations.** Under Section 21D(1)(a) of Model #450, a non-Reciprocal Jurisdiction, in which a U.S. insurance group has operations, that recognizes the U.S. state regulatory approach to group supervision and group capital may be included on the NAIC “Recognize and Accept” List. The Mutual Recognition of Jurisdictions (E) Working Group may rely on written confirmation by a competent regulatory authority in that jurisdiction that insurers and insurance groups whose lead state is accredited by the NAIC under the
NAIC Accreditation Program shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction. The process outlined in this Paragraph will also apply to a jurisdiction that is a Reciprocal Jurisdiction by virtue of a covered agreement, if the Mutual Recognition of Jurisdictions (E) Working Group has determined that the

(a) The Mutual Recognition of Jurisdictions (E) Working Group will perform a due diligence review of available public and confidential documents to confirm that to the best of its determination the representations in the written confirmation are true and accurate.

(b) The jurisdiction must also have an acceptable Memorandum of Understanding to be included on the “Recognize and Accept” List, as described in paragraph 12 of this Process.

(c) NAIC staff will work with the Mutual Recognition of Jurisdictions (E) Working Group and the applicant jurisdiction to prepare an acceptable confirmation letter for this purpose. The NAIC will publish a form letter that a competent regulatory authority of a non-U.S. jurisdiction may use to provide confirmation pursuant to Section 21(D)(1)(a), Section 21(D)(1)(b) and 21(D)(2) of Model #450 as well as a template letter that any “Recognize and Accept” Jurisdiction, including a Reciprocal Jurisdiction, may use to provide confirmation, pursuant to Section 21(E)(1) of Model #450, as to whether or not it requires a group capital filing for any U.S. based insurance group’s operations. NAIC Staff will work with the jurisdiction to modify these forms if necessary for a particular jurisdiction.

11. Evaluation of Non-Reciprocal Jurisdictions with No U.S. Insurance Group Operations. Because the GCC embraces and encourages the concepts of mutual recognition and one group/one group-wide supervisor, a non-U.S. jurisdiction may be included on the “Recognize and Accept” List, enabling its insurance groups to do business in the U.S. without being subject to U.S group-wide supervision, even if no U.S. groups operate in that jurisdiction. Under Section 21D(1)(b) of Model #450, such a jurisdiction must document its recognition and acceptance by indicating formally in writing to the lead state of each of its insurance groups doing business in the U.S., with a copy to the International Association of Insurance Supervisors (IAIS), that the GCC is an acceptable international capital standard. The Mutual Recognition of Jurisdictions (E) Working Group may rely on written confirmation by a competent regulatory authority in that jurisdiction.

(a) The Mutual Recognition of Jurisdictions (E) Working Group will perform a due diligence review of available public and confidential documents to confirm that, to the best of its determination, the representations in the written confirmation are true and accurate.
(b) The jurisdiction must also have an acceptable Memorandum of Understanding to be included on the “Recognize and Accept” List, as described in paragraph 12 of this Process.

(c) NAIC staff will work with the Mutual Recognition of Jurisdictions (E) Working Group and the applicant jurisdiction to prepare an acceptable confirmation letter for this purpose.

12. Memorandum of Understanding. Section 21D(2) of Model #450 requires a non-Reciprocal Jurisdiction that “recognizes and accepts” the GCC to provide confirmation by a competent regulatory authority that information regarding insurers, and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the lead state commissioner in accordance with a memorandum of understanding or similar document between the commissioner and the jurisdiction. Acceptable MOUs include, but are not limited to, the International Association of Insurance Supervisors Multilateral Memorandum of Understanding (“IAIS MMoU”) or other multilateral memoranda of understanding coordinated by the NAIC. The Mutual Recognition of Jurisdictions (E) Working Group will review such memoranda of understanding and include an opinion in the Summary of Findings and Determination as to whether the jurisdiction has met this condition to be included on the “Recognize and Accept” List.

(a) The lead state will act as a conduit for information between the “Recognize and Accept” Jurisdiction and other states that have an insurer from that jurisdiction, and will share information with these states consistent with the terms governing the further sharing of information included in the applicable MOU, and pursuant to the NAIC Master Information Sharing and Confidentiality Agreement. The jurisdiction must also confirm in writing that it is willing to permit this lead state to act as the contact for purposes of obtaining information concerning insurers.

(b) If a jurisdiction has not been approved by the IAIS as a signatory to the MMoU, it must enter into an MOU with the lead state. The MOU will also provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions.

(c) The same requirements and procedures will apply to a Reciprocal Jurisdiction that is subject to a case-by-case “recognize and accept” review, unless the necessary information-sharing procedures are already specified in the applicable covered agreement.

13. Prudential Oversight and Solvency Monitoring. Section 4L(2)(e) of Model #440 directs a lead state commissioner to require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system based in a “Recognize and Accept” Jurisdiction if, after any necessary consultation with other supervisors or officials, the commissioner deems such a “subgroup”
calculation to be appropriate for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace. Section 21E(1) of Model #450 provides that to assist with such a determination, the “Recognize and Accept” List will also identify whether a listed jurisdiction requires a group capital filing for any U.S. based insurance group’s operations in that jurisdiction. The Mutual Recognition of Jurisdictions (E) Working Group will perform a due diligence review of available public and confidential documents to confirm whether or not any “Recognize and Accept” Jurisdiction requires a subgroup group capital filing for a U.S.-based insurance group’s operations, and will attempt to obtain written confirmation from a competent regulatory authority in any such jurisdiction. The NAIC will identify such jurisdictions on the “Recognize and Accept” List. States may rely on this List when making determinations under Section 4L(2)(e) of Model #440.

14. Process for Periodic Evaluation. The process for determining whether a non-U.S. jurisdiction is a “Recognize and Accept” Jurisdiction is ongoing and subject to periodic review. The Mutual Recognition of Jurisdictions (E) Working Group will perform a yearly review of the NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation to determine whether there have been any significant changes over the prior year that might affect inclusion on the List. This yearly review shall follow such abbreviated process as may be determined by the Working Group to be appropriate.

(a) Upon determination by a lead state commissioner that a non-U.S. jurisdiction no longer meets one or more of the requirements to “recognize and accept” the GCC, the lead state commissioner may provide a recommendation to the Working Group that the jurisdiction be removed from the “Recognize and Accept” List. Upon review and after consultation with the “Recognize and Accept” Jurisdiction, the Working Group may remove the jurisdiction from the List, which must then be confirmed by the Financial Condition (E) Committee and the NAIC Executive (EX) Committee and Plenary.

(b) Upon determination by a lead state commissioner that a non-U.S. jurisdiction requires a group capital filing for any U.S. based insurance group’s operations in that non-U.S. jurisdiction, the lead state commissioner may provide a recommendation to the Working Group that the non-U.S. jurisdiction be identified as such on the “Recognize and Accept” List. Upon receipt of any such notice, the Mutual Recognition of Jurisdictions (E) Working Group will also consider whether it is necessary to re-evaluate the jurisdiction’s “Recognize and Accept” status.

(c) The Mutual Recognition of Jurisdictions (E) Working Group will also give due consideration to any notice from a U.S.-based insurance group that it has been required to perform a group capital calculation, at either the group-wide or subgroup level, in a jurisdiction on the “Recognize and Accept” List.
(d) If a jurisdiction referred for re-evaluation under this Paragraph is a Reciprocal Jurisdiction, the Mutual Recognition of Jurisdictions (E) Working Group shall conduct a concurrent review of the jurisdiction’s continuing status as a Reciprocal Jurisdiction, or, in the case of a jurisdiction entitled to that status by virtue of a covered agreement, shall refer the matter to the Reinsurance (E) Task Force for further discussion and communication with appropriate federal and/or international authorities, in accordance with the Process for Evaluating Qualified and Reciprocal Jurisdictions.
Appendix: Letter Templates

Paragraph 10(c) of the *Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation* provides that the NAIC will publish a form letter that a competent regulatory authority of a non-U.S. jurisdiction that is not a Reciprocal Jurisdiction may use to provide confirmation pursuant to Section 21(D)(1)(a), Section 21(D)(1)(b) and 21(D)(2) of the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)*, as well as a template letter that any “Recognize and Accept” Jurisdiction, including a Reciprocal Jurisdiction, may use to provide confirmation, pursuant to Section 21(E)(1) of Model #450, as to whether or not it requires a group capital filing for any U.S. based insurance group’s operations. The following template letters are designed to satisfy these requirements:

A. **Jurisdictions with U.S. Insurance Group Operations.** In order to satisfy the requirements of Sections 21D(1)(a) and 21D(2) of Model #450, the competent regulatory authority of a non-U.S. Jurisdiction in which U.S. insurance groups operate shall provide the NAIC with a written letter, confirming, as follows:

As the competent regulatory authority for [non-U.S. Jurisdiction], I hereby confirm to the National Association of Insurance Commissioners (NAIC) and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories the following:

- [Non-U.S. Jurisdiction] recognizes the U.S. state regulatory approach to group supervision and group capital, and confirms that that insurers and insurance groups whose lead state is accredited by the NAIC under the NAIC Accreditation Program shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction;

- Information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to a lead state commissioner in accordance with a memorandum of understanding or similar document between the commissioner and [non-U.S. Jurisdiction], including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC.

- [Non-U.S. Jurisdiction] will immediately notify the NAIC upon any changes to the assurances provided in this letter.
B. Jurisdictions with No U.S. Insurance Group Operations. In order to satisfy the requirements of Sections 21D(1)(b) and 21D(2) of Model #450, the competent regulatory authority of a non-U.S. Jurisdiction in which no U.S. insurance groups operate shall provide the NAIC with a written letter, confirming, as follows:

As the competent regulatory authority and lead insurance regulatory supervisor for [non-U.S. Jurisdiction], I hereby confirm to the National Association of Insurance Commissioners (NAIC) and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories the following:

- [Non-U.S. Jurisdiction] recognizes the Group Capital Calculation as defined under Section 4L(2) of the NAIC Insurance Holding Company System Regulatory Act (#440) as an acceptable international capital standard.

- Information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to a lead state commissioner in accordance with a memorandum of understanding or similar document between the commissioner and [non-U.S. Jurisdiction], including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC.

- [Non-U.S. Jurisdiction] will immediately notify the NAIC upon any changes to the assurances provided in this letter.

C. Jurisdictions with Subgroup Capital Requirements. Paragraph 13 of the Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation provides that the Mutual Recognition of Jurisdictions (E) Working Group will attempt to obtain written confirmation from a competent regulatory authority in any jurisdiction where the Working Group has evidence indicating that the jurisdiction requires a subgroup group capital filing for any U.S. based insurance group’s operations in that jurisdiction. The NAIC will identify such jurisdictions on the “Recognize and Accept” List. States may rely on this List when making determinations under Section 4L(2)(e) of Model #440.
The NAIC/AICPA (E) Working Group of the Financial Condition (E) Committee conducted an e-vote that concluded May 17, 2021. The following Working Group members participated: Laura Clements (CA); Rylynn Brown (DE); Kevin Clark (IA); Judy Weaver (MI); Shannon Schmoegeer (MO); Doug Bartlett (NH); Dale Bruggeman (OH); and Greg Lathrop (OR).

1. **Adopted Revisions to the Implementation Guide**

The Working Group recently developed and exposed proposed revisions to the NAIC’s *Implementation Guide for the Annual Financial Reporting Model Regulation* (Implementation Guide) to facilitate the collection of information on the engagement partner leading the annual external audit of insurance entities. The revisions request that the lead engagement partner’s name and start date be provided in the annual internal control letter filed with the domestic insurance department to facilitate a review of engagement partner rotation and qualification requirements.


Having no further business, the NAIC/AICPA (E) Working Group adjourned.

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The National Treatment and Coordination (E) Working Group of the Financial Condition (E) Committee met July 14, 2021. The following Working Group members participated: Debbie Doggett, Co-Chair (MO); Linda Johnson, Co-Chair (WY); Cindy Hathaway (CO); Joan Nakano and William Mitchell (CT); Alisa Pritchard (DE); Jason Reynolds (FL); Stewart Guerin and Mike Boutwell (LA); Kari Leonard (MT); Ursula Almada (NM); Cameron Piatt (OH); Greg Lathrop (OR); Cressinda Bybee (PA); Amy Garcia (TX); Jay Sueoka (UT); Ron Pastuch (WA); and Amy Malm (WI).

1. **Adopted its May 13 Minutes**

Ms. Doggett noted a few items for correction on the minutes: 1) items 1 and 2 need to be changed from adopted to discussed; and 2) item 5 includes a typo for “stipulates” to be changed to “stipulate.”

Mr. Lathrop made a motion, seconded by Mr. Piatt, to adopt the Working Group’s May 13 minutes with edits (Attachment Eight-A). The motion passed unanimously.

2. **Adopted Proposal 2021-01 (Primary Application and Instructions)**

Ms. Doggett summarized the comments received on proposal 2021-01 to modify the primary application for start-up company applications. Pennsylvania submitted comments that were incorporated into the current proposal, which included: 1) changing the order on Form 2 for Company Type and Sub-Type to mirror the order on the NAIC company code application form; 2) using the most current Form 3 Lines of Business form; and 3) including the word “notification” on page 51 of the materials.

Ms. Doggett added that further modifications were made to the instructions included on the agenda to indicate that if an application is deemed incomplete, a status will be provided by the application state with an explanation and instructions that the Applicant Company will be allowed to withdraw its application. She added that as work continues on the development of the electronic application, the instructions may be modified to include those enhancements, and those changes will be brought before the Working Group for consideration.

Mr. Piatt made a motion, seconded by Mr. Guerin, to adopt proposal 2021-01 (Attachment Eight-B) with suggested wording. The motion passed unanimously.

3. **Adopted Proposal 2021-02 (Redomestication Application and Instructions)**

Ms. Johnson summarized that proposal 2021-02 is in conjunction with the changes made to the primary application, to separate the redomestication application into its own application. She added that no comments were received on this proposal during the comment period.

Mr. Guerin made a motion, seconded by Mr. Lathrop, to adopt proposal 2021-02 (Attachment Eight-C). The motion passed unanimously.

4. **Adopted Proposal 2021-05 (Form A Review Guidance)**

Ms. Doggett summarized the purpose of proposal 2021-05 to add additional guidance when reviewing the articles of incorporation and limited partnership agreements for complex Form A transactions to determine the ultimate controlling party when not evident in the Form A filing regarding private equity type entities.

Mr. Guerin made a motion, seconded by Ms. Nakano, to adopt proposal 2021-05 (Attachment Eight-D). The motion passed unanimously.
5. Exposed Proposal 2021-06 (Disclaimer Form)

Ms. Johnson said the purpose of proposal 2021-06 is to provide a template for a disclaimer of affiliation or control of an individual, resulting from a survey conducted last fall regarding the primary application, where several states indicated that they allow a disclaimer in lieu of a biographical affidavit. This uniform template will be identified as Form 9, and it will be exposed for a 45-day public comment period ending Aug. 30. Ms. Johnson also noted that prior to exposure, clarifying language will be included in the heading of the proposal to identify that the use of this form is just for individuals.

6. Heard Updates on Ad Hoc Groups

Jane Barr (NAIC) said the NAIC is currently working on negotiations with third-party vendors to assist with the development of the electronic applications. She added that she will provide an update on the next scheduled meeting tentatively scheduled for mid-September.

Crystal Brown (NAIC) reported that the Surplus Lines Drafting Group met June 28 to review and discuss domestic surplus line statutes and regulations and comments submitted on a recent survey to develop a reference chart for industry and state use.

7. Discussed Other Matters

Ms. Barr said she received an email asking states to consider moving towards the elimination of hard copy requirements for their public records. With the development of the electronic application and tools available to the state insurance regulators, the need for hard copies could be greatly reduced. For those states whose statutes reference hard copy required, they may want to consider changing their wording to reference “original” since the term “original” could mean electronic filing.

Ms. Johnson said a Company Licensing Forum call will be scheduled for Aug. 25 to discuss these requirements. Ms. Barr added that she has been requested to add the new risk retention group (RRG) forms to the Forum agenda for those states that may be unaware of their existence.

The next Working Group meeting is tentatively set for September.

Having no further business, the National Treatment and Coordination (E) Working Group adjourned.
The National Treatment and Coordination (E) Working Group of the Financial Condition (E) Committee met May 13, 2021.

The following Working Group members participated: Debbie Doggett, Co-Chair (MO); Linda Johnson, Co-Chair (WY); Cindy Hathaway (CO); Joan Nakano and William Mitchell (CT); Alisa Pritchard (DE); Jason Reynolds (FL); Stewart Guerin and Mike Boutwell (LA); Kari Leonard (MT); Cameron Piatt (OH); Greg Lathrop (OR); Cressinda Bybee (PA); Robert Rudnai (TX); Jay Sueoka (UT); Ron Pastuch (WA); and Amy Malm (WI).

1. Discussed Proposal 2021-01 (Primary Application and Instructions)

Ms. Doggett summarized the purpose of proposal 2021-01 is to modify the primary application for start-up company applications only. All references to a redomestication were removed, and new forms were created to capture management information (Form 4P) and holding company debt to equity information (Form 5P). Ms. Doggett added that the proposal was exposed for a 45-day public comment period ending April 19. One minor editorial comment was made and is reflected in the PDF posted to the Working Group’s web page, which was to change the dollar sign to a percent sign on Question 6 of Form 8 (Questionnaire).

Janet Shemanske (Nautilus) asked whether traditional insurers should be listed in the section identified as “Applicant Company Formed As.” Ms. Doggett said during the last call, it was noted that other states use the Uniform Certificate of Authority Application (UCAA) forms to license other risk-bearing entities. Jane Barr (NAIC) confirmed this information will eventually be carried over to the company code application form when a primary application is approved, and the company is eligible for an NAIC company code. Mr. Boutwell said more states are moving forward with domestic surplus lines, Louisiana being one of those states. Ms. Doggett said it would depend on state law and whether the company becomes licensed as a property/casualty (P/C) insurer and then eventually writes as a surplus lines carrier. Lisa Brown (American Property Casualty Insurance Association—APCIA) asked whether the Applicant Company Formed As section should be clarified for traditional insurers because the list seems to include other non-traditional company types. Ms. Barr explained when the states were surveyed, they indicated the type of entities that could submit UCAA forms based on the list provided on the company code application. She further explained, this information would eventually populate into the company code application form. Ms. Shemanske asked for confirmation that this section may not need to be completed if the applicant company is a traditional insurer. Ms. Barr concurred and reiterated that the proposal was exposed for a 45-day public comment period, and no comments were submitted. The Working Group may want to consider re-exposure if additional edits are suggested.

Ms. Doggett said clarification is needed for the Applicant Company Formed As section. Ms. Malm concurred that clarification is needed so the section is completed, if necessary. Mr. Boutwell suggested adding “if applicable” in parentheses if other than a traditional insurer. Ms. Doggett said it could go at the beginning or end of the section in parenthetical. Ms. Johnson asked whether all insurance types should be listed. Mr. Boutwell said the company code application is labeled “company subtype” and includes the option for none. Ms. Doggett suggested changing the heading to mirror the company code application and adding an option for none. Ms. Barr said she will make the appropriate edits and circulate them to the Working Group members before sending the notice for re-exposure. She suggested a 30-day public comment period to give interested parties ample time to review and submit their comments timely. Ms. Barr reminded the Working Group that proposal 2021-02, which is the next item to consider, should have the same effective date as proposal 2021-01.

2. Discussed Proposal 2021-02 (Redomestication Application and Instructions)

Ms. Johnson summarized that proposal 2021-02 is in conjunction to the changes made to the original primary application, which combined both redomestication and start-up applications on one form. The two applications have been separated, and the focus of the redomestication application is for the initial application between the old and new domiciliary states. Although the forms may look similar, the redomestication forms will be identified with an “R” on each form page (e.g., 1R, 2R, etc.). Ms. Johnson said the redomestication application and instructions were also exposed for a 45-day public comment period ending April 19, and no comments were received. Ms. Shemanske asked whether the instructions should state that a rigorous review is required if the company is already licensed in the state where it plans to redomesticate. Mr. Piatt said Ohio would do a rigorous review because there could be several years between the initial application and the redomestication. Ms. Malm concurred Wisconsin would do the same to ensure that there is no regulatory arbitrage taking place.
The Working Group agreed to table consideration until the primary application is ready to be considered.

3. **Adopted Proposal 2021-03 (Cybersecurity Contact)**

Mr. Boutwell summarized that the purpose of proposal 2021-03 is to include a cybersecurity contact due to the recent adoption of a cybersecurity model law, and this contact information may be useful to the state insurance regulators for speed in contacting the appropriate person. He noted this addition to the list of company contacts on Form 14 may not necessitate an exposure period before consideration by the Working Group.

Ms. Boutwell made a motion, seconded by Mrs. Malm, to adopt proposal 2021-03 (Attachment Eight-A1). The motion passed unanimously.

Ms. Barr added once it is adopted by the Financial Condition (E) Committee, the developers will begin programming this update into the electronic application.

4. **Adopted Proposal 2021-04 (Biographical Affidavit Cover Letter)**

Ms. Johnson said the purpose of proposal 2021-04 is to ensure: 1) the biographical affidavit could be used for more than one application/purpose if the affiant’s signature is not more than six months old; and 2) the biographical affidavit form is not modified in any way to suit the applicant company’s purpose for submission.

Ms. Johnson further explained the cover letter allows information for holding company groups where an affiant may hold a position for multiple companies in a group. If the applicant company is using an affidavit, where the signature is less than six months old, for multiple company applications, the cover letter could be updated for a particular application if the affiant information on the biographical affidavit has not been updated/changed. The cover letter will need to be updated and signed by the applicant company contact for every application submission, and each biographical affidavit will need its own cover letter. Ms. Johnson added that proposal 2021-04 was exposed for a 45-day public comment period ending May 5, and no comments were received.

Ms. Brown asked how companies reuse a biographical affidavit when the applicant company information is changed without requiring a new signature and notarization. Ms. Barr explained the applicant company information on the cover letter should be updated to reflect which company within the group listed submitted the biographical affidavit. Ms. Brown asked whether one affiant can be submitted for multiple companies within the same group. Ms. Barr concurred. Mr. Boutwell said his state would expect to see “see attached” in reference to the applicant company name in the header of the biographical affidavit. Ms. Brown asked whether the UCAA chart reflects the only states that would allow this cover letter for multiple submissions within a group. Ms. Barr said once adopted, she will reach out to the states for confirmation and make the updates to the state charts accordingly.

Mr. Rudnai made a motion, seconded by Mr. Lathrop, to adopt proposal 2021-04 (Attachment Eight-A2). The motion passed unanimously.

5. **Discussed Form A – Private Equity Company**

Ms. Doggett said Missouri has received several Form A applications from private equity (PE) companies, and during the review of the operating agreements, partnership agreements, and articles of incorporation, it was determined the ultimate controlling party was different than the individual/party identified when the Form A was submitted. She suggested the Company Licensing Best Practices Handbook stipulate the importance of the review of operational agreements to identify the ultimate controlling party. She said she will work with NAIC staff to draft wording.

The next Working Group meeting is tentatively set for July.

Having no further business, the National Treatment and Coordination (E) Working Group adjourned.
National Treatment and Coordination (E) Working Group

Company Licensing Proposal Form

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<td>Asst. Deputy Commissioner</td>
<td>[ ] EXPOSED</td>
</tr>
<tr>
<td>AFFILIATION:</td>
<td>[ ] OTHER (SPECIFY)</td>
</tr>
<tr>
<td>Louisiana Dept. of Insurance</td>
<td>[ ]</td>
</tr>
<tr>
<td>ADDRESS:</td>
<td>[ ]</td>
</tr>
<tr>
<td>1702 N. 3rd St.</td>
<td></td>
</tr>
<tr>
<td>Baton Rouge, LA 70802</td>
<td></td>
</tr>
</tbody>
</table>

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

- UCAA Forms
- UCAA Instructions
- Enhancement to the Electronic Application Process
- Company Licensing Best Practices HB
- Forms:
  - Form 1 – Checklist
  - Form 6 - Certificate of Compliance
  - Form 8C- Corporate Amendment Questionnaire
  - Form 11-Biographical Affidavit
  - Form 12-Uniform Consent to Service of Process
  - Form 13- ProForma
  - Form 14- Change of Address/Contact Notification
  - Form 15 – Affidavit of Lost C of A
  - Form 16 – Voluntary Dissolution
  - Form 17 – Statement of Withdrawal

DESCRIPTION OF CHANGE(S)

Adding a contact type of "Cybersecurity Contact" with an explanation of "A person for the state departments to contact regarding data security and data breaches" to page 1 of Form 14

REASON OR JUSTIFICATION FOR CHANGE **

With the adoption of a cybersecurity model law and the current posture of the industry in electronic records, the addition of this contact might be useful for state regulators and help to save time in contacting the appropriate person.

Additional Staff Comments:

** This section must be completed on all forms. Revised 01-2019
Uniform Certificate of Authority Application (UCAA)
CHANGE OF MAILING ADDRESS/CONTACT NOTIFICATION FORM

NAME CHANGE

If there has been a name change, please complete the following:

Previous Applicant Company Name: ________________________________________________
Current Applicant Company Name: ________________________________________________

MAILING ADDRESS/CONTACT CHANGE

If there has been a mailing address or contact person change, please complete the following:

This form will notify regulatory officials of mailing address changes or contact person changes applicable to the Applicant Company or it may be completed as a supplemental filing in conjunction with other corporate amendment filings. Additional corporate amendment filings are required for Statutory Home Office, changes to articles or by-laws or for changes in the addresses related to the person authorized to receive Service of Process. These changes require a Corporate Amendment Application or a Uniform Consent to Service of Process. Check state specific requirements. For each change, please indicate the one or more areas for which the change is applicable:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catastrophe/Disaster Coordination Contact</td>
<td>A contact person for state departments to contact for information if there is a catastrophe or disaster.</td>
</tr>
<tr>
<td>Claim Information Contact</td>
<td>A contact person for the public to contact for claim information.</td>
</tr>
<tr>
<td>Consumer Complaints Contact</td>
<td>A contact person for state consumer complaint staff to contact for resolution of complaints filed with the state department.</td>
</tr>
<tr>
<td>Cybersecurity Contact</td>
<td>A contact person for the state departments to contact regarding data security and data breaches.</td>
</tr>
<tr>
<td>External Healthcare Review Contact</td>
<td>A contact person for state departments to initiate the external healthcare review process.</td>
</tr>
<tr>
<td>Form and/or Rate Filings Contact</td>
<td>A person for state departments to contact regarding issues on policy forms filings or rate filings.</td>
</tr>
<tr>
<td>Fraud Assessment Invoice Contact</td>
<td>A person for state departments to contact regarding issues of payment of fraud assessments.</td>
</tr>
<tr>
<td>Local Office in Domestic/Foreign State Contact</td>
<td>A person for the public or state departments to contact.</td>
</tr>
<tr>
<td>Managing General Agent</td>
<td>A person for the public or state departments to contact.</td>
</tr>
<tr>
<td>Market Conduit Contact</td>
<td>A person for state departments to contact regarding market conduct issues.</td>
</tr>
<tr>
<td>Policyholder Information Contact</td>
<td>A person for the public to contact.</td>
</tr>
<tr>
<td>Producer Licensing Contact (Appointment)</td>
<td>A person for state departments to contact regarding issues of producer licensing or appointments of agents.</td>
</tr>
<tr>
<td>Regulatory Compliance/Government Relations Contact</td>
<td>A person for state departments to contact on matters related to regulation but unrelated to public complaints filed with the state department.)</td>
</tr>
<tr>
<td>Premium Tax Contact</td>
<td>A person for state departments to contact regarding issues of payment of premium tax.</td>
</tr>
<tr>
<td>Company Licenses/Fees Contact</td>
<td>A person for state departments to contact regarding issues of payment of license fees.</td>
</tr>
<tr>
<td>Deposits Contact</td>
<td>A person for state departments to contact regarding statutory deposits.</td>
</tr>
<tr>
<td>U.S. Legal Counsel (for aliens)</td>
<td>A person for state departments to contact.</td>
</tr>
<tr>
<td>Annual Statement Contact</td>
<td>A contact person responsible for answering questions in the completion of the annual statement.</td>
</tr>
</tbody>
</table>
Applicant Company Name: ____________________________________________  NAIC No. ____________________

Company Mailing Address

A change to the mailing address of the company.

NEW CONTACT

Contact Name: _______________________________________________________________________________________

Title: ______________________________________________________________________________________________

Address: ___________________________________________________________________________________________

Phone #: ______________________ Fax #: ___________________  Toll Free/Instate Phone #: _______________________

E-Mail Address: ______________________________________________________________________________________

Previous Contact Name (if changed): ___________________________________________________________________

Entity Name of MGA (if contact or address changed): _______________________________________________________

Note: If there are multiple contacts in different locations, please attach a separate sheet with all pertinent information for each.

NEW MAILING ADDRESS

Address: ___________________________________________________________________________________________

Address 2: __________________________________________________________________________________________

Suite/Mail Stop: ____________________________

City: ____________________________________ State: _________________ Zip Code: _________________________

Email: ____________________________________ Toll Free/Instate Phone #: __________________________

Main Administrative Office Phone Number: ____________________________ Fax: ________________________________

________________________________________  __________________________________________

Signature of Preparer  Date of Preparation

________________________________________

Typed or Printed Name  Title of Preparer

________________________________________

Phone Number of Preparer  Email Address of Preparer
National Treatment and Coordination (E) Working Group

Company Licensing Proposal Form

DATE: April 19, 2021

CONTACT PERSON: Jane Barr
TELEPHONE: ________________________________
EMAIL ADDRESS: jbarr@naic.org
ON BEHALF OF: National Treatment & Coordination (E) Working Group
NAME: ________________________________
TITLE: ________________________________
AFFILIATION: ________________________________
ADDRESS: ________________________________

FOR NAIC USE ONLY
Agenda Item # 2021-04
Year 2021

DISPOSITION
[ ] ADOPTED
[ ] REJECTED
[ ] DEFERRED TO
[ ] REFERRED TO OTHER NAIC GROUP
[ X ] EXPOSED May 5, 2021
[ ] OTHER (SPECIFY)

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

[ ] UCAA Forms    [ ] UCAA Instructions    [ ] Enhancement to the Electronic Application Process
[ ] Company Licensing Best Practices HB

Forms:
[ ] Form 1 – Checklist    [ ] Form 2 - Application    [ ] Form 3 – Lines of Business
[ ] Form 6- Certificate of Compliance    [ ] Form 7 – Certificate of Deposit    [ ] Form 8 - Questionnaire
[ ] Form 8C- Corporate Amendment Questionnaire    [ X ] Form 11-Biographical Affidavit
[ ] Form 12-Uniform Consent to Service of Process    [ ] Form 13- ProForma    [ ] Form 14- Change of Address/Contact Notification
[ ] Form 15 – Affidavit of Lost C of A    [ ] Form 16 – Voluntary Dissolution    [ ] Form 17 – Statement of Withdrawal

DESCRIPTION OF CHANGE(S)
Create a template for a cover letter to accompany the biographical affidavit when the Applicant Company is part of a Holding Company and the affidavit is used for more than one applicant company and the affiant’s signature date is 6 months or less.

REASON OR JUSTIFICATION FOR CHANGE **
The purpose is to clarify that the Applicant Company cannot make any changes to the biographical affidavit once it is signed by the affiant, if the Applicant Company intends to use it for more than one insurer’s (within the same group) application.

Additional Staff Comments:

** This section must be completed on all forms. Revised 01-2019
Uniform Certificate of Authority Application (UCAA)

BIOGRAPHICAL AFFIDAVIT COVER LETTER

HOLDING COMPANY STRUCTURE

Affiant Name:  ________________________________________________________________

Group Name:  ________________________________________________________________

Group Code:  ________________________________________________________________

Purpose of Affidavit:  __________________________________________________________

Applicant Company:  __________________________________________________________

Insurers listed under group code:

<table>
<thead>
<tr>
<th>Company Name and Address</th>
<th>NAIC Cocode</th>
<th>Position with the Company</th>
<th>Effective Date of Position</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Applicant Company Representative Contact Information:

Name:  ________________________________________________________________

Title:  ________________________________________________________________

Phone:  ________________________________________________________________

Email:  ________________________________________________________________

Signature:  _____________________________________________________________

Signature Date:  _______________________________________________________
Addendum Page for additional insurers listed under group code:

<table>
<thead>
<tr>
<th>Company Name and Address</th>
<th>NAIC Cocode</th>
<th>Position with the Company</th>
<th>Effective Date of Position</th>
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<tbody>
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</table>
Addendum Page for additional insurers listed under group code:

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<th>NAIC Cocode</th>
<th>Position with the Company</th>
<th>Effective Date of Position</th>
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</tr>
</tbody>
</table>
**National Treatment and Coordination (E) Working Group**

**Company Licensing Proposal Form**

<table>
<thead>
<tr>
<th>CONTACT PERSON:</th>
<th>Jane Barr</th>
</tr>
</thead>
<tbody>
<tr>
<td>TELEPHONE:</td>
<td>816-783-8413</td>
</tr>
<tr>
<td>EMAIL ADDRESS:</td>
<td><a href="mailto:jbarr@naic.org">jbarr@naic.org</a></td>
</tr>
<tr>
<td>ON BEHALF OF:</td>
<td>Primary Application Ad Hoc Group</td>
</tr>
<tr>
<td>NAME:</td>
<td>NTC(E)WG</td>
</tr>
</tbody>
</table>
| TITLE:          | Linda Johnson (WY) co-chair  
|                | Debbie Doggett (MO) co-chair |

**IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED**

- [X] UCAA Forms     
- [X] UCAA Instructions    
- [X] Enhancement to the Electronic Application Process

**DESCRIPTION OF CHANGE(S)**

The primary application was updated to distinguish the difference between a “new” company (start-up) and a redomestication application in the development of the business rules used to create separate electronic applications. Two separate Forms have been added to include: Management Information (Form 4P) and Holding Company Debt to Equity Information (Form 5P)

**REASON OR JUSTIFICATION FOR CHANGE **

Eventually, all hard copy applications will move to an electronic format, during this process forms will be modified for specific licensing transaction in an effort to incorporate state specific requirements where necessary. The application is specifically for start-up only licensing applications which includes two new forms to separately capture management information and holding company debt to equity information if the Applicant Company is part of a holding company structure.
** Additional Staff Comments: **

3/4/21- Proposal was exposed for a 45-day comment period, ending 5/5/21

5/5/21- One editorial comment regarding a typo on Q6 of Form 8 was noted and corrected to change “$” to a “%”.

5/13/21- Comments during the NTCWG conference call suggesting clarifying language for the company sub-type section to include (if applicable).

5/17/21- Proposal re-exposed for a 30-day comment period, ending June 16th.

6/16/21 – Comments received and included for the Instructions.

** This section must be completed on all forms. **

Revised 01-2019
Uniform Certificate of Authority Application (UCAA)
Primary Application Checklist
For Primary Application Only

The application checklist is intended to help guide the insurer (herein after referred to as “Applicant Company”) with the assembly of a complete Primary Uniform Certificate of Authority Application (UCAA).

1. **Application Form, includes:**
   - UCAA Primary Application Checklist (Form 1P)
   - UCAA Primary Application executed and electronically signed (Form 2P)
   - Lines of insurance the Applicant Company is requesting authority to transact (Form 3).

2. **Filing Fee (pursuant to Section II Filing Requirements Item 2), includes:**
   - Electronic Payment of required filing fee or
   - Copy of check

3. **Minimum Capital and Surplus Requirements (pursuant to Section II Filing Requirements Item 3)**
   - Explanation of compliance with minimum capital & surplus requirements for state for which application is prepared

4. **Statutory Deposit Requirements (pursuant to Section II Filing Requirements Item 4)**
   - Provide financial source of deposit

5. **Name Approval (pursuant to Section II Filing Requirements Item 5)**
   - Evidence of name approval request
   - Copy of Secretary of State approval

6. **Plan of Operation (pursuant to Section II Filing Requirements Item 6)**
   - Completed questionnaire (Form 8)
   - Pro Forma Narrative

7. **Holding Company Act Filings (pursuant to Section II Filing Requirements Item 7)**
   - Ultimate Controlling Party information

8. **Statutory Membership(s)**
   - Attach documentation as listed in Section II Filing Requirements Item 8

9. **SEC Filings or Consolidated GAAP Financial Statement**
   - Attach documentation as listed in Section II Filing Requirements Item 9

10. **Debt-to-Equity Ratio Statement**
    - Attach documentation as listed in Section II Filing Requirements Item 10

11. **Custody Agreements**
    - Attach documentation as listed in Section II Filing Requirements Item 11
Proposed Applicant Company Name: _____________________________  FEIN: ____________________________

12. Public Records Package – Submit ALL items in chart in Section II Item 12, including:
   a. Articles of Incorporation, including:
      ☐ Original Articles
      ☐ Copy of Secretary of State approval
   b. Bylaws, including:
      ☐ Original certification by the Applicant Company’s corporate assistant
   c. Statement with attachments, including:
      ☐ Financial statement of Ultimate Controlling Party, 10K or 10Q
   d. Independent CPA Audit Report

13. NAIC Biographical Affidavit (Form 11) for the following individuals listed on the Management Information Form:
   ☐ Officers
   ☐ Directors
   ☐ Key managerial personnel (including heads of risk management, compliance, internal audit or other individuals who will control the operations of the Applicant Company or have binding authority over the Applicant Company)
   ☐ Any individual with 10% or greater ownership of the Applicant Company and/or the Applicant Company’s ultimate controlling entity. A disclaimer must be filed for any individual stating no control (verify with NAIC legal on language)
   ☐ Affidavit originally signed and notarized within six months of application date
   ☐ Affidavit certified by independent third party

14. State-Specific Information
   ☐ Some jurisdictions may have additional requirements that must be met before a Certificate of Authority can be issued. Before completing a UCAA Primary Application, the Applicant Company should review a listing of requirements for the state to which it is applying.
Uniform Certificate of Authority Application (UCAA)
Primary Application

To the Insurance Commissioner/Director/Superintendent of the State of:
(Select the appropriate state in which the Applicant Company is applying.)

The undersigned Applicant Company hereby certifies that the classes of insurance as indicated on the Lines of Insurance, Form 3, are the lines of business which the Applicant Company is applying to transact.

<table>
<thead>
<tr>
<th>Proposed Name of Applicant Company:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Code (If Applicable)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Registered Office Address:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Administrative Office Address:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mailing Address:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Company Web address: (if available)</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date Incorporated:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Form of Organization:</td>
<td></td>
</tr>
<tr>
<td>Date Organized:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Country of Domicile: (If Applicable)</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Charter, Bylaws or Subscriber's Agreement:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Par Value of Issued Stock: $</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus as regards policyholders: $</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ultimate Owner/Holding Company:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Company Type:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Stock</td>
<td>Limited Liability Corporation</td>
</tr>
<tr>
<td>Reciprocal</td>
<td>U.S. Branch of Alien Insurer</td>
</tr>
<tr>
<td>Fraternal</td>
<td>Cooperative</td>
</tr>
<tr>
<td>Mutual</td>
<td>Charitable Gift Annuity</td>
</tr>
</tbody>
</table>
Proposed Applicant Company Name: ___________________________ FEIN: ___________________________

Applicant Company Formed as Sub-Type (If Applicable):

<table>
<thead>
<tr>
<th>Residual Market Mechanisms</th>
<th>Captive – Pure</th>
<th>City, Town, County, State, Parish, Township</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Retention Group – Captive</td>
<td>Captive- Other</td>
<td>State Insurance Fund/Program</td>
</tr>
<tr>
<td>Risk Retention Group - Traditional</td>
<td>Captive – Special Purpose Financial Insurer</td>
<td></td>
</tr>
<tr>
<td>Special Purpose Vehicle</td>
<td>Manager Managed Limited Liability Co</td>
<td>Surplus Lines Insurer</td>
</tr>
</tbody>
</table>

If Available:

Billing Address:

E-Mail Address: Telephone: Fax:

Premium Tax Statement Address:

E-Mail Address: Telephone: Fax:

Producer Licensing Address:

E-Mail Address: Telephone: Fax:

Rate/Form Filing Address:

E-Mail Address: Telephone: Fax:

Consumer Affairs Address:

E-Mail Address: Telephone: Fax:

Has the Applicant Company ever been refused admission to this or any other state prior to the date of this application?

Yes [ ] No [ ]

If yes, give full explanation in an attached letter. 

The Applicant Company hereby designates (name natural persons only) ____________________________________________, to appoint persons and entities to act as and to be licensed as agents in the State of ____________________________, and to terminate the said appointments.

NOTE: This does not apply to those states that do not require appointments

The following information is required of the individual who is authorized to represent the Applicant Company before the department.

Name:

Title:

Mailing Address:

E-Mail Address: Telephone: /Fax:

If the representative is not employed by the Applicant Company, please provide a company contact person in order to facilitate requests for detailed financial information.

Name:

Title:

Mailing Address:

E-Mail Address: Telephone: /Fax:
Proposed Applicant Company Name: ____________________________  FEIN: __________________________

Applicant Company Incorporators’ Certification and Attestation

One of the officers (listed below) of the Applicant Company must read the following very carefully:

1. I hereby certify, under penalty of perjury, that I have read the application, that I am familiar with its contents, and that all of the information, including the attachments, submitted in this application is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license discipline or other administrative action and may subject me or the Applicant Company, or both, to civil or criminal penalties.

2. I acknowledge that I am familiar with the insurance laws and regulations of said state, accept the Constitution of such state, in which the Applicant Company is licensed or to which the Applicant Company is applying for licensure.

3. I acknowledge that I am the ______________________ of the Applicant Company, am authorized to execute and am executing this document on behalf of the Applicant Company.

4. I hereby certify under penalty of perjury under the laws of the applicable jurisdictions that all of the forgoing is true and correct, executed this __________________ at ___________________.

_________________________ __________________________________
Date Electronic Signature of President

__________________________  __________________________________
Full Legal Name of President

_________________________ __________________________________
Date Electronic Signature of Secretary

__________________________  __________________________________
Full Legal Name of Secretary

_________________________ __________________________________
Date Electronic Signature of Treasurer

__________________________  __________________________________
Full Legal Name of Treasurer

_________________________ __________________________________
Date Electronic Signature of Director

__________________________  __________________________________
Full Legal Name of Director

_________________________ __________________________________
Electronic Name of Applicant Company

_________________________ __________________________________
Date Electronic Signature of Witness

__________________________  __________________________________
Full Legal Name of Witness
Uniform Certificate of Authority Application (UCAA)  
Lines of Insurance

Please complete the state information below which the Applicant Company is currently applying for authority to do business. As a result of statutory and regulatory requirements, each state has its own terminology for the lines of insurance. The Lines of Business Matrix was developed to assist the Applicant Company in completing this form. The matrix includes each line of business as it is reported on the NAIC’s annual statement blanks and corresponding state statute or regulation. The matrix is located on the UCAA website under State Charts.[B01]

This form will only show the lines of business for the state selected as the proposed domiciliary state.

<table>
<thead>
<tr>
<th>ALABAMA</th>
<th>Applying for</th>
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</thead>
<tbody>
<tr>
<td>Life (Sec. 27-5-2), Annuities (Sec. 27-5-3)</td>
<td></td>
</tr>
<tr>
<td>Disability (Sec. 27-5-4)</td>
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<tr>
<td>HMO (Sec. 27-21A-1, 27-21A-2 and 27-21A-3)</td>
<td></td>
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<tr>
<td>Property (Sec. 27-5-5)</td>
<td></td>
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<tr>
<td>Miscellaneous Casualty (Sec. 27-5-6, 27-5-7, 27-5-8, 27-5-9)</td>
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<tr>
<td>Title (Sec. 27-5-10)</td>
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</tbody>
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<table>
<thead>
<tr>
<th>ALASKA</th>
<th>Applying for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life (AS 21.12.040)</td>
<td></td>
</tr>
<tr>
<td>Health (AS 21.12.050)</td>
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<tr>
<td>Disability (AS 21.12.052)</td>
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Proposed Applicant Company Name: ________________________________  FEIN: _____________________________

**ARIZONA (continued)**

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**CALIFORNIA**

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Proposed Applicant Company Name: FLORIDA

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**Life, Accident and Health Insurers**

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<td>Reinsurance - Variable Life</td>
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### GEORGIA

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<td>Life, accident, and sickness [O.C.G.A. § 33-3-5(1)]</td>
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<tr>
<td>Including Variable Annuities [O.C.G.A. § 33-11-66]</td>
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<tr>
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<tr>
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<tr>
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<tr>
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<tr>
<td>Surety [O.C.G.A. § 33-3-5(4)]</td>
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### HAWAII

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<td>Property Insurance (HRS 431:1-206)*</td>
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<td>Marine and Transportation Insurance (HRS 431:1-207)</td>
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<td>Vehicle Insurance (HRS 431:1-208)**</td>
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<td>Title Insurance (HRS 431:20-102)</td>
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* (1) Concurrently licensed in General Casualty is required; (2) Residential hurricane carrier must also meet the requirements specified in Section 431:3-306.5; information required by this Section needs to be included in the application package. Failure to comply with the Section shall cause exclusion of the residential hurricane coverage.

** Local Claims and Sales Office(s) and membership of Hawaii Joint Underwriting Plan are required for all insurers authorized to write and engage in writing vehicle insurance.
**IDAHO**

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<thead>
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**ILLINOIS**

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* See 215/IL5/4 for additional description
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<td>(f) Automobile</td>
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<td>(g) Sprinkler</td>
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### Kansas

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<tbody>
<tr>
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<tr>
<td>Accident and Health</td>
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<td>Stand-Alone Prescription Drug Provider</td>
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### Fire Insurance

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<td>Windstorm &amp; Hail</td>
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<td>Extended Coverage</td>
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<td>Add'l. Perils on Growing Crops</td>
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<td>Hail on Growing Crops</td>
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<td>Optional Perils</td>
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<td>Sprinkler Leakage</td>
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<td>Business Interruption</td>
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<td>Earthquake</td>
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<td>Water Damage</td>
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<td>Aircraft Hull</td>
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<td>Ocean Marine</td>
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<td>Rain</td>
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<td>Automobile Physical Damage</td>
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<td>Flood</td>
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<td>Homeowners Policies</td>
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### Casualty Insurance

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<td>Automobile Liability</td>
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<td>General Liability</td>
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<tr>
<td>Workers’ Compensation</td>
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<tr>
<td>Fidelity, Surety &amp; Forgery Bonds</td>
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<tr>
<td>Glass</td>
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<tr>
<td>Burglary, Theft &amp; Robbery</td>
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<tr>
<td>Boiler &amp; Machinery</td>
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<td>Title</td>
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<td>Malpractice Liability</td>
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<td>Livestock Mortality</td>
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<td>Cargo Liability</td>
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<td>Cost of Legal Services</td>
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<td>Mortgage Guaranty Insurance</td>
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### Kentucky

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<tr>
<td>Life (includes variable &amp; credit) KRS 304.5-020</td>
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<tr>
<td>Annuity (includes variable) KRS 304.5-030</td>
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<td>Health (includes credit) KRS 304.5-040</td>
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Proposed Applicant Company Name: [Iowa (continued)]

Applying for:

- A&H Reciprocal (520)
- Mortgage Guaranty (515C)
- Fraternal (512B)

**FEIN:** _____________________________
**KENTUCKY (continued)**  

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<td>Health (includes credit) KRS 304.5-040</td>
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<td>Casualty All Lines KRS 304.5-070 (1)(a) thru (1)(q)</td>
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**Or, Casualty Limited to:**

- Vehicle Insurance KRS 304.5-070(1)(a)
- Liability Insurance KRS 304.5-070(1)(b)
- Workers’ Compensation and Employers Liability KRS 304.5-070(1)(c)
- Burglary and Theft KRS 304.5-070(1)(d)
- Personal Property Floater KRS 304.5-070(1)(e)
- Glass KRS 304.5-070(1)(f)
- Boiler and Machinery KRS 304.5-070(1)(g)
- Leakage and Fire Extinguishing Equipment KRS 304.5-070(1)(h)
- Credit KRS 304.5-070(1)(i)
- Malpractice KRS 304.5-070(1)(j)
- Elevator KRS 304.5-070(1)(k)
- Congenital Defects KRS 304.5-070(1)(l)
- Livestock KRS 304.5-070(1)(m)
- Entertainments KRS 304.5-070(1)(n)
- Failure of Certain Institutions to Record Documents KRS 304.5-070(o)
- Automobile Guaranty KRS 304.5-070(1)(p)
- Miscellaneous KRS 304.5-070(1)(q)
- Marine and Transportation KRS 304.5-080
- Mortgage Guaranty KRS 304.5-100
- Title KRS 304.5-090

**All Others Companies:**

- Fraternal Benefit Society KRS 304.29-011
- Life
- Health
- Lloyd’s KRS 304.28-010
- Non-Profit Health Service Corporation KRS 304.32-030
- Reciprocal KRS 304.27-010

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**LOUISIANA**

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<td>Vehicle</td>
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<td>Credit Property and Casualty</td>
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*All lines of business are as defined in Louisiana Revised Statutes 22:47.*

**MAINE**

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<td>Inland Marine</td>
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<td>Financial Guaranty</td>
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**MARYLAND**

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<th>Insurance Article of the Annotated Code of Maryland:</th>
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<tr>
<td>Variable Annuities – Section 1-101(d)(e), 16-601, 16-602</td>
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<tr>
<td>Casualty (not including Vehicle Liability, Mortgage Guaranty &amp; Workers’ Compensation) – Section 1-101(i)</td>
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<td>Fraternal – 8-424</td>
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<td>Mortgage Guaranty – Sections 1-101(oo)</td>
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<td>Health – Sections 1-101(p)</td>
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<td>Life, including Annuities and Health (except Variable Life &amp; Variable Annuities) Sections 1-101(d), 1-101(p), 1-101(x)</td>
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<td>Marine, Wet Marine &amp; Transportation – Sections 1-101(z), 1-101(ss)</td>
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<td>Non-Profit Health Service Plan – Section 14-110</td>
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<td>Property and Marine (excluding Wet Marine and Transportation) – Section 1-101(gg), 1-101(z)</td>
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<td>Variable Life – Sections 16-601, 16-602</td>
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<td>Surety – Section 1-101(oo)</td>
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<td>Title – Section 1-101(qq)</td>
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<td>Health Maintenance Organizations – Sections 19-708, 19-709, 19-710</td>
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<td>Provider-Sponsored Organizations – Section 19-7A</td>
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<td>(1) Fire</td>
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<td>(4) Fidelity and Surety</td>
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<td>(5A) Boiler, Fly Wheel, Machinery, Explosion</td>
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<td>(5B) Boiler (no inspector), Fly Wheel, Machinery, Explosion</td>
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<td>(6B) Health - All Kinds</td>
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<td>(6C) Group Accident and Health Only</td>
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<td>(6E) Workers’ Compensation</td>
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<td>(6F) Liability Other than Auto</td>
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<td>(6G) Auto Liability</td>
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<td>(12) Burglary, Robbery, Theft, Forgery, Larceny</td>
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<td>(16A) Life - All Kinds</td>
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<td>(54C) Comprehensive Motor Vehicle and Aircraft - M.G.L. 175 § 54C</td>
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<td>(54D) Personal Property Floater - M.G.L. 175 § 54D</td>
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<td>(54E) Dwellings - M.G.L. 175 § 54E</td>
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**Proposed Applicant Company Name:**

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<td>Separate Account - Variable Life (MCL 500.925)</td>
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<td>Inland Marine (MCL 500.616)</td>
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<td>Automobile Insurance - Limited (MCL 500.620)</td>
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<td>Legal Expense (MCL 500.618)</td>
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<td>Casualty–Steam Boiler, Flywheel and Machinery (MCL 500.624(1)a)</td>
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**MINNESOTA**

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<td>Security and Drafts (9b)</td>
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<td>Personal Property Floater - Casualty (9c)</td>
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<td>Water (9d)</td>
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**MISSISSIPPI**

(MCA 83-19-1 Classifications of Insurance Companies)

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<td>(h) Plate Glass</td>
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<tr>
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**MISSOURI**

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**Proposed Applicant Company Name:**

- Montana

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<td>Home Protection (690B.100)</td>
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Proposed Applicant Company Name: NEW HAMPSHIRE

Applying for
- Fire and Allied Lines (RSA 401.1, I)
- Marine Coverages (RSA 401.1, II)
- Life and Annuities (RSA 401.1, III)
- Variable Annuities Require a Separate License (RSA 401.1, III)
- Accident and/or Health Coverages (401.1, IV)
- Liability/Casualty Coverages, Including Workers' Compensation (RSA 401.1, V)
- Casualty Coverages (RSA 401.1, VI)
- Fidelity, Surety, Credit Insurance, Mortgage Guaranty, Bonds, and Financial Guaranty (RSA 401.1, VII)
- Other Casualty Risks. Insurance against any other casualty risk not otherwise specified under paragraph V. (RSA 401.1, VIII)

Title (RSA 416-A)
- Fraternal (RSA 418:16)

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<td>(24) Accident and Health (Property/Casualty Companies) (N.J.S.A. 17B:17-4)</td>
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<td>(27) Municipal Bond (N.J.A.C. 11:7)</td>
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Proposed Applicant Company Name: ______________________________ FEIN: ______________________________

**NEW MEXICO**

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**NEW YORK**

(Notes 1 and 2)

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**Monoline only:**

- Title – Section 1113(a)(18) & Article 64 of the N.Y. Ins. Law
- Mortgage Guaranty - Section 1113(a)(23) & Article 65 of the N.Y. Ins. Law
- Financial Guaranty - Section 1113(a)(25) & Article 69 of the N.Y. Ins. Law

**Note 1:** A company may only apply for the lines of insurance for which it is authorized in its state of domicile.

**Note 2:** The company must have transacted business for a minimum of three (3) years prior to seeking admission. If the company was recently acquired, at least three (3) years of operating experience under the new management is required. An affiliated insurer admitted in New York and operating under the same ownership/management team for at least three (3) years may satisfy this requirement. If the aforementioned situation applies, a written request for approval of a waiver must be submitted with the application.
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### RHODE ISLAND

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<td>Health Maintenance Organization (Utah Code Ann. §31A-8-101(5))</td>
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<tr>
<td>Limited Health Plan (Utah Code Ann. §31A-8-101(3)(a))</td>
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<tr>
<td>Limited Health Plan – Dental</td>
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<tr>
<td>Limited Health Plan – Vision</td>
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<tr>
<td>Nonprofit Health Plan (Utah Code Ann. §31A-7-102)</td>
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<tr>
<td>Life</td>
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<tr>
<td>Life Insurance, including annuity and variable products (Utah Code Ann. §31A-1-301(110), 31A-1-301(9) &amp; 31A-20-106)</td>
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<tr>
<td><strong>Property and Casualty</strong></td>
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<tr>
<td>Accident &amp; Health (Utah Code Ann. §31A-1-301(1)(a))</td>
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<tr>
<td>Bail Bond Surety (Utah Code Ann. § 31A-1-301(12))</td>
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<tr>
<td>Credit Guarantee (Utah Code Ann. § 31A-1-301(37)(a))</td>
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<tr>
<td>Legal Expense (Utah Code Ann. § 31A-1-301(107)(a))</td>
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<tr>
<td>Liability Insurance (Utah Code Ann. § 31A-1-301(106)(a))</td>
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<td>Marine &amp; Transportation (Utah Code Ann. § 31A-1-301(90) &amp; 31A-1-301 (130))</td>
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<tr>
<td>Motor Club (Utah Code Ann. § 31A-1-301(125))</td>
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<tr>
<td>Professional Liability, excluding medical malpractice (Utah Code Ann. § 31A-1-301(108))</td>
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<td>Professional Liability, including medical malpractice (Utah Code Ann. § 31A-1-301(119) &amp; 31A-1-301(151))</td>
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<td>Property Insurance (Utah Code Ann. § 31A-1-301(152)(a)(b))</td>
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<tr>
<td>Surety Insurance (Utah Code Ann. § 31A-1-301(177))</td>
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<tr>
<td>Title Insurance (Utah Code Ann. § 31A-1-301(180))</td>
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<td>Vehicle Liability Insurance (Utah Code Ann. § 31A-1-301(185))</td>
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<td>Workers’ Compensation Insurance (Utah Code Ann. § 31A-1-301(188))</td>
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<td><strong>VERMONT</strong></td>
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<tr>
<td>Life (Section 3301(a)(1))</td>
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<tr>
<td>Variable Annuity (Section 3301(a)(1)) and (Section 3857)</td>
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<td>Health (Section 3301(a)(2))</td>
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<td>Wet Marine and Transportation (Section 3301(a)(6))</td>
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<td>Surety (Section 3301(a)(8))</td>
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<td>Multiple Line (Section 3301(a)(10))</td>
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<tr>
<td>Proposed Applicant Company Name:</td>
<td>VIRGINIA</td>
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<table>
<thead>
<tr>
<th>Life and Health and Fraternal Benefit Society</th>
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<tr>
<td>§ 38.2 101 through 134</td>
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<tr>
<td>01 Life</td>
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<td>02 Industrial Life</td>
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<td>03 Credit Life</td>
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<td>04 Variable Life</td>
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<td>06 Variable Annuities</td>
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<tr>
<td>07 Accident and Sickness</td>
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<tr>
<td>08 Credit Accident and Sickness</td>
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<tr>
<td>99 Managed Care Health Insurance Plan *</td>
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<tr>
<td>Title</td>
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<tr>
<td>33 Title</td>
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<tr>
<td>Property and Casualty</td>
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<tr>
<td>07 Accident and Sickness</td>
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<tr>
<td>08 Credit Accident and Sickness</td>
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<tr>
<td>09 Fire</td>
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<tr>
<td>10 Miscellaneous Property and Casualty</td>
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<td>11 Farmowners Multi Peril</td>
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<tr>
<td>12 Homeowners Multi Peril</td>
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<tr>
<td>13 Commercial Multi Peril</td>
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<tr>
<td>14 Ocean Marine</td>
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<tr>
<td>15 Inland Marine</td>
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<tr>
<td>16 Workers’ Comp-Emp Liability</td>
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<tr>
<td>17 Liability Other Than Auto</td>
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<td>18 Auto Liability</td>
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<tr>
<td>19 Auto Physical Damage</td>
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<td>20 Aircraft Liability</td>
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<tr>
<td>21 Aircraft Physical Damage</td>
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<tr>
<td>23 Fidelity</td>
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<td>24 Surety</td>
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<td>25 Glass</td>
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<td>26 Burglary and Theft</td>
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<td>27 Boiler and Machinery</td>
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<td>28 Credit</td>
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<td>29 Animal</td>
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<td>30 Water Damage</td>
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<td>32 Legal Services</td>
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<td>55 Home Protection</td>
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<td>56 Mortgage Guaranty</td>
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<td>74 Credit Involuntary Unemployment</td>
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<td>75 Credit Property</td>
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<td>99 Managed Care Health Insurance Plan *</td>
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<tr>
<th>WASHINGTON</th>
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<tbody>
<tr>
<td>Life (RCW 48.11.020)</td>
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<tr>
<td>Disability (RCW 48.11.030)</td>
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<td>Property (RCW 48.11.040)</td>
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<td>Marine and Transportation (RCW 48.11.050)</td>
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<td>Vehicle (RCW 48.11.060)</td>
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<td>General Casualty (RCW 48.11.070)</td>
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## Washington (continued)

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<th>Proposed Applicant Company Name:</th>
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<table>
<thead>
<tr>
<th>Surety (RCW 48.11.080)</th>
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<tr>
<td>Title (RCW 48.11.100)</td>
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<td>Ocean Marine (RCW 48.11.105)</td>
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## West Virginia

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<th>Proposed Applicant Company Name:</th>
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<table>
<thead>
<tr>
<th>Life (WV Code §33-1-10(a))</th>
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<tbody>
<tr>
<td>Accident &amp; Sickness (WV Code §33-1-10(b))</td>
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<tr>
<td>Fire (WV Code §33-1-10(c))</td>
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<tr>
<td>Marine (WV Code §33-1-10(d))</td>
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<tr>
<td>Casualty without Workers’ Compensation (WV Code §33-1-10(e))</td>
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<tr>
<td>Casualty with Workers’ Compensation (WV Code §33-1-10(e)(14))</td>
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<tr>
<td>Surety (WV Code §33-1-10(f)(1)) Fidelity</td>
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<tr>
<td>Surety (WV Code §33-1-10(f)(2)) Performance</td>
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<tr>
<td>Surety (WV Code §33-1-10(f)(3)) Financial Guaranty</td>
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<td>Surety (WV Code §33-1-10(f)(3)) Mortgage Guaranty (monoline)</td>
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<td>Reinsurance (WV Code §33-1-11)*</td>
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<td>Variable Life (WV Code §33-13A)</td>
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<td>Physicians’ Mutual (WV Code §33-20F)</td>
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<td>Reciprocal (WV Code §33-21)**</td>
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<td>Farmers Mutual Fire (WV Code §33-22)</td>
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<td>Fraternal (WV Code §33-23)</td>
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<td>Hospital Service Corporation (WV Code §33-24)</td>
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<td>Medical Service Corporation (WV §33-24)</td>
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<td>Health Service Corporation (WV §33-24)</td>
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<td>Dental Service Corporation (WV §33-24)</td>
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## Wisconsin

<table>
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<tr>
<th>Proposed Applicant Company Name:</th>
<th>FEIN: _____________________________</th>
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<table>
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<tr>
<th>(s. Ins 6.75, Wis. Adm. Code)</th>
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<tbody>
<tr>
<td>(1) (a) Life and Insurance Annuities - Nonparticipating</td>
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<tr>
<td>(1) (a) Life and Insurance Annuities - Participating</td>
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<tr>
<td>(1) (b) Variable Life and Variable Annuities</td>
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<tr>
<td>(1) (c) Disability (includes health)</td>
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<tr>
<td>(2) (a) Fire, Inland Marine and Other Property</td>
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<tr>
<td>(2) (b) Ocean Marine</td>
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<tr>
<td>(2) (c) Disability (includes health)</td>
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<tr>
<td>(2) (d) Liability and Incidental Medical Expense</td>
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<tr>
<td>(2) (e) Automobile</td>
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<td>(2) (f) Fidelity Insurance</td>
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<tr>
<td>(2) (g) Surety Insurance</td>
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<tr>
<td>(2) (h) Title</td>
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<tr>
<td>(2) (i) Mortgage Guaranty</td>
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<td>(2) (j) Credit Insurance</td>
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<td>(2) (k) Workers’ Compensation Insurance</td>
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<td>(2) (l) Legal Expense Insurance</td>
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<td>(2) (m) Credit Unemployment Insurance</td>
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<td>(2) (o) Aircraft</td>
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<td>Proposed Applicant Company Name:</td>
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### WYOMING

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<tr>
<td>Life, including annuities (WS 26-5-102)</td>
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<tr>
<td>Variable Contracts (WS 26-5-102)</td>
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<td>Disability (WS 26-5-103)</td>
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<td>Property (WS 26-5-104)</td>
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<td>Surety (WS 26-5-105)</td>
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<td>Casualty (WS 26-5-106)</td>
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<td>Marine and Transportation (WS 26-5-107)</td>
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<tr>
<td>Multiple Lines (WS 26-5-108)</td>
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<td>Title (WS 26-5-109)</td>
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Applicant Company Name: _____________________________  FEIN: _____________________________

UNIFORM CERTIFICATE OF AUTHORITY APPLICATION (UCAA)
Management Information Form
Complete Listing of Incorporators, Officers
Directors and Shareholders (10% or more)

<table>
<thead>
<tr>
<th>Incorporators</th>
<th>Titles</th>
<th>Ownership Percentage</th>
<th>Bio Provide/Disclaimer*</th>
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<th>Officers:</th>
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<th>Directors:</th>
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<th>Shareholders:</th>
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• Disclaimer IF allowed by State.
Debt-to-Equity Ratio Statement

Members of a holding company system must complete debt-to-equity information. The comprehensive debt-to-equity ratio statement includes the following information.

A. Consolidated outside debt to consolidated equity ratio on a GAAP basis for the holding company. *

<table>
<thead>
<tr>
<th>Debt Duration</th>
<th>Debt Amount ($)</th>
<th>Debt to Consolidated Equity Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 5 years</td>
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<tr>
<td>Up to 10 years</td>
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<tr>
<td>Up to 20 years</td>
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</tbody>
</table>

B. Provide the most recent consolidated holding company financial statement.

C. State if the holding company, on a consolidated basis, has a tangible net worth:
   a) for the past three years;
   b) at present; and
   c) provide projections with assumptions for a three-year period.

D. The Applicant Company must clearly substantiate the sources of repayment of any debt, including, but not limited to, whether the source of repayment is independent from the future income of the insurers.

E. Calculate the debt service (as reported in D above) required of each insurer as a percentage of the Applicant Company’s capital and surplus.

F. List the assets of the holding company, if any, that are pledged to fund the debt service or debt repayment of an affiliate or parent (include the assets or stock of any insurer subsidiaries)

G. List any guarantees (personal or otherwise) from the shareholders for repayment of the debt.

*Some states may require re-statement based upon statutory equity.
Proposed Applicant Company Name: ____________________________ FEIN: ______________________

**Holding Company Questions**

**Lines of Business: Life**

**Uniform Certificate of Authority Application QUESTIONNAIRE**

All questions must be answered. Directions: Each "Yes" or "No" question is to be answered. Other answers and additional explanations or details should be attached to the questionnaire.

1. I hold the position(s) of ____________________________________________________ with the Applicant Company.

2. Has the Applicant Company transferred or encumbered any portion of its assets or business, or has its outstanding capital stock been directly or indirectly pledged?
   
   Yes ____ No ____
   
   If the answer is yes, attach explanation.

3. A. Will the Applicant Company be negotiating or inviting negotiations for any transaction that would transfer or encumber any portion of its assets or business or result in a merger or consolidation with another company in the foreseeable future?
   
   Yes ____ No ____

   B. Does the Applicant Company contemplate a change in management or any transaction that would normally result in a change of management within the reasonably foreseeable future?
   
   Yes ____ No ____

   If the answer to either question is yes, attach explanation.

4. Is the Applicant Company owned or controlled by a holding corporation?

   Yes ____ No ____

   If yes, attach and make a part hereof an affidavit by an executive officer of the Applicant Company who knows the facts listing the principal owners (10% or more of the outstanding shares) of such holding corporation by name and residence address, business occupation and business affiliations.

5. Is the Applicant Company owned, operated or controlled, directly or indirectly, by any other state or province, district, territory or nation or any governmental subdivision or agency?

   Yes ____ No ____

   If yes, provide the details in writing and attach to the Questionnaire

6. Has any person who is presently an officer or director of Applicant Company or an individual who directly or indirectly controls 10% or more of the Applicant Company;

   A. Been convicted on, or pleaded guilty or nolo contendere to, an indictment or information in any jurisdiction charging a felony for theft, larceny or mail fraud or, of violating any corporate securities statute or any insurance statute?

      Yes ____ No ____

   B. Presently engaged in a dispute with any state of federal regulatory agency?
Applicant Company Name: _____________________________
NAIC No. __________________________
FEIN: __________________________

Yes ____ No____

C. A plaintiff or defendant in any legal action other than one arising out of policy claims?
Yes ____ No____
If yes, provide a summary of each case and an estimate of the probable liability, if any, and attach.

7. Does the Applicant Company intend to purchase investment securities through any investment banking or brokerage house or firm from whom any of Applicant Company’s officers, directors, trustees, investment committee members or controlling stockholders receive a commission on such purchases?
Yes____ No____
If yes, provide the details and attach.

8. Is the Applicant Company a,
A. Bank
Yes ____ No____
B. Bank holding company, subsidiary or affiliate
Yes ____ No____
C. Financial holding company
Yes ____ No____
D. Other financial institution
Yes ____ No____
If yes, identify the bank(s), bank holding company(ies) or financial institution and the affiliation of the Applicant Company. Provide the details and attach.

9. Has the Applicant Company, since its inception, done any of the following:
A. Made a loan to an entity owned or controlled directly or through a holding corporation by one or more of Applicant Company’s officers, directors, trustees or investment committee members, or to any such person?
Yes ___ No____
B. Sold or transferred any of its assets or property, real or personal, to any such entity or person?
Yes ____ No____
C. Had its outstanding capital stock directly or indirectly pledged for the debt of an affiliate?
Yes _____ No _____
D. Purchased securities, assets or property of any kind from an entity owned or controlled by one or more of the Applicant Company’s officers, directors, trustees, or any persons who have authority in the management of the Applicant Company’s funds (including a controlling stockholder)?
Yes ____ No____
Applicant Company Name: _____________________________  
NAIC No.  
FEIN: __________________________

If the answer to any of the last four questions is affirmative, did any officer, director, trustee or any person who had authority in the management of the Applicant Company's funds (including a controlling stockholder) receive any money or valuable thing for negotiating, procuring, recommending or aiding in such transaction?

Yes ____ No ____

If yes, provide the details and attach.  

10. Attach an organizational depiction (in the format of a flow chart) showing the various executive management, directors and officers and related material functions that require internal control oversight of the Applicant Company, with the name and official title of those responsible for those offices/functions and the portions of the organization they oversee. Material functions should include, but are not limited to, underwriting, claims adjustment/payments, premium accounting, claims accounting, marketing, financial reporting, and investment management. Note any executive or key staff that has access to funds or bank accounts. Submit a map or narrative explaining where offices are or will be geographically located and the approximate number of employees at each location.

A. Designate any common facilities and/or any of the above functions that are shared with affiliates.
B. Designate any of the above office/functions that are delegated to third parties.
C. Attach copies of signed agreements for office functions delegated to either affiliates or third parties.
D. As applicable, attach a separate chart reflecting any other management positions (if different than what was noted above) that exercise control over insurance operations in other jurisdiction where the Applicant Company is seeking admission.
E. Attach any similar information that was submitted to lenders or investment partners.
F. Attach a copy of the Applicant Company’s investment policy (required for primary and redomestication applications only).

11. Provide a detailed description of the Applicant Company’s sales techniques. The description attached should include:

A. Information regarding recruitment and training of sales representatives.
B. Identification as to whether the Applicant Company will be a direct writer or will use agents, brokers or a combination thereof.
C. Explanation of the compensation and control to be provided by the Applicant Company to its agents, brokers or sales personnel.
D. Sample copies of any agreements entered into between the Applicant Company and its agents or brokers.
E. If the Applicant Company will use a specific agency or managing general agent, identification of the agency or managing general agent and a copy of the agreement for this arrangement.
F. Sample contract forms of all types used and remuneration schedule, including those for general agents, if any.

12. If a parent, subsidiary and/or affiliated insurer is admitted for the classes of insurance requested in the pending application, please differentiate the products and/or markets of the Applicant Company from those of the admitted insurer(s).
13. Attach a detailed description of the advertising that will be used by the Applicant Company to market its products in this state. Include a detailed explanation as to how the Applicant Company will develop, purchase, control and supervise its advertising.

14. Attach a detailed explanation of the following:
   A. How the Applicant Company’s policies will be underwritten, including the issuance of policies and endorsements,
   B. How policies will be cancelled,
   C. How premiums and other funds will be handled, and
   D. How personnel will be trained, supervised, and compensated.

15. Attach a detailed explanation how the Applicant Company will adjust and pay claims, include the following;
   A. Describe how the Applicant Company will train, supervise and compensate the personnel handling claims adjusting and claims payment.
   B. Provide detailed information as to how and by whom claim reserves will be set and modified.
   C. **Will** the Applicant Company pay any representative given discretion as to the settlement or adjustment of claims whether in direct negotiation with the claimant or in supervision of the person negotiating, a compensation which is in any way contingent upon the amount of settlement of such claims?

16. Is the Applicant Company a member of a group of companies that shares any of the following:
   A. Common facilities with another company or companies

   Yes ___ No ___

   B. Services (e.g. accounting personnel for financial statement preparation)

   Yes ___ No ___

   C. Or, is a party to a tax allocation agreement in common with another company

   Yes ___ No ___

   If the answer to any of the above is yes, explain the division of costs between participants. If costs are pro-rated, what is the basis for division? Attach a copy of relevant contracts and include a summary of any attached contract.

17. Will the Applicant Company be party to any reinsurance contracts which contracts that in effect provide that Applicant Company will reimburse or indemnify the Reinsurer for losses payable there under?

   Yes ___ No ___

   If yes, provide the details and attach.

18. Does any salaried employee or officer, exclusive of a director, presently have in force a license as an insurance broker issued by this Department of Insurance?
Applicant Company Name: _____________________________ NAIC No. ________________
FEIN: ________________

Yes ____ No____
If yes, attach a copy of his/her license and indicate position held with applicant.

19. Will any of the Applicant Company’s policies being sold in connection with a mutual fund or investment in securities?
   Yes ____ No____ Not Applicable ____
   If yes, attach detailed explanation, including all sales literature which refers to the insurance and mutual fund or other investment literature that refers to the insurance and mutual fund or other investment plan connection.

21. If the Applicant Company is applying for authority to write Variable Annuities, attach the following:
   A. Copy(ies) of any third-party management or service contracts
   B. Commission schedules
   C. Five-year sales and expense projections
   D. A statement from the Applicant Company’s actuary describing reserving procedures including the mortality and expense risks which the Applicant Company will bear under the contract
   E. Statement of the investment policy of the separate account
   F. Copy of the variable annuity prospectus as filed with the SEC unless the separate account is not required to file a registration under the federal securities law
   G. Copies of the variable annuity laws and regulations of the state of domicile
   H. Copy(ies) of the variable annuity contract(s) and application(s)
   I. A description of any investment advisory services contemplated relating to Separate Accounts
   J. Board of Directors resolution authorizing the creation of the separate account

22. If the Applicant Company is applying for authority to write Variable Life Insurance, attach the following:
   A. Copy(ies) of variable life policy(ies) the Applicant Company intends to issue
   B. Name and experience of person(s) or firm(s) proposed to supply consulting, investments, administrative, custodial or distribution services to the Applicant Company
   C. Disclose whether each investment advisor i) is registered under the Investment Advisers Act of 1940, or ii) is an investment manager under the Employee Retirement Income Security Act of 1974, or iii) whether the Applicant Company will annually file required information and statements concerning each investment advisor as required by its domiciliary state
   D. Copy of the variable life prospectus as filed with the SEC unless the separate account is not required to file a registration under the federal securities law
   E. Statement of the investment policy of any separate account, and the procedures for changing such policy
   F. Copies of the variable life insurance laws and regulations of the state of domicile
G. A statement from the Applicant Company’s actuary describing reserving procedures including the mortality and expense risks which the Applicant Company will bear under the contract

H. Standards of suitability or conduct regarding sales to policyholders

I. Statement specifying the standards of conduct with respect to the purchase or sale of investments of separate accounts (i.e. Board resolution)

J. Board of Directors resolution authorizing the creation of the separate account

23. Will the Applicant Company pay, directly or indirectly, any commission to any officer, director, actuary, medical director or any other physician charged with the duty of examining risks or applications?

Yes_____ No _____ Not Applicable____

If yes, attach the details.
The Primary Application to the Uniform Certificate of Authority Application (UCAA) is designed for use in the formation of a new insurer, or for an existing insurer to use in making application to redomesticate to another state. A Uniform State is one that is committed to using the UCAA review process for company licensing and admissions.

The UCAA Primary Application has four sections designed to guide the Applicant Company through the licensing process:

I. Application Review Process
II. Filing Requirements (New Insurers and Redomestications)
III. Filing Requirements (Redomestications Only)
IV. How to File

The goal of the UCAA is to provide a streamlined approval process. However, some states have state-specific filing requirements based on statutes or internal procedures. The uniform states are working to eliminate non-essential state-specific requirements. All Applicant Companies must be familiar with the insurance laws of the state to which they submit an application. Please see the UCAA charts for information related to obtaining a copy of the laws, regulations and bulletins for the state in which an application is filed.

If the Applicant Company has any questions about the uniform admission process, a list of contact information is provided on the Addresses and Contacts Information for Submission of Application chart. It is highly recommended that the Applicant Company review the state charts, the application instructions and review the Frequently Asked Questions (FAQs) prior to contacting each state with any questions before submitting the application for review.

Primary Application Section I
Application Review Process
Processing Goal: 90 Days

It is the goal of each Uniform State to process all Primary Applications within 90 calendar days with receipt of a complete electronic application. The 90-day review process includes two weeks to determine if the application is complete and acceptable for filing. A completed application includes all required information detailed in the primary application instructions, any state specific requirements and filing fees. During the remaining time-span, the application will receive a financial and operational review. A state may not achieve the 90-day processing goal in instances where the application requires substantial follow-up, or in states with limited resources, or in instances when the Applicant Company files an application during peak business periods such as year-end and annual statement filing periods. Due to varying levels of resources available in each state the review may take longer than 90 days to complete. Anytime the state requests additional information, the state suspends the 90-day goal until it receives the requested information.
Based on the circumstances of a particular application, it may be necessary for the reviewing state to request additional information. Typically, a state will request any additional information it needs within 30 days after the state accepts or acknowledges the application. For more detail regarding the review process, refer to the *Company Licensing Best Practices Handbook*.

**Proprietary Information**

Both regulators and the Applicant Company might deem confidential any communications with insurance regulatory agencies in conjunction with the Primary Application concerning proprietary information about the Applicant Company. States may only share information determined to be confidential with other persons as authorized by law. By law, the state will not disclose to the public any information determined to be proprietary and trade secret. Each applicant company needs to expressly identify all information, in the application and in any subsequent correspondence, that the Applicant Company considers proprietary or trade secret.

The Applicant Company should review the state chart information, and FAQs prior to contacting the appropriate state regulators with any questions before filing any electronic application.

**Step One: Filing An Electronic Application**

The Applicant Company may submit Primary Applications anytime during the year. The state immediately reviews Primary Applications to ensure that the Applicant Company submitted the application in the required format as outlined in the instructions.

Generally, within two weeks from the date the state accepts or acknowledges the application, the state will notify the Applicant Company whether or not the state has accepted the application as complete for filing. If the state accepts the application for filing, it will assign the status date as the official filing date.

If the state does not accept the application for filing due to a deficiency in the application’s format, the state will contact the Applicant Company. Depending upon the nature of the deficiency, the state may give the Applicant Company two weeks from the date of receipt of notification from the department reviewing the application submission date to correct the deficiency. Some states may return to the Applicant Company any applications that are deficient and not accepted for filing. The state will provide a “closed” status date for any application that is deficient and not accepted for filing.

**Step Two: Application Review**

A Primary Application will undergo a rigorous financial and operational review in the state to which the Applicant Company submitted the application. The purpose of the Primary Application is to streamline application processing and the state will make every effort to process a Primary Application as quickly as possible.

At the conclusion of the substantive review by the reviewing state, the state will grant the Applicant Company a Certificate of Authority as a domestic company, allow the Applicant Company to withdraw...
the application, or will deny the application. Notification will be done automatically when the state provides the appropriate status date for approval or denial, respectively.

If the application is denied, the state will notify the Applicant Company provide an appropriate status date and provide include a detailed explanation for the denial which will automatically generate an email notification to the Applicant Company. The Applicant Company can also choose to withdraw their application and must include an explanation for withdraw. After the denial, If the Applicant Company wishes to re-file a Primary Application, the state will require a new application and filing fee will need to be submitted.

If the application is approved and a Certificate of Authority is granted, the Applicant Company should can complete and submit the electronic Company Code Application form. The form can be submitted via email, fax or mail.

Primary Application Section II
Filing Requirements (New Insurers and Redomestications)

This section provides a guide to understanding the focus of each document requirement of the Primary Application. It is important that applications be complete.

All documents attachments submitted in support of the application must be current. However, in certain instances, some states have limited latitude to accept older documents, although generally no more than five (5) years old. Please contact the states individually if there are questions about a specific document.

All required forms required for the Primary Application are available provided under in the electronic Primary Application tab. The Applicant Company can download these documents for printing and submission. The Primary Application cannot be filed electronically via the NAIC/UCAA portal. It must be file directly with the state of domicile. Please contact the state for instructions on the preferred method/format for filing. State specific forms, if available, will be provided.

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1. Application Form and Attachments
2. Filing Fee
3. Minimum Capital and Surplus Requirements
4. Statutory Deposit Requirements
5. Name Approval
6. Plan of Operation
7. Holding Company Act Filings
8. Statutory Membership(s)
9. SEC Filings or Consolidated GAAP Financial Statement
10. Debt-to-Equity Ratio Statement
11. Custody Agreements
12. Public Records Package
13. NAIC Biographical Affidavits
14. State-Specific Information

1. Application Form and Attachments
The application must identify all lines of insurance (Form 3) the Applicant Company is requesting authority to transact, as identified by the Applicant Company’s plan of operation. Only the Applicant Company using this application for a redomestication filing need to complete the section listing the lines of business that the Applicant Company is currently licensed to transact and is transacting in all jurisdictions. Submit a completed checklist (Form 1P) is completed automatically when all required information is provided, and original executed application form (Form 2P) as Item 1 of the application must be electronically signed and notarized.
2. **Filing Fee**

The application must include a filing fee for the state in which an application is being submitted. The payee name and the instructions for submitting the filing fee are included in the *Filing Fees - Primary and Expansion Applications* chart. Submit a copy of the Applicant Company’s check as Item 2 of the application checklist.

3. **Minimum Capital and Surplus Requirements**

The application must show that the Applicant Company meets the state’s statutory minimum capital and surplus requirements. In some states, the minimum capital and surplus requirements are determined by the classes of insurance that the Applicant Company is requesting authority to transact and the classes of insurance the Applicant Company is authorized to transact in all other jurisdictions. The state will determine the level of surplus required after considering the Applicant Company’s product line, operating record and financial condition. Compliance with the statutorily prescribed minimum surplus requirement may not be sufficient for all applicants. Review the chart that identifies the *Minimum Capital and Surplus Requirements* for each *the submitted* Uniform State. This chart also provides a contact person or a link to a state-specific form or additional information regarding RBC requirements and instructions. Submit an explanation of the Applicant Company’s compliance with the capital and surplus requirements as Item 3 of the application checklist.

4. **Statutory Deposit Requirements**

The domiciliary state may require a statutory deposit. The *Statutory Deposit Requirements* chart provides state-specific requirements and identifies those states that require a Statutory Deposit. Submit as Item 4 of the Application checklist, documentation explaining how the Applicant Company meets or is meeting the statutory deposit requirements. Unless otherwise indicated, the Statutory Deposit is for the benefit of all policyholders.

5. **Name Approval**

Each state has different guidelines and procedures for name approval. The *Name Approval Requirements* chart is intended to serve as a guide for the various name approval requirements of each Uniform State. The Applicant Company should check with the state to ensure compliance with all applicable name approval requirements. Where applicable, submit evidence of name approval request as Item 5 of the application checklist.

6. **Plan of Operation**

The plan of operation has three components, a brief narrative, proforma financial statements/projections (Form 13) and a completed Questionnaire (Form 8P). The narrative should include significant information not captured as part of the Questionnaire that the Applicant Company submits in support of the application, such as the reason for redomiciliation/business plan. The proforma is one of the three (3) components in the Plan of Operation. The proforma is available for Life, Property/Casualty, Health and Title companies. Provide a company-wide, three-year proforma balance sheet and income statement. For the lines requested, provide three-year premium and loss projections by line for the application state. Projections must support all aspects of the proposed plan of operation, including reinsurance...
arrangements and any delegated function agreements. Include the assumptions used to arrive at these projections.

The proforma when applied to the primary redomestication application is projected data. The proforma workbook should be the same business type as the financial statement blank filed with the NAIC. As such, the projected amounts need not balance with historical NAIC financial filings. The projected data, however, should be relevant to the Applicant Company’s history of growth and losses as contemplated by the NAIC Accounting Practices and Procedures Manual.

The proforma should be completed by statutory accounting or financial reporting professionals that should be available to answer any questions or concerns from reviewing regulatory staff. The proforma is completed on an annual basis, typically for a full three-year time period, however, some states may require five years. The proforma should start with the first full year of operation that the Applicant Company anticipates actively writing business in the state(s) receiving the application. The proforma excel workbook is password protected and cannot be modified. When projecting five years, two workbooks will be required. Submit the completed electronic Questionnaire and all supporting attachments as Item 6 of the application checklist.

7. Holding Company Act Filings

If the Applicant Company is a member of a holding company system, the application must include either the most recent Holding Company Act (HCA) filings, including the Annual Form B Registration Statement and related Form F or a statement substantially similar to the NAIC Insurance Holding Company System Regulatory Act (440). The filing should include all attachments, exhibits and appendices referenced in the HCA filings. Submit Attach the HCA filings as Item 7 of the application checklist, include all attachments and any amendments up to the application filing date and include copies of all advisory, management and service agreements.

8. Statutory Memberships

In some states, the Applicant Company is required to join one or more rating, guarantee or other organizations before transacting insurance. Generally, the Applicant Company’s authorized lines of insurance govern statutorily mandated memberships. Review the Statutory Membership Requirements chart prior to contacting the licensure state about any required statutory memberships before transacting insurance. Submit Attach documentation supporting membership application(s) as indicated, in states where required, or acknowledgment of required memberships as Item 8 of the application checklist.

9. SEC Filings or Consolidated GAAP Financial Statement

If the Applicant Company, its parent or its ultimate holding company has made a filing or registration with the U.S. Securities and Exchange Commission (SEC) in connection with a public offering within the last three years, or filed an 8K, 10K or 10Q within the last 12 months, the application must note that the filing, including any supplements or amendments, is available electronically from the SEC. If the Applicant Company, its parent or its ultimate holding company is not publicly traded, the application must include attach a copy of the Applicant Company’s most recent Consolidated GAAP financial statement. Submit Attach the notice of SEC filings or copy of a Consolidated GAAP statement as Item 9 of the application checklist.
10. **Debt-to-Equity Ratio Statement**

Members of a holding company system must submit complete debt-to-equity information as Item 10 of the application checklist. The application must include a comprehensive debt-to-equity ratio statement that includes the following information.

A. Provide the consolidated outside debt to consolidated equity ratio on a GAAP basis for the holding company. *

<table>
<thead>
<tr>
<th>Debt Duration</th>
<th>Debt Amount ($)</th>
<th>Debt to Consolidated Equity Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 5 years</td>
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<td>Up to 10 years</td>
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</tr>
<tr>
<td>Up to 20 years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. Provide the most recent consolidated holding company financial statement.

C. State if the holding company, on a consolidated basis, has a tangible net worth: a) for the past three years; b) at present; and c) provide projections with assumptions for a three-year period.

D. The Applicant Company must clearly substantiate the sources of repayment of any debt, including, but not limited to, whether the source of repayment is independent from the future income of the insurers.

E. Calculate the debt service (as reported in D above) required of each insurer as a percentage of the Applicant Company’s capital and surplus.

F. List the assets of the holding company, if any, that are pledged to fund the debt service or debt repayment of an affiliate or parent (include the assets or stock of any insurer subsidiaries)

G. List any guarantees (personal or otherwise) from the shareholders for repayment of the debt.

*Some states may require re-statement based upon statutory equity.

11. **Custody Agreements**

The Applicant Company should include a statement setting forth whether or not any of the Applicant Company’s stocks, bonds, or other physical or book entry securities are in the physical possession of another entity.

If any of the Applicant Company’s stocks, bonds or other securities are not in the Applicant Company’s actual physical possession or in a safe deposit box under the exclusive control of the Applicant Company (except as shown in the Schedule of Special Deposits in the Applicant Company’s Annual Statement), the application must include the written agreement with each entity holding and/or administering these securities. The written agreement should include appropriate safeguards for the handling of the securities, in accordance with those specified in the NAIC Financial Condition Examiners Handbook (Handbook).
Some states have additional requirements for these custody agreements, beyond those called for in the Handbook. Submit the statement and copies of the custody agreements as Item 11 of the application.

12. Public Records Package

Most states have requirements to disclose information to the public under a Public Records Act. To meet these public disclosure requirements certain items must be included with the application. While these documents may or may not be part of the substantive review, please be sure to include the required documents with the application. The Public Records Package chart contains requirements for financial and operational filings. An Applicant Company seeking to redomesticate should provide both financial and operational documents for the application state. An Applicant Company that is seeking to form a new insurer should include all documents listed in the operational section of the chart for the application state. Submit all documents required by the application state as Item 12 of the application checklist.

13. NAIC Biographical Affidavit (Biographical Affidavit)

A. The Applicant Company is required to submit an NAIC Biographical Affidavit (Form 11) in connection with pending or future application(s) for licensure or a permit to organize with a department of insurance in one or more states. The Applicant Company must submit an NAIC Biographical Affidavit on behalf of all officers, directors and key managerial personnel of the Applicant Company and individuals with a ten percent (10%) or more, beneficial ownership in the Applicant Company and the Applicant Company’s ultimate controlling person (“Affiant”).

B. The UCAA defines “Independent Third-Party” as:
   (i) A consumer reporting agency (“CRA”) overseen by the Federal Trade Commission (“FTC”) and, therefore, subject to the FCRA, which have been vetted and is currently on the approved list;
   (ii) Has the ability to perform international background investigations; and
   (iii) One whose officers and directors have no material affiliation with the Applicant Company other than stock ownership amounting to less than one percent (1%) of total stock outstanding, unless prior approval is given by the department of insurance to which application is being made.

C. The NAIC Biographical Affidavit requests information with respect to the Affiant’s employment history, education, personal information and character. The NAIC Biographical Affidavit also includes the Disclosure and Authorization Concerning Background Reports (the “Disclosure & Authorization Form”). The signature of the Affiant on the Disclosure & Authorization Form permits an Independent Third-Party to conduct an independent third-party verification on the Affiant.

D. The NAIC Biographical Affidavit includes three types of the Disclosure & Authorization Form. There are three different Disclosure & Authorization Forms since certain state laws, regulations and rules require different kinds of disclosures and wording within such form. An Affiant must sign the corresponding Disclosure & Authorization Form(s) for the
respective state(s) where the Affiant has lived or worked within the last ten (10) years. Refer to the Disclosure & Authorization Forms for further information.

E. The NAIC Biographical Affidavit is used to evaluate the suitability, competency, character and integrity of the Affiant in connection with an Applicant Company’s pending or future application(s) for licensure or a permit to organize with a department of insurance in one or more states.

The Independent Third-Party uses information contained in the NAIC Biographical Affidavit as a tool to perform an independent third-party verification to determine an individual’s fitness and propriety. The independent third-party verification may contain information bearing on the Affiant’s character, general reputation, personal characteristics, mode of living and credit standing (if required by the state). The Independent Third-Party Vendor shall use the independent third-party verification to create a background report (the “Background Report”).

F. The Disclosure & Authorization Form is valid for a maximum of six months. Additionally, an Affiant may revoke the authorization at any time by delivering a written revocation to the Applicant Company. Refer to the Disclosure & Authorization Form for further information.

G. The Background Reports are subject to the Fair Credit Reporting Act (“FCRA”). Pursuant to FCRA, the state departments of insurance and an Applicant Company who is seeking admission are “users” of consumer reports. The FCRA requires that the Applicant Company provide the Affiant with a copy of the “Summary of Your Rights Under the Fair Credit Reporting Act.” The Applicant Company should provide a copy of the “Summary of Your Rights under the Fair Credit Reporting Act” to each Affiant. This summary can be found at the Federal Trade Commission ("FTC") website. Background Reports are valid for six months from the signature date of the affidavit. Any alteration to the original biographical affidavit or updated signature will require a newly prepared background report.

H. The Applicant Company and state departments of insurance are required to comply with FCRA, especially as it relates to confidentiality of the information contained in such consumer reports. To the extent required by law, the states and Independent Third-Party Vendors should maintain the Background Reports procured under the Disclosure & Authorization Form as confidential. A copy of the FCRA is located here.

I. The department of insurance in the state where an Applicant Company files, or intends to file, an application and the Applicant Company may require the Background Report. An Affiant who desires a copy of their Background Report may request a copy from the Applicant Company or the CRA as indicated on the Disclosure & Authorization Form. Refer to the Disclosure & Authorization Form for further information.

J. Please check state requirements for those states that require additional background information, such as fingerprints, in place of, or in addition to, NAIC Biographical Affidavits. If applying in one of those states, necessary fingerprints and processing fees should be included.
Refer to the list of currently approved Independent Third-Party Vendors for Background Reports.

NAIC Biographical Affidavits must be completed on the most current form [Word | PDF], in effect at the time the affidavit was signed and the Affiant shall not sign the Affidavits more than six months before the date the Applicant Company files the application. Each question on the biographical affidavit must have a response. If an answer is “None”, then so state. Incomplete biographical affidavits could delay the background investigation report and result in a delay of the application review by the state.

Submit original Biographical Affidavits (Form 11 [Word | PDF]) that contain the Disclosure & Authorization Forms to the state department(s) of insurance as Item 13 of the application.

14. State-Specific Information

Some jurisdictions may have additional requirements before a Certificate of Authority is issued. Before completing a UCAA Primary Application, the Applicant Company should review the list of requirements on the State-Specific Requirements for the application state. Submit state-specific requirements as Item 14 of the application.
National Treatment and Coordination (E) Working Group

Company Licensing Proposal Form

DATE: 2/22/2021

CONTACT PERSON: Jane Barr

TELEPHONE: _____________________________

EMAIL ADDRESS: _____________________________

ON BEHALF OF: Co-Chairs: Debbie Doggett (MO) and Linda Johnson (WY)

TITLE: _____________________________

AFFILIATION: NTCWG in conjunction with the Domiciliary State Ad Hoc Group

ADDRESS: _____________________________

FOR NAIC USE ONLY

Agenda Item # 2021-02

Year 2021

DISPOSITION

[ ] ADOPTED

[ ] REJECTED

[ ] DEFERRED TO

[ ] REFERRED TO OTHER NAIC GROUP

[ X ] EXPOSED 5/5/2021

[ ] OTHER (SPECIFY) _____________________________

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

[X ] UCAA Forms  [ X ] UCAA Instructions  [ ] Enhancement to the Electronic Application Process
[ ] Company Licensing Best Practices HB

Forms:

[ X ] Form 1 – Checklist  [ X ] Form 2 - Application  [ X ] Form 3 – Lines of Business
[ ] Form 6- Certificate of Compliance  [ ] Form 7 – Certificate of Deposit  [ X ] Form 8 - Questionnaire
[ ] Form 8C- Corporate Amendment Questionnaire  [ ] Form 11-Biographical Affidavit  [ ] Form 12-Uniform Consent to Service of Process  [ ] Form 13- ProForma  [ ] Form 14- Change of Address/Contact Notification
[ ] Form 15 – Affidavit of Lost C of A  [ ] Form 16 – Voluntary Dissolution  [ ] Form 17 – Statement of Withdrawal

DESCRIPTION OF CHANGE(S)

Updated forms and instructions for domestic redomestications applications only. Identified the forms by placing a (R) after each form that was modified for the domiciliary redomestication application.

REASON OR JUSTIFICATION FOR CHANGE **

Updated the current hard-copy only option by creating an electronic version of the domiciliary state redomestication application. Removed all references and requirements for a start-up company to create this redomestication only electronic option. Only the forms that were modified are included in this proposal, forms not changed but are required for the application are included/referenced in the application instructions.

Additional Staff Comments:

5/13/21 NTCWG call, consideration tabled for re-exposure of primary application.

** This section must be completed on all forms.  

© 2021 National Association of Insurance Commissioners
Applicant Company Name: _____________________________

Uniform Certificate of Authority Application (UCAA)

Domiciliary Redomestication Application Checklist

The application checklist is intended to help guide the insurer (herein after referred to as “Applicant Company”) with the assembly of a complete PrimaryRedomestication Uniform Certificate of Authority Application (UCAA). Please be sure to complete the checklist by appropriately marking the boxes on the left side of the page prior to submitting the application for review. The completed checklist should be attached to the top of their automatically completed within the application.

Regulator Use Only

1. Application Form, containing:
   - Completed UCAA PrimaryRedomestication Application Checklist (Form 1RP)
   - Original UCAA PrimaryRedomestication Application executed and signed (Form 2PR)
   - Include all lines of insurance the Applicant Company is licensed to transact, currently transacting, and requesting authority to transact in all the new domiciliary jurisdictions (Form 3).

2. Filing Fee (pursuant to Section II Filing Requirements Item 2), containing:
   - Payment of required filing fee
   - Copy of check

3. Minimum Capital and Surplus Requirements (pursuant to Section II Filing Requirements Item 3)
   - Provide explanation of compliance with minimum capital & surplus requirements for state for which application is prepared

4. Statutory Deposit Requirements (pursuant to Section II Filing Requirements Item 4)
   - An original Certificate of Deposit prepared by previous state of domicile (Form 7)

5. Name Approval (pursuant to Section II Filing Requirements Item 5)
   - Evidence of name approval request

6. Plan of Operation (pursuant to Section II Filing Requirements Item 6)
   - Completed questionnaire (Form 8R)
   - Pro Forma
   - Narrative

7. Holding Company Act Filings (pursuant to Section II Filing Requirements Item 7)
   - Include Holding Company Act Filings, including Form B, Form F or substantially similar Statement
   - Corporate Governance Annual Disclosure

8. Statutory Membership(s)
   - Submit documentation as listed in Section II Filing Requirements Item 8

9. SEC Filings or Consolidated GAAP Financial Statement
   - Submit documentation as listed in Section II Filing Requirements Item 9

10. Debt-to-Equity Ratio Statement
    - Submit documentation as listed in Section II Filing Requirements Item 10

11. Custody Agreements
    - Submit documentation as listed in Section II Filing Requirements Item 11
Applicant Company Name: _____________________________

FEIN:   __________________________  
Regulator Use Only

12. Public Records Package – Submit ALL items in chart in Section II Item 12, including:
   
a. Articles of Incorporation, including:
   [ ] Original certification by domiciliary state
   
b. Bylaws, including:
   [ ] Original certification by the Applicant Company’s corporate assistant
   
c. Statement with attachments, including:
   [ ] Current year annual statement*, verified and signed, including actuarial opinion
   [ ] Current year quarterly statements (one copy for each quarter), verified and signed
   
   *1. Updated statements should be submitted on a timely basis while application is pending.
   2. If annual statement for two preceding years has not been filed with the NAIC, one copy of each year must be submitted with the application.
   
   [ ] Risk-Based Capital Report
   [ ] Report of Examination
   
d. Independent CPA Audit Report

13. Certificate of Compliance (pursuant to Section III Filing Requirements Item 6)
   [ ] Original certification of compliance (Form 6) completed by domiciliary state insurance regulatory agency

14. NAIC Biographical Affidavit (Form 11) for the following:

   [ ] Officers (as listed on Jurat Page of most recent or upcoming financial statement)
   [ ] Directors (as listed on Jurat Page of most recent or upcoming financial statement)
   [ ] Key managerial personnel (including heads of risk management, compliance, internal audit or other individuals who will control the operations of the Applicant Company or have binding authority over the Applicant Company)
   [ ] Any individual (including management not represented of the Jurat Page or not in key managerial positions) with 10% or greater ownership of the Applicant Company and/or the Applicant Company’s ultimate controlling entity
   [ ] Affidavit originally signed and notarized within six months of application date
   [ ] Affidavit certified by independent third party

15. State-Specific Information
   [ ] Some jurisdictions may have additional requirements that must be met before a Certificate of Authority can be issued. Before completing a UCAA PrimaryRedomestication Application, the Applicant Company should review a listing of requirements for the state to which it is applying.

Filing Requirements – Redomestications Only

The requirements of this section are only for those Applicant Company’s seeking to redomesticate from one state to another and are in addition to the requirements of Section II, items 1-14 of the Primary Checklist. A Redomestication is defined as the process where any insurer organized under the laws of any other state may become a domestic insurer that transfers its domicile to another state by merger or consolidation or any other lawful method. The Primary Application when used for a redomestication is filed with the Applicant Company’s new state of domicile.

15. Annual Statement with Attachments
   [ ] Submit documentation as listed in Section III Filing Requirements Item 1

16. Quarterly Statements
   [ ] Submit documentation as listed in Section III Filing Requirements Item 2
17. **Risk-Based Capital Report**

Submit documentation as listed in Section III Filing Requirements Item 3
18. Independent CPA Audit Report
   Submit documentation as listed in Section III Filing Requirements Item 4

19. Reports of Examination
   Includes a copy of the most recent Report of Financial Examination from its domiciliary state and a note of all more recent examinations, completed by any state, including market conduct examinations along with a description of each examination.

20. Certificate of Compliance (pursuant to Section III Filing Requirements Item 6
   Original certification of compliance (Form 6) completed by domiciliary state insurance regulatory agency.
UNIFORM CERTIFICATE OF AUTHORITY APPLICATION (UCAA)
Management Information Form
Complete Listing of Incorporators*, Officers
Directors and Shareholders (10% or more)

Incorporators:  
Titles:  
Ownership Percentage:  

Officers:  

Directors:  

Shareholders:  

*Primary Application Only
Uniform Certificate of Authority Application (UCAA)
Redomestication Application

To the Insurance Commissioner/Director/Superintendent of the State of:
(Select the appropriate state in which the Applicant Company is applying.)

The undersigned Applicant Company hereby certifies that the classes of insurance as indicated on the Lines of Insurance, Form 3, are the lines of business which the Applicant Company is (a) currently authorized for transaction, (b) currently transacted and (c) which the Applicant Company is applying to transact.

<table>
<thead>
<tr>
<th>Applicant Company Name:</th>
<th>NAIC Cocode:</th>
<th>Group Code: (If Applicable)</th>
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<tbody>
<tr>
<td>Home Office Address:</td>
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<tr>
<td>Administrative Office Address:</td>
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<tr>
<td>Mailing Address:</td>
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<tr>
<td>Company Web Address:</td>
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Are these addresses the same as those shown on the Applicant Company’s Annual Statement?

Yes [ ] No [ ]

If not, indicate why: [Attachment Button]

<table>
<thead>
<tr>
<th>Phone:</th>
<th>Fax:</th>
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<tbody>
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<tr>
<th>Form of Organization:</th>
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<tr>
<th>Country of Domicile:</th>
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<tr>
<th>Date of Charter</th>
<th>Date of Bylaws</th>
<th>Date of Subscriber's Agreement</th>
<th>Date of Last Market Conduct Examination:</th>
<th>Date of Last Financial Examination:</th>
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<th>Surplus as regards policyholders:</th>
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<th>Certificate of Deposit (Prior State)</th>
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Ultimate Owner/Holding Company: [Attachment Button]

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<th>Date of Original Last Amendment</th>
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© 2021 National Association of Insurance Commissioners
Applicant Company Name: _____________________________ NAIC Cocode: _____________________________

Billing Address: ____________________________________________________________

E-Mail Address: __________________ Phone: __________________ Fax: ________________

Premium Tax Statement Contact and Address:
First Name: __________________ Last Name: __________________
E-Mail Address: __________________ Phone: __________________ Fax: ________________

Producer Licensing Contact and Address:
First Name: __________________ Last Name: __________________
E-Mail Address: __________________ Phone: __________________ Fax: ________________

Rate/Form Filing Contact and Address:
First Name: __________________ Last Name: __________________
E-Mail Address: __________________ Phone: __________________ Fax: ________________

Consumer Affairs Contact and Address:
First Name: __________________ Last Name: __________________
E-Mail Address: __________________ Phone: __________________ Fax: ________________

Regulatory Compliance Contact and Address:
First Name: __________________ Last Name: __________________
E-Mail Address: __________________ Phone: __________________ Fax: ________________

Has the Applicant Company ever been refused admission to this or any other state prior to the date of this application?
Yes ☐ No ☐
If yes, give full explanation in an attached letter. Attachment Button

The Applicant Company hereby designates (name natural persons only) ____________________________, to appoint persons and entities to act as and to be licensed as agents in the State of ____________________________, and to terminate the said appointments.

NOTE: This does not apply to those states that do not require appointments

The following information is required of the individual who is authorized to represent the Applicant Company before the department.

Name: _____________________________
Title: _____________________________
Mailing Address: _____________________________
E-Mail Address: _____________________________ Phone: /Fax: ________________

If the representative is not employed by the Applicant Company, please provide a company contact person in order to facilitate requests for detailed financial information.

Name: _____________________________
Title: _____________________________
Mailing Address: _____________________________
E-Mail Address: _____________________________ Phone: /Fax: ________________
Applicant Company Name: ___________________________________ NAIC Cocode: __________________________
FEIN: ____________________________________________________________

Applicant Company Incorporators' Certification and Attestation

One of the officers (listed below) of the Applicant Company must read the following very carefully:

1. I hereby certify, under penalty of perjury, that I have read the application, that I am familiar with its contents, and that all of the information, including the attachments, submitted in this application is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license discipline or other administrative action and may subject me or the Applicant Company, or both, to civil or criminal penalties.

2. I acknowledge that I am familiar with the insurance laws and regulations of said state, accept the Constitution of such state, in which the Applicant Company is licensed or to which the Applicant Company is applying for licensure.

3. I acknowledge that I am the ______________________ of the Applicant Company, am authorized to execute and am executing this document on behalf of the Applicant Company.

4. I hereby certify under penalty of perjury under the laws of the applicable jurisdictions that all of the forgoing is true and correct, executed this __________________ at ___________________.

__________________________________
Date Electronic Signature of President

__________________________________
Full Legal Name of President

__________________________________
Date Electronic Signature of Secretary

__________________________________
Full Legal Name of Secretary

__________________________________
Date Electronic Signature of Treasurer

__________________________________
Full Legal Name of Treasurer

__________________________________
Electronic Name of Applicant Company

__________________________________
Date Electronic Signature of Witness

__________________________________
Full Legal Name of Witness
**Uniform Certificate of Authority Application (UCAA)**

Lines of Insurance

Please complete the information below for each state in which the Applicant Company is currently licensed indicating currently authorized, currently transacting and applying for authority to do business. As a result of statutory and regulatory requirements, each state has its own terminology for the lines of insurance. The Lines of Business Matrix was developed to assist the Applicant Company in completing this form. The matrix includes each line of business as it is reported on the NAIC’s annual statement blanks and corresponding state statute or regulation. The matrix is located on the UCAA website under State Charts incorporated into the Form 3, Lines of Business (electronic only).

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<td>(3) Workers’ Compensation and Employers Liability</td>
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## Arkansas

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## California

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<td>Applicant Company Name: _____________________________</td>
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Presently, lines listed above for casualty are checked off as individual lines on the certificate of authority application form. 18 Del. C. Section 906(b) – Provision of medical, hospital, surgical and funeral benefits, and of coverage against accidental death or injury, as incidental to and part of other insurance as stated under subdivisions (1) vehicle, (2) liability, (4) burglary and theft, (7) boiler and machinery, (10) malpractice and (11) elevator of subsection (a) shall for all purposes be deemed to be the same kind of insurance to which it is so incidental and shall not be subject to provisions of this title applicable to life and health insurance.
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<td>R270 Boiler and Machinery</td>
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<td>R280 Credit</td>
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<td>* R285 Title (Title Companies Only)</td>
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<td>* R290 Livestock</td>
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<td>* R450 Accident and Health</td>
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<td>* R520 Industrial Extended Coverage</td>
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<td>* R540 Mobile Home Multi Peril</td>
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<td>* R550 Mobile Home Physical Damage</td>
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<td>* R570 Crop Hail</td>
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<td>* R607 Home Warranties</td>
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<td>* R608 Service Warranties</td>
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<td>* R610 Other Warranty</td>
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<td>* R620 Miscellaneous Casualty</td>
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Life, Accident and Health Insurers

| | Ordinary Life | Endowment |
| | | |
| | Term Life | |
| | Industrial Life | |
| | Individual Annuities | |
| | Universal Life | |

| | Individual Variable Annuities | |
| | Group Variable Annuities | |
| | Group Life and Annuities | |
| | Variable Life | |
Applicant Company Name: _____________________________  
NAIC No. ___________________________  
FEIN: ___________________________

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<td>0430 Fraternal Health</td>
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<td>0441 Credit Disability</td>
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<td>R405 Reinsurance - Individual/Group Variable Annuities</td>
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<td>R410 Reinsurance - Group Life and Annuity</td>
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<td>R420 Reinsurance - Variable Life</td>
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<td>R450 Reinsurance - Accident and Health</td>
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* For purposes of applicant’s plan of operations, these lines should be listed as “all other lines.” If any are combined with other lines on the proforma (i.e. mobile home combined with homeowners), the plan of operations should specify that this was done.

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<td>Including Variable Annuities [O.C.G.A. § 33-11-66]</td>
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<td>Including Variable Life [O.C.G.A. § 33-11-65]</td>
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<td>Property, marine, and transportation [O.C.G.A. § 33-3-5(2)]</td>
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<td>Casualty [O.C.G.A. § 33-3-5(3)]</td>
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<td>Including Workers’ Compensation [O.C.G.A. § 33-7-3]</td>
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<td>Surety [O.C.G.A. § 33-3-5(4)]</td>
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<td>Including Variable Life and Variable Annuity</td>
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<td>Excluding Variable Life and Variable Annuity</td>
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<td>Accident and Health Insurance (HRS 431:1-205)</td>
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<td>Property Insurance (HRS 431:1-206)*</td>
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<td>Including Residential Hurricane (HRS 431:3-306.5)</td>
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<td>Marine and Transportation Insurance (HRS 431:1-207)</td>
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<td>Including Ocean Marine (HRS 431:1-211)</td>
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<td>Vehicle Insurance (HRS 431:1-208)**</td>
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<td>Title Insurance (HRS 431:20-102)</td>
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* (1) Concurrently licensed in General Casualty is required; (2) Residential hurricane carrier must also meet the requirements specified in Section 431:3-306.5; information required by this Section needs to be included in the application package. Failure to comply with the Section shall cause exclusion of the residential hurricane coverage.

** Local Claims and Sales Office(s) and membership of Hawaii Joint Underwriting Plan are required for all insurers authorized to write and engage in writing vehicle insurance.
### IDAHO

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<td>Property - 41-504</td>
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### ILLINOIS

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<td>(d) Workers’ Compensation</td>
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<td>(e) Burglary and Forgery</td>
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<td>(f) Glass</td>
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<td>(g) Fidelity and Surety</td>
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<td>(k) Livestock and Domestic Animals</td>
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<td>(e) Vehicle</td>
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<td>(f) Property Damage, Sprinkler Leakage and Crop</td>
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<td>(g) Other Fire and Marine Risks</td>
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**Fraternal Benefit Society**

Fraternal Benefit Society [215 ILCS 5/282.1 et seq.]

**Health Maintenance Organization**

Health Maintenance Organization (HMO) [215 ILCS 125/1-1 et seq.]

**Limited Health Service Organization**

Limited Health Service Organization (LHSO) [215 ILCS 130/1001 et seq.]

* See 215/ILS/4 for additional description
### INDIANA

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<td>(c) Variable Life and Annuities (Segregated Amounts)</td>
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<td>(c) Burglary, Theft</td>
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<td>(d) Glass</td>
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<td>(e) Boiler and Machinery</td>
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<td>(f) Automobile</td>
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<td>(g) Sprinkler</td>
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<tr>
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<td>(b) Crops</td>
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### IOWA

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*Life includes credit life, variable life, annuities, and variable annuities.

### Kansas

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**LOUISIANA***

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*All lines of business are as defined in Louisiana Revised Statutes 22:47.

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**Health-General Article of the Annotated Code of Maryland:**

| Health Maintenance Organizations – Sections 19-708, 19-709, 19-710 | | | |
| Provider-Sponsored Organizations – Section 19-7A | | | |

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### MICHIGAN

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**NAIC No.:** _____________________________

**FEIN:** _____________________________

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**Monoline only:**

- Title – Section 1113(a)(18) & Article 64 of the N.Y. Ins. Law
- Mortgage Guaranty - Section 1113(a)(23) & Article 65 of the N.Y. Ins. Law
- Financial Guaranty - Section 1113(a)(25) & Article 69 of the N.Y. Ins. Law

**Note 1:** A company may only apply for the lines of insurance for which it is authorized in its state of domicile.

**Note 2:** The company must have transacted business for a minimum of three (3) years prior to seeking admission. If the company was recently acquired, at least three (3) years of operating experience under the new management is required. An affiliated insurer admitted in New York and operating under the same ownership/management team for at least three (3) years may satisfy this requirement. If the aforementioned situation applies, a written request for approval of a waiver must be submitted with the application.

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#### Property & Casualty (O.R.C. 3929.01(A))

- **Fire**
- **Allied Lines**
- **Farmowners Multiple Peril**
- **Homeowners Multiple Peril**
- **Commercial Multiple Peril**
- **Ocean Marine**
- **Inland Marine**
- **Financial Guarantee**
- **Medical Malpractice**
- **Earthquake**
- **Group A&H**
- **Credit A&H (Group and Individual)**
- **Collectively Renewable A&H**
- **Noncancellable A&H**
- **Guaranteed Renewable A&H**
- **Nonrenewable for Stated Reasons Only**
- **Other Accident Only**
- **All Other A&H**
- **Workers' Compensation (to the extent permitted by law)**
- **Other Liability**
  - **Private Passenger Auto No-Fault (personal injury protection to the extent permitted by law)**
  - **Other Private Passenger Auto Liability**
  - **Commercial Auto No-Fault (personal injury protection to the extent permitted by law)**
  - **Other Commercial Auto Liability**
  - **Private Passenger Auto Physical Damage**
  - **Commercial Auto Physical Damage**
- **Aircraft (all perils)**
- **Fidelity**
- **Surety**
- **Glass**
- **Burglary and Theft**
- **Boiler and Machinery**
- **Credit**
- **Reinsurance Only**
- **Other (list)**

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<td>Title (only) (ORS 731.190)</td>
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### PENNSYLVANIA (Notes 1 and 2)

<table>
<thead>
<tr>
<th>Authorized to Transact</th>
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<th>Applying for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life and Annuities (40 P.S. § 382(a)(1))</td>
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<td></td>
</tr>
<tr>
<td>Separate Account – Variable Life (40 P.S. § 382 (a)(1))</td>
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<tr>
<td>Separate Account – Variable Annuities (40 P.S. § 382 (a)(1))</td>
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<tr>
<td>Accident and Health (40 P.S. § 382(a)(2))</td>
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<tr>
<td>Property</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire and Allied Lines (40 P.S. § 382(b)(1))</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inland Marine &amp; Auto Physical (40 P.S. § 382(b)(2))</td>
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<tr>
<td>Ocean Marine (40 P.S. § 382(b)(3))</td>
<td></td>
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<tr>
<td>Casualty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fidelity and Surety (40 P.S. § 382(c)(1))</td>
<td></td>
<td></td>
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<tr>
<td>Accident and Health (40 P.S. § 382(c)(2))</td>
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<tr>
<td>Glass (40 P.S. § 382 (c)(3))</td>
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<tr>
<td>Other Liability (40 P.S. § 382 (c)(4))</td>
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<tr>
<td>Steam Boiler &amp; Machinery (40 P.S. § 382 (c)(5))</td>
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<tr>
<td>Burglary-Theft (40 P.S. § 382 (c)(6))</td>
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<tr>
<td>Credit (40 P.S. § 382 (c)(7))</td>
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<tr>
<td>Water (40 P.S. § 382 (c)(8))</td>
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Applicant Company Name: _____________________________  
NAIC No. ____________________________  
FEIN: ____________________________

### PENNSYLVANIA (continued)

<table>
<thead>
<tr>
<th>Line of Insurance</th>
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<th>Applying for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elevator (40 P.S. § 382 (c)(9))</td>
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<tr>
<td>Livestock (40 P.S. § 382 (c)(10))</td>
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<tr>
<td>Auto Liability (40 P.S. § 382 (c)(11))</td>
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<tr>
<td>Mine &amp; Machinery (40 P.S. § 382 (c)(12))</td>
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<tr>
<td>Personal Property Floater (40 P.S. § 382 (c)(13))</td>
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<tr>
<td>Workers’ Compensation (40 P.S. § 382 (c)(14)) (Note 3)</td>
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<tr>
<td>Other (40 P.S. § 382 (c))</td>
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<tr>
<td>Title (40 P.S. § 910-1)</td>
<td></td>
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</tbody>
</table>

**Note 1:** A company may only apply for the lines of insurance for which it is authorized in its state of domicile.

**Note 2:** The company must have transacted business for a minimum of one (1) year prior to seeking admission. If the company was recently acquired, at least one (1) year of operating experience under the new management is required. An affiliated insurer admitted in Pennsylvania and operating under the same ownership/management team for at least one year may satisfy this requirement. If the aforementioned situation applies, a written request for approval of a waiver must be submitted with the application.

**Note 3:** The Department of Labor and Industry requires all insurers that are applying to write workers’ compensation to complete and file an Initial Report of Accident and Illness Prevention Services. The Insurance Department will not issue a Certificate of Authority to an insurer to write workers’ compensation insurance until the Department of Labor and Industry has indicated the company has made the necessary filing as required by the Workers’ Compensation Act. The necessary form with instructions can be obtained at: [http://www.insurance.pa.gov/Companies/DoingBusiness/Documents/LIBC_211I.pdf](http://www.insurance.pa.gov/Companies/DoingBusiness/Documents/LIBC_211I.pdf).

### PUERTO RICO

<table>
<thead>
<tr>
<th>Line of Insurance</th>
<th>Authorized to Transact</th>
<th>Currently Transacting</th>
<th>Applying for</th>
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</thead>
<tbody>
<tr>
<td>Agricultural (Section 4.060 of the Insurance Code)</td>
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<tr>
<td>Casualty (Section 4.080 of the Insurance Code)</td>
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<tr>
<td>Disability (Section 4.030 of the Insurance Code)</td>
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<tr>
<td>Fraternal Life (Chapter 36 of the Insurance Code)</td>
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<tr>
<td>Health (Chapter 19 of the Insurance Code)</td>
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</tr>
<tr>
<td>Life (Section 4.020 of the Insurance Code)</td>
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<tr>
<td>Marine &amp; Transportation (Section 4.050 of the Insurance Code)</td>
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<tr>
<td>Mortgage Loans (Chapter 23 of the Insurance Code)</td>
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<tr>
<td>Surety (Section 4.090 of the Insurance Code)</td>
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<tr>
<td>Property (Section 4.040 of the Insurance Code)</td>
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<tr>
<td>Variable Life (Section 4.020 of the Insurance Code)</td>
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<tr>
<td>Variable Annuities (Section 4.020 of the Insurance Code)</td>
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<tr>
<td>Vehicle (Section 4.070 of the Insurance Code)</td>
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### RHODE ISLAND

**Life and Health Companies:**

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<tbody>
<tr>
<td>Life</td>
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</tr>
<tr>
<td>Accident and Health</td>
<td>(Note 1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annuities</td>
<td>(Note 1)</td>
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<td>Variable Life</td>
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<td>Variable Annuity</td>
<td>(Note 1)</td>
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</tr>
<tr>
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<td>(Notes 1 and 2)</td>
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**Property and Casualty Companies:**

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<tbody>
<tr>
<td>Fire</td>
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<tr>
<td>Allied Lines</td>
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<tr>
<td>Multi-Peril Crop</td>
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<tr>
<td>Federal Flood</td>
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### RHODE ISLAND (continued)

<table>
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<td>Homeowners Multi-Peril</td>
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<tr>
<td>Commercial Multi-Peril</td>
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<tr>
<td>Ocean Marine</td>
<td></td>
<td></td>
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<tr>
<td>Inland Marine</td>
<td></td>
<td></td>
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<tr>
<td>Medical Malpractice/Medical Liability</td>
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<tr>
<td>Earthquake</td>
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<tr>
<td>Accident &amp; Health</td>
<td></td>
<td></td>
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<tr>
<td>Workers’ Compensation</td>
<td></td>
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<tr>
<td>Other Liability</td>
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<td>Automobile (Full Coverage)</td>
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<td>Aircraft (All Perils)</td>
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<tr>
<td>Fidelity</td>
<td></td>
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</tr>
<tr>
<td>Surety</td>
<td></td>
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</tr>
<tr>
<td>Glass</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burglary and Theft</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boiler and Machinery</td>
<td></td>
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</tr>
<tr>
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<tr>
<td>Warranty</td>
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<tr>
<td>Title</td>
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<td></td>
</tr>
<tr>
<td>Financial Guaranty or Mortgage Guaranty</td>
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</tbody>
</table>

A company will be granted authority for a line of business in Rhode Island only on the condition that the company already has authority to sell that line in its state of domicile.

Note 1: Includes individual and group, and credit and non-credit.

Note 2: Variable Contracts includes Variable Life and Variable Annuity.

Note 3: Or alternatively: All lines except Life, Annuities, Title, Mortgage Guaranty and Financial Guaranty.

### SOUTH CAROLINA

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<tr>
<th>Authorized to Transact</th>
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<th>Applying for</th>
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</thead>
<tbody>
<tr>
<td>Life and Annuities</td>
<td></td>
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</tr>
<tr>
<td>Accident and Health</td>
<td></td>
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</tr>
<tr>
<td>Property</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Casualty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surety</td>
<td></td>
<td></td>
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<tr>
<td>Marine</td>
<td></td>
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### SOUTH DAKOTA

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<tbody>
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<tr>
<td>(2) Health</td>
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<td>(3) Fire &amp; Allied Lines</td>
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<tr>
<td>(4) Inland &amp; Ocean Marine</td>
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<td>(5) Workers’ Compensation</td>
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<tr>
<td>(6) Bodily Injury (No Auto)</td>
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<td>(7) Property Damage (No Auto)</td>
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<td>(8) Bodily Injury (Auto)</td>
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<tr>
<td>(9) Property Damage (Auto)</td>
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<td>(10) Physical Damage (Auto)</td>
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<tr>
<td>(11) Fidelity &amp; Surety Bonds</td>
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### SOUTH DAKOTA (continued)

<table>
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<tbody>
<tr>
<td>(12)</td>
<td>Glass</td>
</tr>
<tr>
<td>(13)</td>
<td>Burglary &amp; Theft</td>
</tr>
<tr>
<td>(14)</td>
<td>Boiler &amp; Machinery</td>
</tr>
<tr>
<td>(15)</td>
<td>Aircraft</td>
</tr>
<tr>
<td>(16)</td>
<td>Credit (includes Credit Life; Credit Health; Credit Mortgage Guaranty and GAP (Guaranteed Auto Protection))</td>
</tr>
<tr>
<td>(17)</td>
<td>Crop - Hail</td>
</tr>
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<td>(18)</td>
<td>Livestock</td>
</tr>
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<td>(19)</td>
<td>Title</td>
</tr>
<tr>
<td>(20)</td>
<td>Variable Annuity</td>
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<td>(21)</td>
<td>Variable Life</td>
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<tr>
<td>(22)</td>
<td>Reinsurance</td>
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<td>Travel</td>
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<td>(23-C)</td>
<td>Bail Bonds</td>
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<td>(24)</td>
<td>SD Farm Mutual (County)</td>
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<td>(25)</td>
<td>SD Farm Mutual (State)</td>
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<td>(27)</td>
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### TENNESSEE

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<tbody>
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<tr>
<td>Accident and Health</td>
<td>(TCA 56-2-201), (a)</td>
</tr>
<tr>
<td>Credit</td>
<td>(TCA 56-2-201), (a)</td>
</tr>
<tr>
<td>Variable Contracts</td>
<td>(TCA 56-2-201), (a)</td>
</tr>
<tr>
<td>Property</td>
<td>(TCA 56-2-201), (a), (b)</td>
</tr>
<tr>
<td>Vehicle</td>
<td>(TCA 56-2-201), (a), (c)</td>
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<tr>
<td>Casualty</td>
<td>(TCA 56-2-201) (a), (d)</td>
</tr>
<tr>
<td>Surety</td>
<td>(TCA 56-2-201) (a), (e)</td>
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<tr>
<td>Title</td>
<td>(TCA 56-35-112) (a)</td>
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</tbody>
</table>

(a) Company may only write lines in Tennessee that they are authorized to write in their domiciliary state.

(b) Includes Fire and Extended Coverage, Other Allied Lines, Homeowners Multiple Peril, Commercial Multiple Peril, Earthquake, Growing Crops, Water Damage – Sprinkler Leakage, Ocean Marine and Inland Marine.

(c) Automobile Bodily Injury, Automobile Property Damage and Automobile Physical Damage. (The Vehicle class is to be used when the company requests Vehicle only and no other Casualty line)

(d) All lines listed under (c) above in addition to Disability, General Liability, Workers’ Compensation, Burglary and Theft, Personal Property Floater, Glass, Boiler, Water Damage, Credit, Elevator, Livestock, Collision, Malpractice, Miscellaneous.

(e) Credit, Accident and Health, Fidelity, Performance Contracts and Bonds, Indemnification Insurance and Mortgage Guaranty.

### TEXAS

<table>
<thead>
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<th>Line</th>
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<tbody>
<tr>
<td>Fire</td>
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<tr>
<td>Allied Coverages</td>
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<td>Hail, growing crops only</td>
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<tr>
<td>Rain</td>
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</tr>
<tr>
<td>Inland Marine</td>
<td>(b)</td>
</tr>
<tr>
<td>Ocean Marine</td>
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</tr>
<tr>
<td>Aircraft Liability</td>
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</tr>
<tr>
<td>Aircraft Physical Damage</td>
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<tr>
<td>Accident</td>
<td></td>
</tr>
<tr>
<td>Health</td>
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<tr>
<td>TEXAS (continued)</td>
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<tr>
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<td>------------------------</td>
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<tr>
<td>Workers’ Comp &amp; Emp. Liability</td>
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<tr>
<td>Employer's Liability</td>
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<tr>
<td>Automobile Liability (c)</td>
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<tr>
<td>Automobile Physical Damage (d)</td>
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<td>Liability other than Automobile (c)</td>
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<td>Glass</td>
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<tr>
<td>Burglary and Theft</td>
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<td>Forgery</td>
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<td>Boiler and Machinery</td>
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<td>Credit (f)</td>
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<td>Livestock (g)</td>
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<td>Mortgage Guaranty Type II (i)</td>
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<tr>
<td>Variable Annuity</td>
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</tbody>
</table>

When one of the above coverages includes more than one kind or sub-line of insurance, the selection of that coverage authorizes the company to write one or more of the specified kinds of insurance included in that coverage.

(a) Includes, but not limited to, Extended Coverage, Windstorm, Lightning, Hurricane, Hail (except growing crops), Explosion, Riot, Civil Commotion, Smoke, Aircraft, Land Vehicles, Physical Loss Form, Additional Extended Coverage, Vandalism, Malicious Mischief.

(b) Includes Personal Property Floater.

(c) Includes Bodily Injury, Medical Payments, Property Damage, and other Automobile Liability.

(d) Includes Fire, Theft, Collision, Comprehensive and other Automobile Physical Damage.

(e) Includes Bodily Injury, Medical Payments and Property Damage with regards to Comprehensive Personal Liability, Owners, Landlords and Tenants, Manufacturers and Contractors, Product, Contractual, Elevator (including Elevator Collision), Employers' Liability, Professional Liability for Physicians, Podiatrists, Certified Anesthetists, and Hospitals, and other Liability other than Automobile.

(f) Includes Credit Involuntary Unemployment; excludes Mortgage Guaranty.

(g) Mortality.

(h) May be written only by Title insurance companies except those companies transacting title insurance prior to October 1, 1967. Includes Attorney's Title insurance companies as authorized by Texas Insurance Code, Chapter 2551.

(i) May be written only by Mortgage Guaranty insurance companies as authorized by Texas Insurance Code, Chapter 3502.

<table>
<thead>
<tr>
<th>UTAH</th>
<th>Authorized to Transact</th>
<th>Currently Transacting</th>
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<tbody>
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<td>Health</td>
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<td>Health Maintenance Organization (Utah Code Ann. §31A-8-101(5))</td>
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<td>Limited Health Plan (Utah Code Ann. §31A-8-101(3)(a))</td>
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<td>Limited Health Plan – Dental</td>
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<td>Limited Health Plan – Vision</td>
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<td>Nonprofit Health Plan (Utah Code Ann. §31A-7-102)</td>
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<td>Life</td>
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<td>Life Insurance (Utah Code Ann. §31A-1-301(110))</td>
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<td>Annuity (Utah Code Ann. §31A-1-301(99))</td>
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<tr>
<td>Variable Contract (Utah Code Ann. §31A-20-106)</td>
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### UTAH (continued)

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### VERMONT

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### VIRGINIA

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<td>99</td>
<td>Managed Care Health Insurance Plan *</td>
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* Companies applying to operate a Managed Care Health Insurance Plan (MCHIP) will be required to obtain a Certificate of Quality Assurance (Certificate) from the Virginia Department of Health pursuant to § 38.2-5800 et seq. of the Code of Virginia. Upon receipt of an application to operate an MCHIP, the Bureau of Insurance will send a letter to the applicant describing the requirements for operating an MCHIP that includes the requirement to obtain a Certificate of Quality Assurance from the Virginia Department of Health.

### WASHINGTON

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### WEST VIRGINIA

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* Indicate above the kinds of insurance to be reinsured, if application is for authority to transact reinsurance only.

** Indicate above the kinds of insurance to be written by the reciprocal insurer

### WISCONSIN

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<td>(2) (b) Ocean Marine</td>
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**UNIFORM CERTIFICATE OF AUTHORITY APPLICATION (UCAA)**
Management Information Form
Complete Listing of Incorporators, Officers
Directors and Shareholders (10% or more)

<table>
<thead>
<tr>
<th>Incorporators</th>
<th>Titles</th>
<th>Ownership Percentage</th>
<th>Bio Provide/Disclaimer*</th>
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**Officers:**

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**Directors:**

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**Shareholders:**

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- Disclaimer IF allowed by State.
Debt-to-Equity Ratio Statement

Members of a holding company system must complete debt-to-equity information. The comprehensive debt-to-equity ratio statement includes the following information.

A. Consolidated outside debt to consolidated equity ratio on a GAAP basis for the holding company. *

<table>
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<th>Debt Amount ($)</th>
<th>Debt to Consolidated Equity Ratio</th>
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<tr>
<td>Up to 20 years</td>
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B. Provide the most recent consolidated holding company financial statement.

C. State if the holding company, on a consolidated basis, has a tangible net worth:
   a) for the past three years;
   b) at present; and
   c) provide projections with assumptions for a three-year period.

D. The Applicant Company must clearly substantiate the sources of repayment of any debt, including, but not limited to, whether the source of repayment is independent from the future income of the insurers.

E. Calculate the debt service (as reported in D above) required of each insurer as a percentage of the Applicant Company’s capital and surplus.

F. List the assets of the holding company, if any, that are pledged to fund the debt service or debt repayment of an affiliate or parent (include the assets or stock of any insurer subsidiaries)

G. List any guarantees (personal or otherwise) from the shareholders for repayment of the debt.

*Some states may require re-statement based upon statutory equity.
Uniform Certificate of Authority Application

QUESTIONNAIRE

Directions: Each "Yes" or "No" question is to be answered by marking an "X" in the appropriate space. All questions should be answered. If the Applicant Company denotes a question as "Not Applicable" (N/A) an explanation must be provided. Other answers and additional explanations or details may be provided in writing attached to the questionnaire. Please complete this form and file it with the Applicant Company's application for a Certificate of Authority.

1. I hold the position(s) of ____________________________ with the Applicant Company.

2. A. Has the Applicant Company transferred or encumbered any portion of its assets or business, or has its outstanding capital stock been directly or indirectly pledged?
   Yes ____ No ____

   B. Has the Applicant Company merged or consolidated with any other company within the last five years?
   Yes ____ No ____

   If the answer to either question is yes, provide the details in writing and attach to the Questionnaire.

3. Is the Applicant Company presently negotiating for or inviting negotiations for any transaction described above?
   Yes ____ No ____

   If yes, provide the details in writing and attach to the Questionnaire.

4. Has the Applicant Company ever changed its name?
   Yes ____ No ____

   If yes, attach copies of the instruments effecting such transaction certified by the Secretary over corporate seal as a true copy of the originals, including any official state regulatory approvals and filing data.

5. A. Has the Applicant Company undergone a change of management or control since the date of its latest annual statement filed in support of this application?
   Yes ____ No ____

   B. Does the Applicant Company contemplate a change in management or any transaction that would normally result in a change of management within the reasonably foreseeable future?
   Yes ____ No ____

   If the answer to either question is yes, provide the details in writing and attach to the Questionnaire.

6. Is the Applicant Company owned or controlled by a holding corporation?
   Yes ____ No ____

   If yes, attach and make a part hereof an affidavit by an executive officer of the Applicant Company who knows the facts listing the principal owners (10% or more of the outstanding shares) of such holding corporation by name and residence address, business occupation and business affiliations.
Applicant Company Name: _____________________________

7. Is the Applicant Company owned, operated or controlled, directly or indirectly, by any other state or province, district, territory or nation or any governmental subdivision or agency?
   Yes ___ No ___
   If yes, provide the details in writing and attach to the Questionnaire

8. A. Has the Applicant Company’s certificate of authority to do business in any state been suspended or revoked within the last ten years?
   Yes ___ No ___

   B. Has the Applicant Company’s application for admission to any state been denied within the last ten years?
   Yes ___ No ___
   If the answer to either question is yes, provide the details in writing and attach to the Questionnaire.

9. Has any person who is presently an officer or director of Applicant Company been convicted on, or pleaded guilty or no contest to, an indictment or information in any jurisdiction charging a felony for theft, larceny or mail fraud or, of violating any corporate securities statute or any insurance statute?
   Yes ___ No ___
   If yes, provide the details in writing and attach to the Questionnaire.

10. Is the Applicant Company presently engaged in a dispute with any state of federal regulatory agency?
    Yes ___ No ___
    If yes, provide the details in writing and attach to the Questionnaire.

11. Is the Applicant Company a plaintiff or defendant in any legal action other than one arising out of policy claims?
    Yes ___ No ___
    If yes, provide a summary of each case and an estimate of the Applicant Company's probable liability, if any, and attach to the Questionnaire.

12. Does the Applicant Company purchase investment securities through any investment banking or brokerage house or firm from whom any of Applicant Company's officers, directors, trustees, investment committee members or controlling stockholders receive a commission on such purchases?
    Yes ___ No ___
    If yes, provide the details in writing and attach to the Questionnaire.

13. Is the Applicant Company a,
    A. Bank
       Yes ___ No ___
    B. Bank holding company, subsidiary or affiliate
       Yes ___ No ___
    C. Financial holding company
       Yes ___ No ___
Applicant Company Name: _____________________________  NAIC No.  __________________________
FEIN:   __________________________

D. Other financial institution
   Yes ____ No ____
   If yes, identify the bank(s), bank holding company(ies) or financial institution and the affiliation of the Applicant Company. Provide the details in writing and attach to the Questionnaire.

14. Has the Applicant Company, within 18 months last preceding the date of this affidavit, done any of the following:

A. Made a loan to an entity owned or controlled directly or through a holding corporation by one or more of Applicant Company’s officers, directors, trustees or investment committee members, or to any such person?
   Yes ____ No ____

B. Sold or transferred any of its assets or property, real or personal, to any such entity or person?
   Yes ____ No ____

C. Had its outstanding capital stock directly or indirectly pledged for the debt of an affiliate?
   Yes _____ No _____

D. Purchased securities, assets or property of any kind from an entity owned or controlled by one or more of the Applicant Company’s officers, directors, trustees, or any persons who have authority in the management of the Applicant Company's funds (including a controlling stockholder)?
   Yes ____ No ____

If the answer to any of the last four questions is affirmative, did any officer, director, trustee or any person who had authority in the management of the Applicant Company's funds (including a controlling stockholder) receive any money or valuable thing for negotiating, procuring, recommending or aiding in such transaction?
   Yes ____ No ____

   If yes, provide the details in writing and attach to the Questionnaire.

15. Attach an organizational depiction (in the format of a flow chart) showing the various executive management, directors and officers and related material functions that require internal control oversight of the Applicant Company, with the name and official title of those responsible for those offices/functions and the portions of the organization they oversee. Material functions should include, but are not limited to, underwriting, claims adjustment/payments, premium accounting, claims accounting, marketing, financial reporting, and investment management. Note any executive or key staff that has access to funds or bank accounts. Submit a map or narrative explaining where offices are geographically located and the approximate number of employees at each location.

A. Designate any common facilities and/or any of the above functions that are shared with affiliates.

B. Designate any of the above office/functions that are delegated to third parties.

C. Attach copies of signed agreements for office functions delegated to either affiliates or third parties.

D. As applicable, attach a separate chart reflecting any other management positions (if different than what was noted above) that exercise control over insurance operations in other jurisdiction where the Applicant Company is seeking admission.

E. Attach any similar information that was submitted to lenders or investment partners.

F. Attach a copy of the Applicant Company’s investment policy (required for primary and redomestication applications only).
16. Provide a detailed description of the Applicant Company’s sales techniques. The description should include:

A. Information regarding recruitment and training of sales representatives.
B. Identification as to whether the Applicant Company will be a direct writer or will use agents, brokers or a combination thereof.
C. Explanation of the compensation and control to be provided by the Applicant Company to its agents, brokers or sales personnel.
D. Sample copies of any agreements entered into between the Applicant Company and its agents or brokers.
E. If the Applicant Company will use a specific agency or managing general agent, identification of the agency or managing general agent and a copy of the agreement for this arrangement.
F. Sample contract forms of all types used and remuneration schedule, including those for general agents, if any.

17. For each state in which the Applicant Company is filing, explain the following:

A. The product lines currently sold or planned by the Applicant Company,
B. Specialty line or lines currently sold and planned,
C. Captive business,
D. The Applicant Company’s marketing plan, including a description of the financial, corporate or other connections productive of insurance,
E. The Applicant Company’s current and expected competition (both regionally and nationally), and
F. How each state in which admission has been requested fits into the marketing plan. General description of the classes to be transacted is not an adequate response. For example, if the Applicant Company plans to market credit life and disability products tailored for use by credit unions, simply stating that it will transact credit life and disability is inadequate.

18. If a parent, subsidiary and/or affiliated insurer is admitted for the classes of insurance requested in the pending application, please differentiate the products and/or markets of the Applicant Company from those of the admitted insurer(s).

19. Provide a detailed description of the advertising that will be used by the Applicant Company to market its products in each state. Include a detailed explanation as to how the Applicant Company will develop, purchase, control and supervise its advertising.

20. For each State, explain in detail the following:

A. How the Applicant Company’s policies will be underwritten, including the issuance of policies and endorsements,
B. How policies will be cancelled,
C. How premiums and other funds will be handled, and
D. How personnel will be trained, supervised, and compensated.
21. Explain in detail how the Applicant Company will adjust and pay claims.
   A. Describe how the Applicant Company will train, supervise and compensate the personnel handling claims adjusting and claims payment.
   B. Provide detailed information as to how and by whom claim reserves will be set and modified.
   C. Does the Applicant Company pay any representative given discretion as to the settlement or adjustment of claims whether in direct negotiation with the claimant or in supervision of the person negotiating, a compensation which is in any way contingent upon the amount of settlement of such claims?
      Yes ____ No ____

22. Is the Applicant Company a member of a group of companies that shares any of the following:
   A. Common facilities with another company or companies
      Yes ____ No ____
   B. Services (e.g. accounting personnel for financial statement preparation)
      Yes ____ No ____
   C. Or, is a party to a tax allocation agreement in common with another company
      Yes ____ No ____

If the answer to any of the above is yes, explain the division of costs between participants. If costs are pro-rated, what is the basis for division? Attach a copy of relevant contracts and include a summary of any attached contract.

23. Does the Applicant Company have any reinsurance contracts which contracts that in effect provide that Applicant Company will reimburse or indemnify the Reinsurer for losses payable there under?
    Yes ____ No ____

    If yes, provide the details in writing and attach to the Questionnaire.

24. Does any salaried employee or officer, exclusive of a director, presently have in force a license as an insurance broker issued by the ________________ Department of Insurance?
    (Name of Application State)
    Yes ____ No ____

    If yes, please identify his/her license and position held with applicant.

25. Does the Applicant Company have outstanding unexercised stock options?
    Yes ____ No ____

    A. If yes, to whom and in what number of shares?
    B. If options are outstanding for a number of shares greater than 10% of the number of shares presently issued and outstanding, a copy of the option form and of the plan pursuant to which they were granted are attached.

26. Are any of the Applicant Company's policies being sold in connection with a mutual fund or investment in securities?
    Yes ____ No ____ Not Applicable ____
If yes, supply details including all sales literature which refers to the insurance and mutual fund or other investment literature that refers to the insurance and mutual fund or other investment plan connection.

27. If the Applicant Company is applying for authority to write Variable Annuities, provide the following:
   A. Copy(ies) of any third-party management or service contracts
   B. Commission schedules
   C. Five-year sales and expense projections
   D. A statement from the Applicant Company's actuary describing reserving procedures including the mortality and expense risks which the Applicant Company will bear under the contract
   E. Statement of the investment policy of the separate account
   F. Copy of the variable annuity prospectus as filed with the SEC unless the separate account is not required to file a registration under the federal securities law
   G. Copies of the variable annuity laws and regulations of the state of domicile
   H. Copy(ies) of the variable annuity contract(s) and application(s)
   I. A description of any investment advisory services contemplated relating to Separate Accounts
   J. Board of Directors resolution authorizing the creation of the separate account

28. If the Applicant Company is applying for authority to write Variable Life Insurance, provide the following:
   A. Copy(ies) of variable life policy(ies) the Applicant Company intends to issue
   B. Name and experience of person(s) or firm(s) proposed to supply consulting, investments, administrative, custodial or distribution services to the Applicant Company
   C. Disclose whether each investment advisor i) is registered under the Investment Advisers Act of 1940, or ii) is an investment manager under the Employee Retirement Income Security Act of 1974, or iii) whether the Applicant Company will annually file required information and statements concerning each investment advisor as required by its domiciliary state
   D. Copy of the variable life prospectus as filed with the SEC unless the separate account is not required to file a registration under the federal securities law
   E. Statement of the investment policy of any separate account, and the procedures for changing such policy
   F. Copies of the variable life insurance laws and regulations of the state of domicile
   G. A statement from the Applicant Company’s actuary describing reserving procedures including the mortality and expense risks which the Applicant Company will bear under the contract
   H. Standards of suitability or conduct regarding sales to policyholders
   I. Statement specifying the standards of conduct with respect to the purchase or sale of investments of separate accounts (i.e. Board resolution)
   J. Board of Directors resolution authorizing the creation of the separate account
29. If the Applicant Company is applying for authority to write Life Insurance, has the Applicant Company at any time in any jurisdiction while operating under its present management, or at any time within the last five years irrespective of changes in management, taught or permitted its agents to sell insurance by using any of the following devices, or representations resembling any of the following:

A. “Centers of influence” and “advisory board,”
   Yes____ No____

B. A charter or founder’s policy,
   Yes____ No____

C. A profit sharing plan,
   Yes____ No____

D. Only a limited number of a certain policies will be sold in any given geographical area;
   Yes____ No____

E. “Profits” will accrue or be derived from mortality savings, lapses and surrenders, investment earnings, savings in administration;
   Yes____ No____

F. A printed list of several large American or Canadian insurers showing the dollar amounts of "savings", "profits" or "earnings" they have made in such categories.
   Yes____ No____

If the answer to any of the above is yes, supply a complete set of all sales material including the sales manual, all Applicant Company instructional material, brochures, illustrations, diagrams, literature, “canned” sales talks, copies of the policies which are no longer in use, list of states where such methods were used and the date (by year) when they were used, the approximate amount of insurance originally written in each state on each policy form thusly sold, the amount currently in force, and the lapse ratio on each form year by year and cumulatively in gross to the present date.

30. Does the Applicant Company pay, directly or indirectly, any commission to any officer, director, actuary, medical director or any other physician charged with the duty of examining risks or applications?
   Yes_____ No _____ Not Applicable____

If yes, provide the details in writing and attach to the Questionnaire.

The following questions are to be completed only if the Applicant Company is redomesticating to another state.

31. Does the Applicant Company have any permitted practices allowed by its current state of domicile?
   Yes____ No _____ Not Applicable____

If yes, provide the details in writing and attach a copy of the state of domicile’s approval to the Questionnaire.

32. Does the Applicant Company’s current state of domicile prescribe any practices of the Applicant Company that are not in accordance with,

A. Laws, regulations or bulletins of proposed state of domicile;
   Yes_____ No _____ Not Applicable____

If yes, provide the details in writing and attach to the Questionnaire.
B. Reserving requirements of proposed state of domicile; or
   Yes_____ No _____ Not Applicable____
   If yes, provide the details in writing and attach to the Questionnaire.

C. NAIC guidelines
   Yes_____ No _____ Not Applicable____
   If yes, provide the details in writing and attach to the Questionnaire.

33. Will the Applicant Company’s investments comply with the investment laws, regulations or bulletins of the proposed state of domicile?
   Yes_____ No _____ Not Applicable____
   If no, provide the details in writing and attach to the Questionnaire.

34. Does the Applicant Company have any outstanding surplus notes?
   Yes_____ No _____ Not Applicable____
   If yes, provide the details in writing and attach to the Questionnaire and attach copy(ies) of the surplus notes reflecting the state of domicile’s approval.
The Primary Redomestication Application to the Uniform Certificate of Authority Application (UCAA) is designed for use in the formation of a new insurer, or for an existing insurer to use in making an application to redomesticate to another state. A Uniform State is one that is committed to using the UCAA review process for company licensing and admissions.

The UCAA Primary Redomestication Application has four three sections designed to guide the Applicant Company through the licensing process:

I. Application Review Process
II. Filing Requirements (New Insurers and Redomestications)
III. Filing Requirements (Redomestications Only)
IV. How to File

The goal of the UCAA is to provide a streamlined approval process. However, some states have state-specific filing requirements based on statutes or internal procedures. The uniform states are working to eliminate non-essential state-specific requirements. All Applicant Companies must be familiar with the insurance laws of the state to which they submit an application. Please see the UCAA charts for information related to obtaining a copy of the laws, regulations and bulletins for the state in which an application is filed.

If the Applicant Company has any questions about the uniform admission process, a list of contact information is provided on the Addresses and Contacts Information for Submission of Application chart. It is highly recommended that the Applicant Company review the state charts, the application instructions and review the Frequently Asked Questions (FAQs) prior to contacting each state with any questions before submitting the application for review.

Primary Redomestication Application Section I
Application Review Process
Processing Goal: 90 Days

It is the goal of each Uniform State to process all Primary Redomestication Applications within 90 calendar days with receipt of a complete application. The 90-day review process includes two weeks to determine if the application is complete and acceptable for filing. A completed application includes all required information detailed in the primary-redomestication application instructions, any state specific requirements and filing fees. During the remaining time-span, the application will receive a financial and operational review. A state may not achieve the 90-day processing goal in instances where the application requires substantial follow-up, or in states with limited resources, or in instances when the Applicant Company files an application during peak business periods such as year-end and annual statement filing periods. Due to varying levels of resources available in each state the review may take longer than 90 days to complete. Anytime the state requests additional information, the state suspends the 90-day goal until it receives the requested information.
Based on the circumstances of a particular application, it may be necessary for the reviewing state to request additional information. Typically, a state will request any additional information it needs within 30 days after the state accepts the application. For more detail regarding the review process, refer to the *Company Licensing Best Practices Handbook*.

**Proprietary Information**

Both regulators and the Applicant Company might deem confidential any communications with insurance regulatory agencies in conjunction with the *Primary Redomestication* Application concerning proprietary information about the Applicant Company. States may only share information determined to be confidential with other persons as authorized by law. By law, the state will not disclose to the public any information determined to be proprietary and trade secret. Each Applicant Company needs to expressly identify all information, in the application and in any subsequent correspondence, that the Applicant Company considers proprietary or trade secret.

The Applicant Company should review the state chart information, and FAQs prior to contacting the appropriate state regulators with any questions before filing any application.

**Step One: Filing An Application**

The Applicant Company may submit *Primary Redomestication* Applications anytime during the year. The state immediately reviews *Primary Redomestication* Applications to ensure that the Applicant Company submitted the application in the required format as outlined in these instructions.

Generally, within two weeks from the date the state receives the application, the state will notify the Applicant Company whether or not the state has accepted the application for filing. If the state accepts the application for filing, it will assign an official filing date.

If the state does not accept the application for filing due to a deficiency in the application’s format, the state will contact the Applicant Company. Depending upon the nature of the deficiency, the state may give the Applicant Company two weeks from the date of receipt of notification from the department reviewing the application to correct the deficiency. Some states may return to the Applicant Company any applications that are deficient and not accepted for filing.

**Step Two: Application Review**

A *Primary Redomestication* Application will undergo a rigorous financial and operational review in the state to which the Applicant Company submitted the application. The purpose of the *Primary Redomestication* Application is to streamline application processing and the state will make every effort to process a *Primary Redomestication* Application as quickly as possible.

At the conclusion of the substantive review by the reviewing state, the state will grant the Applicant Company a Certificate of Authority or Amend its current Certificate of Authority as a domestic company, allow the Applicant Company to withdraw the application, or will deny the application.

If the application is denied, the state will notify the Applicant Company and provide a detailed explanation for the denial. After the denial, if the Applicant Company wishes to re-file a *Primary Redomestication* Application, the state will require a new application and filing fee.
If the application is approved and a Certificate of Authority is granted or reissued, the Applicant Company should complete the Company Code Application form or contact the NAIC of its change in domiciliary state. The form can be submitted via email, fax or mail.

**Primary Redomestication Application Section II**

**Filing Requirements (New Insurers and Redomestications)**

This section provides a guide to understanding the focus of each document of the Primary Redomestication Application. It is important that applications be complete.

All documents submitted in support of the application must be current. However, in certain instances, some states have limited latitude to accept older documents, although generally no more than five (5) years old. Please contact the states individually if there are questions about a specific document.

All forms and instructions required for to complete the Primary Redomestication Application are available under the Primary Redomestication Application tab. The Applicant Company can access the electronic Redomestication for download these documents for printing and submission. The Primary Application cannot be filed electronically via the NAIC/UCAA portal. It must be file directly with the state of domicile. Please contact the state for instructions on the preferred method/format for filing. A redomestication is the process whereby any insurer organized under the laws of any state may become a domestic insurer that transfers its domicile to another state by merger or consolidation or any other lawful method. The Applicant Company files the Primary Application with the Applicant Company’s new state of domicile when used for a redomestication.

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1. Application Form and Attachments

The application must identify all lines of insurance (Form 3) the Applicant Company is requesting authority to transact, as identified by the Applicant Company’s plan of operation. Only the Applicant Company using this application for a redomestication filing need to complete must identify the lines of business it is requesting authority to transact, and identify the section listing the lines of business that the Applicant Company is currently licensed to transact and is transacting in all jurisdictions. Submit a completed checklist (Form 1PForm 1R) and original executed application form (Form 2PForm 2R) will be automatically generated as Item 1 of the application.
2. **Filing Fee**

The application must include a filing fee for the state in which an application is being submitted. The payee name and the instructions for submitting the filing fee are included in the Filing Fees – Primary, Redomestication and Expansion Applications chart. Submit a copy of the Applicant Company’s check as Item 2 of the application.

3. **Minimum Capital and Surplus Requirements**

The application must show that the Applicant Company meets the state’s statutory minimum capital and surplus requirements. In some states, the minimum capital and surplus requirements are determined by the classes of insurance that the Applicant Company is requesting authority to transact and the classes of insurance the Applicant Company is authorized to transact in all other jurisdictions. The state will determine the level of surplus required after considering the Applicant Company’s product line, operating record and financial condition. Compliance with the statutorily prescribed minimum surplus requirement may not be sufficient for all applicants. Review the chart that identifies the Minimum Capital and Surplus Requirements for each Uniform State. This chart also provides a contact person or a link to a state-specific forms or RBC requirements and instructions. Submit an explanation of the Applicant Company’s compliance with the capital and surplus requirements in the electronic Redomestication portal as Item 3 of the application.

4. **Statutory Deposit Requirements**

The domiciliary state may require a statutory deposit. The Statutory Deposit Requirements chart provides state-specific requirements and identifies those states that require a Statutory Deposit. Submit as Item 4 of the Application. Documentation explaining how the Applicant Company meets or is meeting the statutory deposit requirements is Item 4 of the application. Unless otherwise indicated, the Statutory Deposit is for the benefit of all policyholders.

5. **Name Approval**

Each state has different guidelines and procedures for name approval. The Name Approval Requirements chart is intended to serve as a guide for the various name approval requirements of each Uniform State. The Applicant Company should check with the state to ensure compliance with all applicable name approval requirements. Where applicable, submit evidence of name approval request as Item 5 of the application.

6. **Plan of Operation**

The plan of operation has three components, a brief narrative, proforma financial statements/projections (Form 13) and a completed Questionnaire (Form 8). The narrative should include significant information not captured as part of the Questionnaire that the Applicant Company submits in support of the application, such as the reason for redomestication. The proforma is one of the three (3) components in the Plan of Operation. The proforma is available for Life, Property/Casualty, Health and Title companies. Provide a company-wide, three-year proforma balance sheet and income statement. For the lines requested, provide three-year premium and loss projections by line for the application state. Projections must support all
aspects of the proposed plan of operation, including reinsurance arrangements and any delegated function agreements. Include the assumptions used to arrive at these projections.

The proforma when applied to the primary redomestication application is projected data. The proforma workbook should be the same business type as the financial statement blank filed with the NAIC. As such, the projected amounts need not balance with historical NAIC financial filings. The projected data, however, should be relevant to the Applicant Company’s history of growth and losses as contemplated by the NAIC Accounting Practices and Procedures Manual.

The proforma should be completed by statutory accounting or financial reporting professionals that should be available to answer any questions or concerns from reviewing regulatory staff. The proforma is completed on an annual basis, typically for a three year time period, however, some states may require five years. The proforma should start with the first full year of operation that the Applicant Company anticipates actively writing business in the state(s) receiving the application. The proforma excel workbook is password protected and cannot be modified. When projecting five years, two workbooks will be required. Submit Attach the completed Questionnaire Proforma and all relevant attachments as Item 6 of the application.

7. Holding Company Act Filings

If the Applicant Company is a member of a holding company system, the application must include either the most recent Holding Company Act (HCA) filings, including the Annual Form B Registration Statement and related Form F or a statement substantially similar to the NAIC Insurance Holding Company System Regulatory Act (#440). The filing should include all attachments, exhibits appendices referenced in the HCA filings, and the most recent Corporate Governance Annual Disclosure, include any updates if the disclosure has not been restated, as Item 7 of the application. Include all attachments and any amendments up to the application filing date and include copies of all advisory, management and service agreements.

8. Statutory Memberships

In some states, the Applicant Company is required to join one or more rating, guarantee or other organizations before transacting insurance. Generally, the Applicant Company’s authorized lines of insurance govern statutorily mandated memberships. Review the Statutory Membership Requirements chart prior to contacting the licensure state about any required statutory memberships before transacting insurance. Submit Attach documentation supporting membership application(s) as indicated, in states where required, as Item 8 of the application.

9. SEC Filings or Consolidated GAAP Financial Statement

If the Applicant Company, its parent or its ultimate holding company has made a filing or registration with the U.S. Securities and Exchange Commission (SEC) in connection with a public offering within the last three years, or filed an 8K, 10K or 10Q within the last 12 months, the application must note that the filing, including any supplements or amendments, is available electronically from the SEC. If the Applicant Company, its parent or its ultimate holding company is not publicly traded, the application must include Attach a copy of the Applicant Company’s most recent Consolidated GAAP financial statement. Submit Attach the notice of SEC filings or copy of a Consolidated GAAP statement as Item 9 of the application.
10. **Debt-to-Equity Ratio Statement**

Members of a holding company system must submit complete the debt-to-equity information as Item 10 of the application. The application must include a comprehensive debt-to-equity ratio statement that includes the following information.

A. Provide the consolidated outside debt to consolidated equity ratio on a GAAP basis for the holding company. *

<table>
<thead>
<tr>
<th>Debt Duration</th>
<th>Debt Amount ($)</th>
<th>Debt to Consolidated Equity Ratio</th>
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<tbody>
<tr>
<td>Up to 5 years</td>
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<tr>
<td>Up to 10 years</td>
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<td></td>
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<tr>
<td>Up to 20 years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. Provide the most recent consolidated holding company financial statement.

C. State if the holding company, on a consolidated basis, has a tangible net worth: a) for the past three years; b) at present; and c) provide projections with assumptions for a three-year period.

D. The Applicant Company must clearly substantiate the sources of repayment of any debt, including, but not limited to, whether the source of repayment is independent from the future income of the insurers.

E. Calculate the debt service (as reported in D above) required of each insurer as a percentage of the Applicant Company’s capital and surplus.

F. List the assets of the holding company, if any, that are pledged to fund the debt service or debt repayment of an affiliate or parent (include the assets or stock of any insurer subsidiaries)

G. List any guarantees (personal or otherwise) from the shareholders for repayment of the debt.

*Some states may require re-statement based upon statutory equity.

11. **Custody Agreements**

The Applicant Company should include attach a statement setting forth whether or not any of the Applicant Company’s stocks, bonds, or other physical or book entry securities are in the physical possession of another entity.

If any of the Applicant Company’s stocks, bonds or other securities are not in the Applicant Company’s actual physical possession or in a safe deposit box under the exclusive control of the Applicant Company (except as shown in the Schedule of Special Deposits in the Applicant Company’s Annual Statement), the application must include the written agreement with each entity holding and/or administering these securities. The written agreement should include appropriate safeguards for the handling of the securities, in accordance with those specified in the NAIC *Financial Condition Examiners Handbook* (Handbook).
Some states have additional requirements for these custody agreements, beyond those called for in the Handbook. **Submit Attach** the statement and copies of the custody agreements as Item 11 of the application.

### 12. Public Records Package

Most states have requirements to disclose information to the public under a Public Records Act. To meet these public disclosure requirements certain items must accompany the application. While these documents may or may not be part of the substantive review, please be sure to include the required documents with the application. The [Public Records Package](#) chart contains requirements for financial and operational filings. An Applicant Company seeking to redomesticate should provide both financial and operational documents for the application state. An Applicant Company that is seeking to form a new insurer should include all documents listed in the operational section of the chart for the application state. **Submit Attach** all documents required by the application state as Item 12 of the application.

### 13. NAIC Biographical Affidavit (Biographical Affidavit)

A. The Applicant Company is required to submit an NAIC Biographical Affidavit ([Form 11](#)) in connection with pending or future application(s) for licensure or a permit to organize with a department of insurance in one or more states. The Applicant Company must **submit attach** an NAIC Biographical Affidavit on behalf of all officers, directors and key managerial personnel of the Applicant Company and individuals with a ten percent (10%), or more, beneficial ownership in the Applicant Company and the Applicant Company’s ultimate controlling person (“Affiant”).

B. The UCAA defines “Independent Third-Party” as:

   (i) A consumer reporting agency (“CRA”) overseen by the Federal Trade Commission (“FTC”) and, therefore, subject to the FCRA, which have been vetted and is currently on the approved list;

   (ii) Has the ability to perform international background investigations; and

   (iii) One whose officers and directors have no material affiliation with the Applicant Company other than stock ownership amounting to less than one percent (1%) of total stock outstanding, unless prior approval is given by the department of insurance to which application is being made.

C. The NAIC Biographical Affidavit requests information with respect to the Affiant’s employment history, education, personal information and character. The NAIC Biographical Affidavit also includes the Disclosure and Authorization Concerning Background Reports (the “Disclosure & Authorization Form”). The signature of the Affiant on the Disclosure & Authorization Form permits an Independent Third-Party to conduct an independent third-party verification on the Affiant.

D. The NAIC Biographical Affidavit includes three types of the Disclosure & Authorization Form. There are three different Disclosure & Authorization Forms since certain state laws, regulations and rules require different kinds of disclosures and wording within such...
form. An Affiant must sign the corresponding Disclosure & Authorization Form(s) for the respective state(s) where the Affiant has lived or worked within the last ten (10) years. Refer to the Disclosure & Authorization Forms for further information.

E. The NAIC Biographical Affidavit is used to evaluate the suitability, competency, character and integrity of the Affiant in connection with an Applicant Company’s pending or future application(s) for licensure or a permit to organize with a department of insurance in one or more states.

The Independent Third-Party uses information contained in the NAIC Biographical Affidavit as a tool to perform an independent third-party verification to determine an individual’s fitness and propriety. The independent third-party verification may contain information bearing on the Affiant’s character, general reputation, personal characteristics, mode of living and credit standing (if required by the state). The Independent Third-Party Vendor shall use the independent third-party verification to create a background report (the “Background Report”).

F. The Disclosure & Authorization Form is valid for a maximum of six months. Additionally, an Affiant may revoke the authorization at any time by delivering a written revocation to the Applicant Company. Refer to the Disclosure & Authorization Form for further information.

G. The Background Reports are subject to the Fair Credit Reporting Act (“FCRA”). Pursuant to FCRA, the state departments of insurance and an Applicant Company who is seeking admission are “users” of consumer reports. The FCRA requires that the Applicant Company provide the Affiant with a copy of the “Summary of Your Rights Under the Fair Credit Reporting Act.” The Applicant Company should provide a copy of the “Summary of Your Rights under the Fair Credit Reporting Act” to each Affiant. This summary can be found at the Federal Trade Commission (“FTC”) website. Background Reports are valid for six months from the signature date of the affidavit. Any alteration to the original biographical affidavit or updated signature will require a newly prepared background report.

H. The Applicant Company and state departments of insurance are required to comply with FCRA, especially as it relates to confidentiality of the information contained in such consumer reports. To the extent required by law, the states and Independent Third-Party Vendors should maintain the Background Reports procured under the Disclosure & Authorization Form as confidential. A copy of the FCRA is located here.

I. The department of insurance in the state where an Applicant Company files, or intends to file, an application and the Applicant Company may require the Background Report. An Affiant who desires a copy of their Background Report may request a copy from the Applicant Company or the CRA as indicated on the Disclosure & Authorization Form. Refer to the Disclosure & Authorization Form for further information.

J. Please check state requirements for those states that require additional background information, such as fingerprints, in place of, or in addition to, NAIC Biographical Affidavits. If applying in one of those states, necessary fingerprints and processing fees should be included.
Refer to the list of currently approved Independent Third-Party Vendors for Background Reports.

NAIC Biographical Affidavits must be completed on the most current form [Word | PDF], in effect at the time the affidavit was signed and the Affiant shall not sign the Affidavits more than six months before the date the Applicant Company files the application. Each question on the biographical affidavit must have a response. If an answer is “None”, then so state. Incomplete biographical affidavits could delay the background investigation report and result in a delay of the application review by the state.

Submit original Biographical Affidavits (Form 11 [Word | PDF]) that contain the Disclosure & Authorization Forms to the state department(s) of insurance as Item 13 of the application.

14. State-Specific Information

Some jurisdictions may have additional requirements before a Certificate of Authority is issued. Before completing a UCAA Primary Application, the Applicant Company should review the list of requirements on the State-Specific Requirements for the application state. Submit state-specific requirements as Item 14 of the application.

Primary Application Section III
Filing Requirements – Redomestications Only

The requirements of this section are only for those Applicant Company’s seeking to redomesticate from one state to another and are in addition to the requirements of Section II, Items 1 through 14 of the Primary Application. A redomestication is the process whereby any insurer organized under the laws of any state may become a domestic insurer that transfers its domicile to another state by merger or consolidation or any other lawful method. The Applicant Company files the Primary Application with the Applicant Company’s new state of domicile when used for a redomestication.

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15. Annual Statements with Attachments
16. Quarterly Financial Statements
17. Risk-Based Capital Report
18. Independent CPA Audit Report
19. Reports of Examination
20. Certificate of Compliance
21. Corporate Governance Annual Disclosure

145. Annual Statement with Attachments

Include a copy of the Applicant Company’s most recent annual statement as filed in the current state of domicile including all statements and supplements in accordance with the Annual Statement Instructions, including the Statement of Actuarial Opinion and Management’s Discussion and Analysis. The annual statement should be signed and verified and include an original certification from the state insurance regulatory agency of the Applicant Company’s domiciliary state.
Include one copy of the Applicant Company’s annual statement for the two (2) preceding years in addition to the most recent annual statement.

Property/Casualty insurers must attach the Insurance Expense Exhibit, Accident and Health Policy Experience Exhibit and/or Schedule P to the annual statement.

Life insurers must include a Certificate of Valuation from the domiciliary state insurance regulatory agency.

Members of a holding company system must attach a copy of the most recent consolidated annual statement, if filed with its current state of domicile. Submit the annual statement, with the necessary attachments, as Item 15 of the application.

**1615. Quarterly Statements**

Include one (1) copy of each quarterly statement that follows the most recent annual statement. In addition, the Applicant Company must immediately forward any new quarterly statements that become available while the application is pending to all states in which applications are pending. Submit the quarterly statements as Item 16 of the application.

**1716. Risk-Based Capital Report**

Include a Risk-Based Capital Report, submitted in the level of detail required by the NAIC, as Item 17 of the application. Please note that the states will maintain confidentiality of these reports.

**1817. Independent CPA Audit Report**

Include a CPA Audit Report, performed by a certified public accountant that is not an employee of the Applicant Company. Submit the CPA Audit Report as Item 18 of the application. Some states allow exemptions to this requirement for small insurers. Please contact the states individually regarding exemptions.

**1918. Reports of Examination**

The application must include a copy of the Applicant Company’s most recent Report of Financial Examination from its domiciliary state. The Applicant Company must also note all more recent examinations completed by any state, including market conduct examinations, and provide a description of each examination. Refer to the Reports of Examination Requirements chart for the exam “as of” date. Submit the Report of Financial Examination and a list of more recent examinations with descriptions as Item 19 of the application.

**2019. Certificate of Compliance**

Include a Certificate of Compliance (Form 6) with the application. Please refer to the Certificate of Compliance and Certificate of Deposit Requirements chart for specific requirements for the date of issuance of the Certificate of Compliance (Form 6) from the file date of the application. The current domiciliary state must complete the Certificate of Compliance. Submit as Item 20 of the application.
204. Corporate Governance Annual Disclosure

If applicable, include the most recent Corporate Governance Annual Disclosure, include any updates if the disclosure has not been restated. Submit the Registration Statement and Annual Disclosure as Item 21 of the application.

21. State-Specific Information

Some jurisdictions may have additional requirements before a Certificate of Authority is issued. Before completing a UCAA Redomestication Application, the Applicant Company should review the list of requirements on the State-Specific Requirements for the application state. Submit state-specific requirements as Item 14 of the application.

Primary Redomestication Application Section IIIIV

How to File

To facilitate the prompt review of the Primary Redomestication Application, please ensure that the application adheres to the formatting required instructions provided in this section. States will not accept any applications that fail to meet these formatting requirements. Section IV–III will address the following areas:

1. Communication Between Applicant Company and Agency
2. Questions
3. Application Checklist
4. Application and Supporting Documents
5. Addresses for Submission of Application
6. Updates/Changes
7. Filing Fee
8. Forms
9. State-Specific Information

1. Communication Between Applicant Company and Agency

Once the state accepts a Primary Redomestication Application for filing, the state will notify the Applicant Company of the official filing date via the status date in the electronic application and provide the agency contact person. The state will provide names, addresses, email (if available) and telephone numbers of the individual(s) assigned to the application.

Prior to receiving the name of the agency contact person, an Applicant Company may contact the agency personnel listed on the Addresses and Contacts for Submission of Application chart to obtain information regarding the status of a Primary Redomestication Application.

2. Questions

Section II and Section III–Filing Requirements, provide detailed guidelines regarding both the type and format of information required for the Primary Redomestication Application. In most cases, the state provides an agency contact person for each item in the Filing Requirements
section. For additional information, or clarification, Applicant Company’s may use the contact names provided in the Addresses and Contacts for Submission of Application chart.

3. **Application Checklist**

The application checklist (Form 1PForm 1R) provides a guide for assembling a complete application. Complete the checklist before submitting a Primary Application for review. Attach a completed checklist to the top of each application. A completed checklist is automatically generated as the Applicant Company meets the required items in Section II, Filing Requirements.

4. **Application and Supporting Documents**

Submit one copy of the Checklist, completed application and all supporting documentation to the reviewing state. California, Kentucky and New York require two (2) complete copies. Each item identified in Section II and Section III of the Filing Requirements should have a cover sheet as specified below.

Each cover sheet should be on paper suitable for use as a cover sheet, such as binder divider pages.

A cover letter should be attached detailing specific items that should be brought to the agency’s attention. The cover letter should provide a reason why a particular item was not attach or completed in the application. Below are examples of why the Application Company may not be included in the application.

The Applicant Company needs to tab each cover sheet on the right-hand side of the page with a number corresponding to the document’s item number in the Primary Application checklist.

If a particular item is not included with the cover sheet, the Applicant Company must attach to the cover sheet a written explanation stating the reason the item has not been included. Set forth below are examples of why the Applicant Company may not attach a particular item to the cover sheet.

- “Item not applicable to this application for the following reason ... (state reason).”
- “Item has been attached separately because of size.”

5. **Addresses for Submission of Application Filing Fees**

Submit the application filing fee by mailing it to the appropriate address noted on the Addresses and Contact Information for Submission of Application or Filing Fees chart.

6. **Updates/Changes**

The Applicant Company is responsible for informing states of any significant changes that occur or that the Applicant Company discovers during the application review period. Examples of significant changes include: changes in officers and directors, material acquisition or disposal of assets, changes in reinsurance, acquisition of the insurer, change in proposed shareholders, regulatory actions taken against the insurer, change in current business plan, etc.
The Applicant Company must supply revised forms amend the application promptly if any changes occur that materially affect the accuracy of the forms filed in support of the application. For example, the Applicant Company must forward new quarterly statements as soon as they become available.

7. **Filing Fee**

Please see the [Filing Fees – Primary, Redomestication and Expansion Applications](#) chart to determine the correct fee and filing instructions for the application state.

8. **Forms**

All forms are available under the [Primary–Redomestication Application](#) tab and labeled as **UCAA Forms**. All forms can be downloaded, printed and submitted via the electronic application portal with a completed application. The forms MUST NOT be altered. At this time, the forms cannot be submitted electronically.

9. **State-Specific Information**

Some jurisdictions may have additional requirements that the Applicant Company must meet before a state can issue a Certificate of Authority. Before completing a UCAA [Primary Redomestication Application](#), the Applicant Company should review a listing of requirements for the application state under [State-Specific Requirements](#).
National Treatment and Coordination (E) Working Group
Company Licensing Proposal Form

DATE: 5/27/2021
FOR NAIC USE ONLY
Agenda Item # 2021-05
Year 2021

CONTACT PERSON: Jane Barr
TELEPHONE: ____________________________
EMAIL ADDRESS: ____________________________
ON BEHALF OF: National Treatment & Coordination WG
NAME: Debbie Doggett
TITLE: ____________________________
AFFILIATION: MO. Dept. of Insurance
ADDRESS: ____________________________

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED
[ ] UCAA Forms [ ] UCAA Instructions [ ] Enhancement to the Electronic Application Process
[ X ] Company Licensing Best Practices HB

Forms:
[ ] Form 1 – Checklist [ ] Form 2 - Application [ ] Form 3 – Lines of Business
[ ] Form 6- Certificate of Compliance [ ] Form 7 – Certificate of Deposit [ ] Form 8 - Questionnaire
[ ] Form 8C- Corporate Amendment Questionnaire [ ] Form 11-Biographical Affidavit [ ] Form 12-Uniform Consent to
Service of Process [ ] Form 13- ProForma [ ] Form 14- Change of Address/Contact Notification
[ ] Form 15 – Affidavit of Lost C of A [ ] Form 16 – Voluntary Dissolution [ ] Form 17 – Statement of Withdrawal

DESCRIPTION OF CHANGE(S)
Include additional guidance to Form A Review item 2f: Carefully scrutinize and understand complex organization and
ownership structures by requesting and reviewing all organizational documents such as Articles of Incorporation, Articles of
Association, Partnership Agreements and Operating Agreements for entities from the proposed immediate parent up to the
proposed ultimate controlling person (UCP). Review and consider who has the voting rights based on these organizational
documents. Verify who should be considered the UCP based upon this review.

REASON OR JUSTIFICATION FOR CHANGE **
States may determine that the Ultimate Controlling Party is a different party (individual or entity), after reviewing the
partnership agreements, operating agreements or articles of incorporation or association, other than what was initially
identified in the Form A application.

Additional Staff Comments:

** This section must be completed on all forms.

Revised 01-2019

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NAIC Company Licensing Best Practices Handbook
Appendix D – Form A Review Best Practices

Every Form A review should be tailored to the risks associated with the proposed acquisition, including the target company, acquiring entity, and the complexity of the transaction. The following best practices are presented as a guide for regulatory review and analysis of Form A acquisitions, recognizing that this list may not be comprehensive and not all items will apply to every acquisition. This list is intended to be a regulatory tool. The NAIC Form A database should be updated as applicable throughout the Form A review process.

1. Initial Review
   a) Determine if the filing is complete, note the missing items and promptly send a deficiency letter to the Applicant
   b) Identify attorneys, party contacts, and the other insurance regulator reviewing the Form A, including the lead regulator.
   c) The lead regulator should obtain key contact information from each state reviewing the Form A and consider organizing a regulator to regulator call to discuss concerns with the filing
   d) Assign appropriate analyst, legal and other professional staff to conduct regulatory review
   e) Carefully consider whether regulatory review can be completed by Applicant’s target close date, including any interim deadlines and obtain deemer extension or waiver if appropriate, and
   f) Schedule and notice hearing/consolidated hearing, if applicable, within statutory timeframes

2. Background, Identity and Risk Profile of Acquiring Persons
   a) Identify and review all relevant parties to the proposed acquisition
   b) Assess the feasibility of the acquiring persons holding company structure including location and control (direct/indirect) of the target company post acquisition
   c) Review the lead state’s assessment of the acquiring persons most recent ORSA Summary Report and Form F ERM, if applicable, to better understand the related risks
   d) Determine Ultimate Controlling Person and/or Parent (UCP), cross check with source of funds and consider debt funding sources
   e) Review NAIC and other external sources to gain a better understanding of the acquiring persons, its affiliates, and the UCP.
   f) Carefully scrutinize and understand complex organization and ownership structures by requesting and reviewing all organizational documents such as Articles of Incorporation, Articles of Association, Partnership Agreements and Operating Agreements for entities from the proposed immediate parent up to the proposed ultimate controlling person(s) (UCP). Review and consider who has the voting rights under these organizational documents. Verify who should be considered the UCP based upon the reviewed information and document why the determination was made.
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g) Review Audited Financial Statements (or CPA reviewed financial statements for individuals) of the acquiring persons, its holding company, and the UCP, 10K and 10Qs, and other current financial information for enterprise condition, potential debt service by the UCP and its ability to service such debt. Understand the level of reliance on cash flow/dividends from the target company to service debt and other obligations of the holding company and UCP.

h) Based upon nature of acquiring party, review detailed audited financial statement of all individuals who are source of funds.

a. If not available, consider acceptability of unaudited financial statements, compiled personal financial or net worth statements and/or tax returns.

i) Consider suitability of UCP through background review and regulatory review of the prospective new owners, using UCAA biographical affidavits and third-party background reviews by NAIC listed independent third-party reviewing companies or fingerprinting criminal checks if applicable, and

j) Consider acceptability of SEC disclosures by board members of publicly traded UCPs in suitability review.

3. Communication and Record Maintenance

a) Communicate response to any confidentiality requests in writing as soon as possible

b) Create a contact list of relevant persons and representatives

c) Separate confidential and public documents, information, and communications and maintain as appropriate

d) Contact and collaborate with other reviewing regulators involved in the review process, as appropriate, including the lead state regulator regarding ORSA and ERM reviews

e) As applicable, contact other regulators of noninsurance entities of the acquiring party or target

f) Respond as appropriate to questions from third parties and interested regulators

g) Keep the acquiring party representatives informed as to status of review

h) Receive and consider any information provided by external sources, including possible financial or other incentives or motivation of those commenting on a particular transaction

i) Summarize review, findings, conclusions and action taken on Form A review in final action document, including stipulations, and conditions subsequent, and

j) File and maintain documents under state procedures.

4. Transaction Review
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a) Determine how acquisition will be achieved by carefully reviewing transactional documents, e.g. merger, stock purchase, stock exchange
b) Consider disposition of all classes of target shares, including addressment of any beneficial owners
c) Ascertain propriety of disposition of minority interests and concerns, if applicable
d) Consider any affiliate or employee benefit as appropriate
e) Determine how any ancillary regulatory reviews or other interim procedural steps will be completed, including Form E-Pre-Acquisition Notification Form, for other licensed states
f) Obtain copies of shareholder communications or sole shareholder consent
g) Consider obtaining copies of fairness and other contractually required opinions if available
h) Review relevant portions of board resolutions, power points and related board minutes pertinent to the Form A transaction, use care to keep documents confidential, and
i) Determine whether additional professional transaction review is warranted.

5. Purchase Consideration

a) Determine fairness (equivalency) of total amount to be paid to total value to be received, including derivation of price and value of target under standard valuation methodologies or to book value
b) Consider quality of consideration, giving careful scrutiny to payments other than cash or cash equivalents which are disfavored particularly when any funds are being transferred to the target.
c) Consider fairness opinions and actuarial appraisals, if provided
d) Consider source, type and valuation basis of funds to be used for consideration
i. If funds are from a regulated entity, confirm the existence and valuation of such assets with that entity’s regulator
e) If applicable, consider implications of any debt financing including
i. The mechanics of any debt financing to be used to fund the transaction, whether funds are being borrowed in the ordinary course of business or on terms that are less favorable than generally commercial loans.
ii. The percentage of debt versus non-debt funds to be used
iii. The source of funds or stream of income to be used by parent for repayment and the ability of the acquiring party to repay the debt from sources other than the target
iv. Identity of the creditor(s) and creditors’ financial condition.

v. How will debt be secured; consider prohibiting securing of debt on shares of target or target’s assets if not already prohibited by state statute,

vi. Compare time period of loan commitment with parent’s income stream over the same time period, including the ability of the acquiring party to repay the debt from sources other than the target until loan is repaid/retired, and

vii. Consider the long term impact of parent’s debt service on operations of the target company and group.

viii. Follow-up on Parent’s financial commitment to underlying insurer.

6. Target License Qualification /Insurer Operations

a) Determine whether target insurer meets license qualifications upon change of control

b) Consider operational changes post-acquisition, including business plans and projections

c) Review required statutory deposits and authorized lines of business

d) Consider changes to target management and key employees

e) Consider suitability of changes to target management and key employees through background review and regulatory review of new owners, using UCAA biographical affidavits and third-party background reviews or fingerprinting criminal checks, if applicable

f) Consider plans for technological interfacing with new affiliates and any potential adverse impact on operations including claims

g) Consider suitability of any new affiliated and non-affiliated material agreements, including managing general agents, third party administrators, any professional organizations and reinsurance arrangements

h) Review any ERM analysis of the transaction performed by the acquiring entity, including impacts on risk assessment, risk appetite and tolerances, and prospective solvency (capital and liquidity)

i) Require Form D filings for any affiliated material transactions, post-acquisition; consider including language in the approval order

j) Determine target’s estimated financial condition and stability, post-acquisition, and

k) Consider with disfavor any plans to liquidate the target or sell its assets, consolidate or merge, that may be unfair, unreasonable, or hazardous to policyholders

l) Consider impact of U.S. insurer merging into an international insurer and/or alerting the legal entity structure and regulatory oversight performed by domestic state(s).
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Appendix D – Form A Review Best Practices

7. Market Impact
   a) Consider anticompetitive impact of acquisition on lines or products, including whether transaction will create a monopoly or lessen competition in insurance in the state; Disapprove transaction if completion will create a monopoly
   b) Consider Form E information and market concentration for combined lines and other appropriate information to assess market impact if warranted by nature of transaction, including coordination with other states where the target is admitted, and
   c) Consider imposing tailored conditions subsequent or undertakings as necessary to address competitive market concerns

8. Post-Approval Considerations, if applicable
   a) Receive notification of changes to effective closing date
   b) Confirm compliance with conditions precedent
   c) Receive waivers for market conduct or financial examination, and
   d) Receive notification if transaction does not close and consider withdrawal of approval.

9. Post-Acquisition Considerations
   a) Receive confirmation of the transaction following the closing, per your state’s statutory requirement timeframe
   b) Request written details of the final purchase price after all adjustments are complete on the transaction
   c) Request confirmation of any capital contribution contemplated in the transaction.
   d) Request the names and titles of those individuals whom will be responsible for the filing of the amended Insurance Holding Company System Annual Registration Statement
   e) Request an amended Insurance Holding Company System Registration statement per your state’s statutory timeframe within each applicable state’s statutory required timeframe after the close of the proposed transaction.
   f) Consider requesting for a period of two years, commencing six months from closing, a semiannual report under oath of its business operations in your state, including but not limited to, integration process; any changes to the business of the Domestic Insurers; changes to employment levels; changes in offices of the Domestic Insurers; any changes in location of its operations in your state; and notice of any statutory compliance or regulatory actions taken by other state regulatory authorities against the acquiring parties or the Domestic Insurers
   g) Consider prior approval of all dividends for a two-year period from the close date
   h) Consider undergoing a target financial and/or market conduct examination following the closing or
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i) In lieu of an examination a meeting, conference call or receipt of certain information can be requested

j) Confirm compliance or satisfaction with any other conditions subsequent or undertakings, and

k) Monitor target’s market performance to projections two years after transaction close date

l) Consider proactive communication with state(s) where the insurer conducts business if changes to the insurer’s corporate structure occurs post-acquisition.
MEMORANDUM

TO: Dale Bruggeman (OH), Chair, Statutory Accounting Principles (E) Working Group
Carrie Mears (IA), Vice-Chair, Statutory Accounting Principles (E) Working Group

FROM: Commissioner Scott A. White (VA), Chair, Financial Condition (E) Committee

DATE: July 22, 2021

RE: Terminology Change – Substantive and Nonsubstantive

In response to the discussion on SSAP No. 71—Policy Acquisition Costs and Commissions, it has been highlighted that the statutory accounting terminology of “substantive” and “nonsubstantive” to describe statutory accounting revisions being considered by the Statutory Accounting Principles (E) Working Group to the Accounting Practices and Procedures Manual (AP&P Manual) could be misunderstood by those who are not familiar with the specific definitions and intended application of those terms. To avoid the incorrect perception that these terms may reflect the degree of financial impact to companies based on their common usage, the Financial Condition (E) Committee requests that the Statutory Accounting Principles consider updating these terms to prevent future misunderstandings.

The Financial Condition (E) Committee understands the terms “substantive” and “nonsubstantive” were crafted as part of the statutory accounting principles (SAP) codification, which was finalized in 1998, and were intended to be simple, concise terms to differentiate whether proposed revisions reflect new SAP concepts (substantive) or clarification of existing SAP concepts (nonsubstantive). The source location for the definitions and classification criteria of these terms is the NAIC Policy Statement on Maintenance of Statutory Accounting Principles, but it is noted that the terms and definitions are referred to throughout SAP guidance, other policy statements, issue papers, and agenda items.

Pursuant to this Committee request, the Working Group should consider eliminating “substantive” and “nonsubstantive” and instead refer to the type of revisions in accordance with the general nature in which those terms were intended to reflect. As such, a revision that would have previously been considered “substantive” could be referred to as a “New SAP Concept” and a revision that would have previously been considered as “nonsubstantive” could be referred to as a “SAP Clarification.” The Committee is not proposing that the Working Group reassess the classification criteria but is simply requesting terminology changes to prevent future misinterpretations or assessments by others. As such, unless the Working Group believes further revisions are necessary, statutory revisions that would have been previously classified as “nonsubstantive” are anticipated to continue to fall within that definition and be captured under the new terminology as a “SAP Clarification.”

To illustrate the intent of this request, draft revisions are presented for Working Group consideration. The Working Group should feel welcome to modify these draft revisions as deemed appropriate to best reflect this requested change.

If you have any questions on this request, please contact Commissioner Scott A. White, Chair of the Financial Condition (E) Committee or Dan Daveline, NAIC staff.

c: Julie Gann, Robin Marcotte, Jim Pinegar, Jake Stultz, Fatima Sediqzad
Potential Revisions to the Policy Statement:

NAIC Policy Statement on Maintenance of Statutory Accounting Principles

1. Statutory accounting principles (SAP) provide the basis for insurers to prepare financial statements to be filed with and utilized by state insurance departments for financial regulation purposes. Accuracy and completeness of such filings are critical to meaningful solvency monitoring. Accordingly, maintenance of SAP guidance for changes in the industry and changes in regulatory concerns is vital to preserving the usefulness of SAP financial statements.

2. The promulgation of new or revised SAP guidance by the NAIC ultimately requires action of the entire NAIC membership. Responsibility for proposing new or revised SAP guidance will be delegated through the NAIC committee structure to the Accounting Practices and Procedures (E) Task Force (Task Force). The Task Force will charge the Statutory Accounting Principles (E) Working Group (Working Group) with the exclusive responsibility to develop and propose new statements of statutory accounting principles (SSAPs), to revise existing SSAPs, and to issue interpretations.

Composition of the Statutory Accounting Principles (E) Working Group

3. The chair of the Task Force shall determine membership of the Working Group subject to approval by the Financial Condition (E) Committee. The Working Group shall be limited in size to no more than 15 members and will include representation from the four zones of the NAIC. Membership shall be vested in the state (until such time as the membership may be changed) but continuity of individuals, to the extent possible, is extremely desirable.

Development of New SSAPs or New SAP Concepts in an Existing SSAPSubstantively Revised SSAPs

4. New SSAPs will be developed to address, but will not be limited to: 1) concepts not previously addressed by a SSAP and that do not fit within the scope of an existing SSAP; 2) concepts that fit within the scope of an existing SSAP, but the Working Group elects to supersede existing SSAPs and 3) existing concepts that warrant significant revisions. Substantively revised New SAP concepts to existing SSAPs will be developed to address, but will not be limited to: 1) concepts that fit within the accounting topic of an existing SSAP, but have not been addressed by the Working Group; 2) changes to the valuation and/or measurement of an existing SSAP; and 3) modifications to the overall application of existing SSAPs. The decision to undertake development of a new SSAP or substantially new SAP concept in an existing revised SSAP will rest with the Working Group. New SSAPs or substantially new SAP concept in an existing revised SSAPs will have a specified effective date.

5. Research and drafting of new SSAP or substantially new SAP concept in an existing revised SSAPs will be performed by NAIC staff under the direction and supervision of the Working Group which may enlist the assistance of interested parties and/or consultants with requisite technical expertise as needed or desired. The first step in developing new SSAPs and substantially new SAP concepts in existing revised SSAPs will commonly be the drafting of an issue paper, which will contain a summary of the issue, a summary conclusion, discussion, and a relevant literature section. Public comments will be solicited on an issue paper (at least one exposure period), and at least one public hearing will be held before the issue paper is converted to a SSAP. Upon approval by the Working Group, all proposed SSAPs will be exposed for public comment for a period commensurate with the length of the draft and the complexities of the issue(s). After a hearing of comments, adoption of new SSAPs or new SAP concepts in existing revised SSAPs (including any amendments from exposure) may be made by simple majority. If no comments are received during the public comment period, the Working Group may adopt the proposal collectively (one motion/vote) with other non-contested positions after the opportunity is given during the hearing to separately discuss the proposal. All new SSAPs and substantially new SAP concepts in existing SSAPs must be on the agenda for at least one public hearing before presentation to the Task Force for
consideration. Adoption by the Task Force, its parent and the NAIC membership shall be governed by the NAIC bylaws.

6. The Working Group may, by a super majority vote (7 out of 10 members, 8 out of 11 or 12, 9 out of 13, 10 out of 14, and 11 out of 15) elect to: 1) combine the IP and SSAP process, resulting in concurrent exposure of the two documents; 2) expose and adopt revisions to a SSAP prior to the drafting/adoption of the related IP; and/or 3) forego completion of an IP and only proceed with a new SSAP or new SAP concepts in an existing revisions to a substantively revised SSAP.

7. If accounting guidance, reserving standards, asset valuation standards, or any other standards or rules affecting accounting practices and procedures are first developed by other NAIC working groups, task forces, subcommittees, or committees, such proposed guidance, standards or rules shall be presented to the Working Group for consideration. In cases where such guidance has already been subjected to substantial due process (e.g., public comment periods and/or public hearings), the Working Group may elect to shorten comment periods and/or eliminate public hearings, and in such cases, will notify the Task Force of these actions.

Development of SAP Clarifications

8. SAP clarifications Nonsubstantive revisions to SSAP will be developed to address, but will not be limited to: 1) clarification of the intent or application of existing SSAPs; 2) new disclosures and modification of existing disclosures; 3) revisions that do not change the intent of existing guidance; and 4) revisions to Appendix A—Excerpts of NAIC Model Laws to reflect amendments to NAIC adopted model laws and regulations. Research and drafting of SAP clarification nonsubstantive revisions will be performed by NAIC staff under the direction and supervision of the Working Group. Public comment will be solicited on nonsubstantive these revisions, and the item will be included on the agenda for at least one public hearing before the Working Group adopts nonsubstantive revisions. Nonsubstantive-SAP clarification revisions are considered effective immediately after adoption by the Working Group, unless the Working Group incorporates a specific effective date. If comments are not received during the public comment period, the Working Group may adopt the proposal collectively (one motion/vote) with other “non-contested” positions after opportunity is given during the hearing to separately discuss the proposal. At its discretion, the Working Group may request that an issue paper be drafted for nonsubstantive-SAP clarification revisions in order to capture historical discussion and adopted revisions. Adoption of nonsubstantive these revisions by the Task Force, its parent and the NAIC membership shall be governed by the NAIC bylaws.

New Footnote 1: Prior to (adoption date), the term used to describe a new SAP concept was “substantive” and the term used to describe a SAP clarification was “nonsubstantive.” The new terms will be reflected in materials to describe revisions to statutory accounting principles on a prospective basis and historical documents will not be updated to reflect the revised terms.

Development of Interpretations to SSAPs and Referencing Interpretations Within SSAPs

Interpretations Which DO NOT Amend, Supersede or Conflict with Existing SSAPs

9. Interpretations may be developed to address issues requiring timely application or clarification of existing SAP, which shall not amend, supersede or conflict with existing SSAPs. Issues being considered as an interpretation must be discussed at no less than two open meetings. (Original introduction of the issue when the Working Group identifies the intent to address the issue as an “interpretation” during a public discussion is considered the first open meeting discussion.) The process must allow opportunity for interested parties to provide comments, but as interpretations are intended to provide timely responses to questions of application or interpretation and clarification of guidance, no minimum exposure timeframe is required.

10. As these interpretations do not amend, supersede or conflict with existing SSAP guidance, the interpretation is effective upon Working Group adoption unless specifically stated otherwise. The voting requirement to adopt an
interpretation of this type is a simple majority. The Working Group shall report the adopted interpretation to the Account ing Practices and Procedures (E) Task Force as part of its public report during the next NAIC national meeting (or earlier if applicable). Interpretations can be overturned, amended or deferred by a two-thirds majority of the Task Force membership. For clarification, a two-thirds majority of the Task Force requires two-thirds of the entire Task Force membership, not just those electing to vote. Additionally, interpretations can be overturned, amended, deferred, or referred to either the Task Force and/or the Working Group by a simple majority of the Financial Condition (E) Committee.

Interpretations Which Amend, Supersede or Conflict with Existing SSAPs

11. In certain circumstances such as catastrophes and other time-sensitive issues requiring immediate, temporary statutory accounting guidance, the Working Group may adopt an interpretation which creates new SAP or conflicts with existing SSAPs. Historically, these interpretations temporarily modified statutory accounting principles and/or specific disclosures were developed in response to nationally significant events (e.g., Hurricane Sandy, September 11, 2001). (Examples of time-sensitive issues that have previously provided INT exceptions to SAP include the transition from LIBOR and special situations such as the federal TALF program.) Interpretations that conflict with existing SSAPs shall be temporary and restricted to circumstances arising from the need to issue guidance for circumstances requiring immediate guidance. In order to adopt an interpretation that creates new SAP or conflicts with existing SSAPs, the Working Group must have 67% of its members voting (10 out of 15 members) with a super majority (7 out of 10, 8 out of 11, 9 out of 12, 9 out of 13, 10 out of 14, or 11 out of 15) supporting adoption.

   a. These interpretations are effective upon Working Group adoption, unless stated otherwise, and shall be reported to the Accounting Practices and Procedures (E) Task Force as part of its public report during the next NAIC national meeting (or earlier if applicable). In circumstances where the Working Group adopts an interpretation (which creates new SAP or conflicts with existing SSAPs) that is controversial in nature (i.e., due to regulator or industry feedback or could have a policy level impact), the Working Group may elect to postpone the effective date until the item has been discussed by the Task Force and the Financial Condition (E) Committee and both have had an opportunity to review the interpretation.

   b. These interpretations can be overturned, amended or deferred by a two-thirds majority of the Task Force membership. For clarification, a two-thirds majority of the Task Force requires two-thirds of the entire Task Force membership, not just those electing to vote. Additionally, interpretations can be overturned, amended, deferred, or referred to either the Task Force and/or the Working Group by a simple majority of the Financial Condition (E) Committee.

12. As new SSAPs are developed, it is essential to review and, if necessary, update the status of interpretations related to SSAPs that are being replaced and/or new SSAPs being developed. The following options are available to the Working Group when a SSAP with existing interpretations is replaced:

   a. **Interpretation of the new SSAP** - If the Working Group would like to maintain the interpretation, the new SSAP can be added to the list of statements interpreted by the interpretation. In addition, the status section of the new SSAP will list the interpretation number next to the heading "Interpreted by."

   b. **Nullification** - When an interpretation is nullified by a subsequent SSAP or superseded by another interpretation, the interpretation is deemed no longer technically helpful, is shaded and moved to Appendix H (Superseded SSAPs and Nullified Interpretations), and the reason for the change is noted beneath the interpretation title. The status section of the SSAP describes the impact of the new guidance and the effect on the interpretation (for example, nullifies, incorporated in the new SSAP with paragraph reference, etc.).
c. **Incorporation** - When an interpretation is incorporated into a new SSAP, the Working Group can choose from the following two options:

i. If the interpretation only interprets one SSAP, then the interpretation is listed as being nullified under the “affects” section of the SSAP and is not referenced under the “interpreted by” section of the status page of the SSAP.

ii. If the interpretation references additional SSAPs, and the Working Group intends to maintain the guidance, the interpretation is unchanged (no nullification). The new SSAP (Summary of Issue section) reflects that the interpretation issue has been incorporated into the new statement.
Process for Evaluating Qualified and Reciprocal Jurisdictions
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I. Preamble

Purpose

The revised Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (collectively, the Credit for Reinsurance Models) require an assuming insurer to be licensed and domiciled in a “Qualified Jurisdiction” in order to be eligible for certification by a state as a certified reinsurer for reinsurance collateral reduction purposes. In 2012, the NAIC Reinsurance (E) Task Force was charged to develop an NAIC process to evaluate the reinsurance supervisory systems of non-U.S. jurisdictions, for the purposes of developing and maintaining a list of jurisdictions recommended for recognition by the states as Qualified Jurisdictions. This charge was extended in 2019 to encompass the recognition of Reciprocal Jurisdictions in accordance with the 2019 amendments to the Credit for Reinsurance Models, including the maintenance of a list of recommended Reciprocal Jurisdictions. The purpose of the Process for Evaluating Qualified and Reciprocal Jurisdictions is to provide a documented evaluation process for creating and maintaining these NAIC lists.

Background

On November 6, 2011, the NAIC Executive (EX) Committee and Plenary adopted revisions to the Credit for Reinsurance Models. These revisions serve to reduce reinsurance collateral requirements for certified reinsurers that are licensed and domiciled in Qualified Jurisdictions. Under the previous version of the Credit for Reinsurance Models, in order for U.S. ceding insurers to receive reinsurance credit, the reinsurance was required to be ceded to U.S.-licensed reinsurers or secured by collateral representing 100% of U.S. liabilities for which the credit is recorded. When considering revisions to the Credit for Reinsurance Models, the Reinsurance (E) Task Force contemplated establishing an accreditation-like process, modeled on the current NAIC Financial Regulation Standards and Accreditation Program, to review the reinsurance supervisory systems of non-U.S. jurisdictions. Under the revised Credit for Reinsurance Models, the approval of Qualified Jurisdictions is left to the authority of the states; however, the models provide that a list of Qualified Jurisdictions will be created through the NAIC committee process, and that individual states must consider this list when approving jurisdictions.

The enactment in 2010 of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act), enacted in 2010, Further, the Dodd-Frank Act authorizes the U.S. Treasury Secretary and the U.S. Trade Representative (USTR), jointly, to negotiate and enter into “covered agreements” on behalf of the United States. These are bilateral or multilateral—agreements with foreign governments, authorities or regulators relating to insurance prudential measures, which can preempt contrary state insurance laws or regulatory measures. The Dodd-Frank Act also created the Federal Insurance Office (FIO), which has the following authority: (1) coordinate federal efforts and develop federal policy on prudential aspects of international insurance matters; (2) assist the Secretary of the U.S. Department of the Treasury in negotiating covered agreements (as defined in the Dodd-Frank Act); (3) determine whether the states’ insurance measures are preempted by covered agreements; and (4) consult with the states (including state insurance regulators) regarding insurance matters of national importance and prudential insurance matters of international importance. Further, the Dodd-Frank Act authorizes the U.S. Treasury Secretary and the U.S. Trade Representative (USTR), jointly, to negotiate and enter into covered agreements on behalf of the United States. It is the NAIC’s intention to communicate and coordinate with the FIO and related federal authorities as appropriate with respect to the evaluation of the reinsurance supervisory systems of non-U.S. jurisdictions.
On September 22, 2017, the United States and the European Union (EU) entered into the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance.” A similar agreement with the United Kingdom (UK) was signed on December 18, 2018. Both agreements (collectively referred to as the “Covered Agreements”) will require the states to eliminate reinsurance collateral requirements for reinsurers licensed and domiciled in these jurisdictions within 60 months (five years) after signing or face potential federal preemption by the Federal Insurance Office (FIO) under the Dodd-Frank Act.

**Reciprocal Jurisdictions**

On June 25, 2019, the NAIC Executive (EX) Committee and Plenary adopted revisions to the Credit for Reinsurance Models. These revisions were intended to conform the Models to the relevant provisions of the Covered Agreements. The Covered Agreements would eliminate reinsurance collateral requirements for EU and UK reinsurers that maintain a minimum amount of own funds equivalent to $250 million and a solvency capital requirement (SCR) of 100% under Solvency II, among other conditions. Conversely, U.S. reinsurers that maintain capital and surplus equivalent to 226 million euros with a risk-based capital (RBC) of 300% of authorized control level would not be required to maintain a local presence in order to do business in the EU or UK or post reinsurance collateral. Under the revised Credit for Reinsurance Models, jurisdictions that are subject to in-force Covered Agreements are considered to be Reciprocal Jurisdictions, and reinsurers that have their head office or are domiciled in a Reciprocal Jurisdiction are not required to post reinsurance collateral if they meet all of the requirements of the Credit for Reinsurance Models.

Under the revised Credit for Reinsurance Models, not only are jurisdictions that are subject to Covered Agreements treated as Reciprocal Jurisdictions for reinsurance collateral purposes, but any other Qualified Jurisdictions can also have a pathway to qualify for collateral elimination as Reciprocal Jurisdictions States that meet the requirements of the NAIC Financial Standards and Accreditation Program are also considered to be Reciprocal Jurisdictions.

The NAIC has updated and revised this Process for Evaluating Qualified and Reciprocal Jurisdictions to specify how Qualified Jurisdictions that recognize key NAIC solvency initiatives, including group supervision and group capital standards, and also meet the other requirements under the revised Credit for Reinsurance Models, will be recognized as Reciprocal Jurisdictions and receive similar treatment as that provided under the EU and UK Covered Agreements, including the elimination of reinsurance collateral and local presence requirements by the states.

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1 The hypothetical possibility that a future covered agreement might not relate to reinsurance is addressed in Section 2F(1)(a)(i) of Model #785, which limits automatic Reciprocal Jurisdiction status to a covered agreement that “addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance.”
II. Principles for the Evaluation of Non-U.S. Jurisdictions

1. The NAIC model revisions applicable to certified reinsurers are intended to facilitate cross-border reinsurance transactions and enhance competition within the U.S. market, while ensuring that U.S. insurers and policyholders are adequately protected against the risk of insolvency. To be eligible for certification, a reinsurer must be domiciled and licensed in a Qualified Jurisdiction as determined by the domestic regulator of the ceding insurer. A Qualified Jurisdiction not subject to an in-force Covered Agreement under the Dodd-Frank Act may also be determined to be a Reciprocal Jurisdiction, and reinsurers that have their head office or are domiciled in any such Reciprocal Jurisdiction will not be required to post reinsurance collateral, provided they meet the minimum capital and financial strength requirements and comply with the other requirements of the Credit for Reinsurance Models.

2. The evaluation of non-U.S. jurisdictions as Qualified Jurisdictions and Reciprocal Jurisdictions will be conducted in accordance with the provisions of the Credit for Reinsurance Models and any other relevant guidance developed by the NAIC.

3. The evaluation of non-U.S. jurisdictions as Qualified Jurisdictions is intended as an outcomes-based comparison to financial solvency regulation under the NAIC Financial Regulation Standards and Accreditation Program (Accreditation Program), adherence to international supervisory standards, and relevant international guidance for recognition of reinsurance supervision. It is not intended as a prescriptive comparison to the NAIC Accreditation Program. In order for a Qualified Jurisdiction that is not subject to an in-force Covered Agreement to be evaluated as a Reciprocal Jurisdiction, that Qualified Jurisdiction must agree to recognize the states’ approach to group supervision, including group capital, and other such requirements as provided under the Credit for Reinsurance Models.

4. The states shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system within the Qualified Jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the jurisdiction to reinsurers licensed and domiciled in the U.S. The determination of Qualified Jurisdiction status is based on the effectiveness of the entire reinsurance supervisory system within the jurisdiction.

5. Each state may evaluate a non-U.S. jurisdiction to determine if it is a Qualified Jurisdiction. A list of Qualified Jurisdictions will be published through the NAIC committee process. A state must consider this list in its determination of Qualified Jurisdictions, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Qualified Jurisdictions contained in the Credit for Reinsurance Models. The creation of this list does not constitute a delegation of regulatory authority to the NAIC. The regulatory authority to recognize a Qualified Jurisdiction resides solely in each state and the NAIC List of Qualified Jurisdictions is not binding on the states.

6. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the List of Reciprocal Jurisdictions. A state must consider this list in its determination of Reciprocal Jurisdiction status, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Reciprocal Jurisdictions contained in the Credit for Reinsurance Models. Under the
Credit for Reinsurance Model Law (as adopted by a state) the state must recognize the Reciprocal Jurisdiction status of jurisdictions subject to an in-force Covered Agreement.

7. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting,” as discussed more fully below in paragraph 15 of Section III, under which the commissioner has the discretion to defer to another state’s determination that a jurisdiction is a Qualified or Reciprocal Jurisdiction. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings. The NAIC Lists of Qualified and Reciprocal Jurisdictions are intended to facilitate the passporting process.

8. Both Qualified Jurisdictions and Reciprocal Jurisdictions have must agreed to share information and cooperate with the state with respect to all applicable reinsurers domiciled within that jurisdiction, in accordance with the Credit for Reinsurance Models, as adopted by the state. Critical factors in the evaluation process include but are not limited to the history of performance by assuming insurers in the applicant jurisdiction and any documented evidence of substantial problems with the enforcement of final U.S. judgments in the applicant jurisdiction. A jurisdiction will not be a Qualified Jurisdiction if the commissioner has determined that it does not adequately and promptly enforce final U.S. judgments or arbitration awards.

9. The determination of Qualified Jurisdiction status can only be made with respect to the reinsurance supervisory system in existence and applied by a non-U.S. jurisdiction at the time of the evaluation.

10. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to the evaluation of the reinsurance supervisory systems of non-U.S. jurisdictions.
III. Procedure for Evaluation of Non-U.S. Jurisdictions

   a. Priority will be given to requests from the states and from those jurisdictions specifically requesting an evaluation by the NAIC.
   b. Formal notification of the NAIC’s intent to initiate the evaluation process will be sent by the NAIC to the reinsurance supervisory authority in the jurisdiction selected, with copies to the FIO and other relevant federal authorities as appropriate. The NAIC will issue public notice on the NAIC website upon confirmation that the jurisdiction is willing to participate in the evaluation process. The NAIC will at this time request public comments with respect to consideration of the jurisdiction as a Qualified Jurisdiction. The process of evaluation and all related documentation are private and confidential matters between the NAIC and the applicant jurisdiction, unless otherwise provided in this document, subject to a preliminary confidentiality and information sharing agreement between the NAIC, relevant states and the applicant jurisdiction.
   c. Relevant U.S. state and federal authorities will be notified of the NAIC’s decision to evaluate a jurisdiction.

2. Evaluation of Jurisdiction
   a. Evaluation Materials. The Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group will initiate evaluation of a jurisdiction’s regulatory system by using the information identified in Section A through Section G of the Evaluation Methodology (Evaluation Materials). The Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group will begin by undertaking a review of the most recent Financial Sector Assessment Program (FSAP) Report prepared by the International Monetary Fund (IMF), including the Technical Note on Insurance Sector Supervision, and any other publicly available information regarding the laws, regulations, practices and procedures applicable to the reinsurance supervisory system. The Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group will also invite each jurisdiction or its designee to provide information relative to Section A through Section G of the Evaluation Methodology in order to update, complete or supplement publicly available information. The Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group may also request or accept relevant information from reinsurers domiciled in the jurisdiction under review.
   
   b. The Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group will notify the jurisdiction of any information upon which the Working Group is relying. In that communication, the NAIC will invite the supervisory authority to compare the materials identified by the NAIC to the materials described in Appendix A and Appendix B, and provide information required to update the identified public information or supplement the public information, as required, to address the topics identified in Section A through Section G of the Evaluation Methodology. The use of publicly available information (e.g., the FSAP Report and/or the Insurance Sector Technical Note) is intended to lessen the burden on applicant jurisdictions by requiring the production of information that is readily available, while still addressing substantive areas of inquiry detailed in the Evaluation Methodology. The Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group’s review at this stage will be focused on how the jurisdiction’s laws, regulations, administrative practices and procedures, and regulatory authorities regulate the financial solvency of its domestic reinsurers in comparison to key
principles underlying the U.S. financial solvency framework\(^2\) and other factors set forth in the Evaluation Methodology.

c. After reviewing the Evaluation Materials, the Qualified Jurisdiction Working Group (E) Working Group may request that the applicant jurisdiction submit supplemental information as necessary to determine whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. The Working Group will address specific questions directly with the jurisdiction related to items detailed in the Evaluation Methodology that are not otherwise addressed in the Evaluation Materials.

d. The NAIC will request that all responses from the jurisdiction being evaluated be provided in English. Any responses submitted with respect to a jurisdiction’s laws and regulations should be provided by a person qualified in that jurisdiction to provide such analyses and, in the case of statutory analysis, qualified to provide such legal interpretations, to ensure that the jurisdiction is providing an accurate description.

e. The NAIC does not intend to review confidential company-specific information in this process, and has focused the procedure on reviewing publicly available information. No confidential company-specific information shall be disclosed or disseminated during the course of the jurisdiction’s evaluation unless specifically requested, subject to appropriate confidentiality safeguards addressed in a preliminary confidentiality and information-sharing agreement. If no such agreement is executed or the jurisdiction is unable to enter into such an agreement under its regulatory authority, the NAIC will not accept any confidential company-specific information.

3. NAIC Review of Evaluation Materials

a. NAIC staff and/or outside consultants with the appropriate knowledge, experience and expertise will review the jurisdiction’s Evaluation Materials.

b. Expenses with respect to the evaluations will be absorbed within the NAIC budget. This will be periodically reviewed.

c. Timeline for review. A project management approach will be developed with respect to the overall timeline applicable to each evaluation.

d. Upon completing its review of the Evaluation Materials, the internal reviewer(s) will report initial findings to the Qualified Jurisdiction Working Group (E) Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation. Copies of the initial findings may also be made available to FIO and other relevant federal authorities subject to appropriate confidentiality and information-sharing agreements being in place.

4. Discretionary On-site Review

a. The NAIC may ask the jurisdiction under consideration for the opportunity to perform an on-site review of the jurisdiction’s reinsurance supervisory system. Factors that the Qualified Jurisdiction Working Group (E) Working Group will consider in determining whether an on-

\(^2\) The U.S. financial solvency framework is understood to refer to the key elements provided in the NAIC Financial Regulation Standards and Accreditation Program. Appendix A and Appendix B are derived from this framework.
site review is appropriate include the completeness of the information provided by the jurisdiction under review, the general familiarity of the jurisdiction by the NAIC staff or other state regulators participating in the review based on prior conduct or dealings with the jurisdiction, and the results of other evaluations performed by other regulatory or supervisory organizations. If the review is performed, it will be coordinated through the NAIC, utilizing personnel with the appropriate knowledge, experience and expertise. Individual states may also request that representatives from their state be added to the review team.

b. The review team will communicate with the supervisory authority in advance of the on-site visit to clearly identify the objectives, expectations and procedures with respect to the review, as well as any significant issues or concerns identified within the review of the Evaluation Materials. Information to be considered during the on-site review includes, but is not limited to, the following:

i. Interviews with supervisory authority personnel.

ii. Review of organizational and personnel practices.

iii. Any additional information beneficial to gaining an understanding of document and communication flows.

c. Upon completing the on-site review, the reviewer(s) will report initial findings to the Qualified Jurisdiction Working Group Mutually Recognized Jurisdictions (E) Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation.

5. Standard of Review

The evaluation is intended as an outcomes-based comparison to financial solvency regulation under the NAIC Accreditation Program, adherence to international supervisory standards and relevant international guidance for recognition of reinsurance supervision. The standard for qualification of a jurisdiction is that the NAIC must reasonably conclude that the jurisdiction’s reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction, that the jurisdiction’s demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system, and that the jurisdiction’s laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

6. Additional Information to be Considered as Part of Evaluation

The NAIC may also consider information from sources other than the jurisdiction under review. This information includes:

a. Documents, reports and information from appropriate international, U.S. federal and U.S. state authorities.

b. Public comments from interested parties.

c. Rating agency information.

d. Any other relevant information.
7. Preliminary Evaluation Report

a. NAIC staff and/or outside consultants will prepare a Preliminary Evaluation Report for review by the Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group. This preliminary report will be private and confidential (i.e., may only be reviewed by Working Group members, designated NAIC staff, consultants, the states, the FIO and other relevant federal authorities that specifically request to be kept apprised of this information, provided that such entities have entered into a preliminary confidentiality and information-sharing agreement with the foreign jurisdiction. Any outside consultants retained by the NAIC will be required to enter into a confidentiality and nondisclosure agreement.).

b. The report will be prepared in a consistent style and format to be developed by NAIC staff. It will contain detailed advisory information and recommendations with respect to the evaluation of the jurisdiction’s reinsurance supervisory system and the documented practices and procedures thereunder. The report will contain a recommendation as to whether the NAIC should recognize the jurisdiction as a Qualified Jurisdiction.

c. All workpapers and reports, including supporting documentation and data, produced as part of the evaluation process are the property of the NAIC and shall be maintained at the NAIC Central Office. In the event that the NAIC shall come into possession of any confidential information, the information shall be held subject to a confidentiality and information-sharing agreement, which will outline the appropriate actions necessary to protect the confidentiality of such information.


a. The Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group’s review of the Preliminary Evaluation Report will be held in regulator-to-regulator session in accordance with the NAIC Policy Statement on Open Meetings.

b. The Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group will make a preliminary determination as to whether the jurisdiction under consideration satisfies the Standard of Review and is deemed acceptable to be included on the NAIC List of Qualified Jurisdictions. If the preliminary determination is that the jurisdiction should not be included on the NAIC List of Qualified Jurisdictions, the Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group will set forth its specific findings and identify those areas of concern with respect to this determination.

c. The results of the Preliminary Evaluation Report will be immediately communicated in written form to the supervisory authority of the jurisdiction under review.


a. Upon receipt of the Preliminary Evaluation Report, the supervisory authority will have an opportunity to respond to the initial findings and determination. This is not intended to be a formal appeals process that would initiate U.S. state administrative due process requirements.

b. The Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group will consider any response, and will proceed to prepare its Final Evaluation Report. The Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group will consider the Final Evaluation Report for approval in regulator-to-regulator session in accordance with the NAIC Policy Statement on
Open Meetings. This report will be approved upon an affirmative vote of a majority of the members in attendance at this meeting.

c. Upon approval of the Final Evaluation Report, the Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group will issue a public statement and a summary of its findings with respect to its determination. At this time, the Working Group will release the summary for public comment. The detailed report will be a confidential, regulator-only document. The report may be shared with any state indicating that it is considering relying on the NAIC List of Qualified Jurisdictions and has entered into a preliminary confidentiality and information-sharing agreement with the foreign jurisdiction.

10. NAIC Determination Regarding List of Qualified Jurisdictions

a. Once the Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group has adopted its Final Evaluation Report, it will submit the summary of its findings and its recommendation to the Reinsurance (E) Task Force at an open meeting. Upon approval by the Reinsurance (E) Task Force, the summary and recommendation will be submitted to the Executive (EX) Committee and Plenary, as well as to the FIO, USTR and other relevant federal authorities for consultation purposes. Upon approval as a Qualified Jurisdiction by the Executive (EX) Committee and Plenary, the jurisdiction will be added to the NAIC List of Qualified Jurisdictions. The NAIC will maintain the List of Qualified Jurisdictions on its public website and in other appropriate NAIC publications.

b. In the event that a jurisdiction is not approved as a Qualified Jurisdiction, the supervisory authority will be eligible for reapplication at the discretion of the NAIC.

c. Upon final adoption of the Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group’s determination with respect to a jurisdiction, the Final Evaluation Report will be made available to individual U.S. state insurance regulators upon request and confirmation that the information contained therein will remain confidential.

11. Memorandum of Understanding (MOU)

a. A Qualified Jurisdiction must agree to share information and cooperate on a confidential basis with the U.S. state insurance regulatory authority with respect to all certified reinsurers domiciled within that jurisdiction.

b. The International Association of Insurance Supervisors (IAIS) Multilateral Memorandum of Understanding (MMoU) is the recommended method under which a Qualified Jurisdiction will agree to share information and cooperate with U.S. state insurance regulatory authorities. However, until such time as a state has been approved as a signatory to the MMoU by the IAIS, the state may rely on an MOU entered into by a “Lead State” designated by the NAIC. This Lead State will act as a conduit for information between the Qualified Jurisdiction and other states that have certified a reinsurer domiciled in that jurisdiction, and will share information with these states consistent with the terms governing the further sharing of information included in the NAIC Master Information Sharing and Confidentiality Agreement, and, as applicable, in the applicable IAIS MMoU, or in a bilateral MOU between the Lead State and the Qualified Jurisdiction and pursuant to the NAIC Master Information Sharing and Confidentiality Agreement. The jurisdiction must also confirm in writing that it is willing to permit this Lead State to act as the contact for purposes of obtaining information concerning its certified reinsurers, provided the Lead State share that information with the other states requesting the information only in a manner consistent with the terms
governing the further sharing of information included, as in the applicable, in the IAIS MMoU or bilateral MOU between the Lead State and the Qualified Jurisdiction.

c. If a Qualified Jurisdiction has not been approved by the IAIS as a party to the MMoU, it must enter into an MOU with a Lead State. The MOU must provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions.

d. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to this process.

12. Process for Evaluation after Initial Approval

a. The process for determining whether a non-U.S. jurisdiction is a Qualified Jurisdiction is ongoing and subject to periodic review. The Qualified Jurisdiction Working Group will perform a yearly review of Qualified Jurisdictions to determine whether there have been any significant changes over the prior year that might affect their status as Qualified Jurisdictions. This yearly review shall follow such abbreviated process as may be determined by the Qualified Jurisdiction Working Group to be appropriate. It shall include a review of the jurisdiction’s status as a Reciprocal Jurisdiction if the jurisdiction has been recognized by the NAIC as a Reciprocal Jurisdiction through the process established in paragraph 13.

b. Qualified Jurisdictions must provide the Qualified Jurisdiction Working Group with notice of any material change in the applicable reinsurance supervisory system that may affect the status of the Qualified Jurisdiction. A U.S. jurisdiction should also notify the Qualified Jurisdiction Working Group if it receives notice of any material change in the applicable reinsurance supervisory system, or any adverse developments with respect to enforcement of final U.S. judgments, that may affect the status of the Qualified Jurisdiction. U.S. ceding insurers may also initiate notice to the Qualified Jurisdiction Working Group if they receive notice of any material change in the applicable reinsurance supervisory system or any adverse developments with respect to enforcement of final U.S. judgments. Upon receipt of any such notice, the Qualified Jurisdiction Working Group will consider whether it is necessary to re-evaluate the status of the Qualified Jurisdiction. Any review will be conducted in accordance with the procedure set forth in paragraph 14.

c. If the Qualified Jurisdiction Working Group finds the jurisdiction to be out of compliance at any time with the requirements to be a Qualified Jurisdiction, the specific reasons will be documented in a report to the jurisdiction under review, and the status as a Qualified Jurisdiction may be placed on probation, suspended or revoked.

d. The Qualified Jurisdiction Working Group will consider whether it is necessary to re-evaluate the status of the Qualified Jurisdiction. Any review will be conducted in accordance with the procedure set forth in paragraph 14.

e. The Qualified Jurisdiction Working Group will monitor those jurisdictions that have been approved as Qualified or Reciprocal Jurisdictions by individual states, but are not included on the applicable NAIC List of Qualified Jurisdictions.
13. Review of Qualified Jurisdictions as Potential Reciprocal Jurisdictions

a. In undertaking the evaluation of whether to designate a Qualified Jurisdiction as a Reciprocal Jurisdiction, the Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group shall utilize such processes and procedures as outlined in the immediately-preceding paragraphs 1 – 12 of Section III. Procedure for Evaluation of Non-U.S. Jurisdictions such as the Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group deems is appropriate. Specifically, the Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group will use processes and procedures outlined in paragraph 1 (Initiation of Evaluation of the Reinsurance Supervisory System of an Individual Jurisdiction), paragraph 3 (NAIC Review of Evaluation Materials), paragraph 7 (Preliminary Evaluation Report), paragraph 8 (Review of Preliminary Evaluation Report), paragraph 9 (Opportunity to Respond to Preliminary Evaluation Report), paragraph 10 (NAIC Determination regarding List of Qualified Jurisdictions), paragraph 11 (Memorandum of Understanding) and paragraph 12 (Process for Evaluation after Initial Approval), as modified for use with applicants for Reciprocal Jurisdiction status.

b. A Qualified Jurisdiction may not be reviewed for inclusion on the NAIC List of Reciprocal Jurisdictions, unless it has undergone the Evaluation Methodology outlined in Section IV, and remains in good standing with the NAIC as a Qualified Jurisdiction. The Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group may, if it determines an extended review period to be appropriate after its initial approval of a new Qualified Jurisdiction, defer consideration of that jurisdiction as a possible Reciprocal Jurisdiction until there has been sufficient United States experience with that jurisdiction and its Certified Insurers that the Working Group believes it is appropriate to progress from collateral reduction to collateral elimination. Nothing in this process requires a finding that a Qualified Jurisdiction meets the standards for recognition as a Reciprocal Jurisdiction, and the Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group may base such recommendation its determination on all relevant information, which may include factors not specifically included in this Process for Evaluating Qualified and Reciprocal Jurisdictions.

c. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the NAIC List of Reciprocal Jurisdictions. In making its recommendation with respect to whether a Qualified Jurisdiction that is not automatically designated as a Reciprocal Jurisdiction should be added to the NAIC List of Reciprocal Jurisdictions, the Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group shall undertake the following analysis in making its evaluation:

   i. The Qualified Jurisdiction must confirm that an insurer which has its head office or is domiciled in that jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as the same insurer would receive credit for reinsurance assumed by an assuming insurers domiciled in that jurisdiction is received by United States ceding insurers;

   ii. The Qualified Jurisdiction must confirm that it does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by that jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;
iii. The Qualified Jurisdiction must recognize the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by its competent regulatory authority that insurance groups that are domiciled or maintain their worldwide headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision, including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision by the Qualified Jurisdiction at the level of the worldwide parent undertaking of the insurance or reinsurance group by the Qualified Jurisdiction;

iv. The Qualified Jurisdiction must provide written confirmation by its competent regulatory authority that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the Qualified Jurisdiction, including but not limited to the IAIS MMoU or other multilateral memoranda of understanding coordinated by the NAIC. This requirement may be satisfied by an MOU with a Lead State, which shall provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions, similar to the MOU requirement outlined in paragraph 11 of this section III; and

v. The Qualified Jurisdiction must confirm that it will provide to the states on an annual basis confirmation that each eligible assuming insurer that is domiciled in the Qualified Jurisdiction continues to comply with the requirements set forth in Section 9C(2) and (3) of Model #786; i.e., must maintain, on an ongoing basis, minimum capital and surplus of no less than $250,000,000, and maintains on an ongoing basis the required minimum solvency or capital ratio, as applicable.

d. In order to satisfy the requirements of subsection (c) above, the chief insurance supervisor of the Qualified Jurisdiction being evaluated as a Reciprocal Jurisdiction may provide the NAIC with a written letter confirming, as follows:

[Jurisdiction] is a Qualified Jurisdiction under the NAIC Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786), and is currently in good standing on the NAIC List of Qualified Jurisdictions. As the lead insurance regulatory supervisor for [Jurisdiction], I hereby confirm to the National Association of Insurance Commissioners (NAIC) and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories the following:

- An insurer which has its head office or is domiciled in [Jurisdiction] shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit would be granted for reinsurance assumed by insurers domiciled in [Jurisdiction]-is received by United States ceding insurers. [Jurisdiction] does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by [Jurisdiction] or as a condition to allow the ceding insurer to recognize credit for such reinsurance.
• [Jurisdiction] recognizes the U.S. state regulatory approach to group supervision and group capital, and confirms that insurance groups that are domiciled or maintain their worldwide headquarters in jurisdictions accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the [Jurisdiction].

• [Jurisdiction] confirms that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the [Jurisdiction].

• [Jurisdiction] will annually provide to the states confirmation that applicable assuming insurers domiciled in [Jurisdiction] maintain minimum capital and surplus of no less than $250,000,000, and maintain on an ongoing basis the required minimum solvency or capital ratio, as applicable.

• Finally, I confirm that [Jurisdiction] will immediately notify the NAIC upon any changes to the assurances provided in this letter.

e. The Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group will perform a due diligence review of available public and confidential documents to confirm that to the best of its determination, the representations in the letter are true and accurate, and will prepare for the review by the Reinsurance Task Force a Summary of Findings and Determination recommending that the Qualified Jurisdiction be recognized as a Reciprocal Jurisdiction. Upon approval by the Task Force, the Summary of Findings and Determination must be adopted by will be submitted for a vote of the NAIC Executive (EX) Committee and Plenary for inclusion on the List of Reciprocal Jurisdictions.

f. The Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group, working in coordination with the Qualified Jurisdiction and the Reinsurance Financial Analysis (E) Working Group, must make a determination on a minimum solvency or capital ratio under which reinsurers licensed and domiciled in the Qualified Jurisdiction may assume insurance from U.S. ceding companies without posting reinsurance collateral. The applicable minimum solvency or capital ratio must be an effective measure of solvency, comparable to either an NAIC risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, or one hundred percent (100%) of the solvency capital requirement (SCR) as calculated under the Solvency II Directive issued by the European Union, giving due consideration to any applicable equivalency assessment conducted by the European Insurance and Occupational Pensions Authority (EIOPA) on the Qualified Jurisdiction with respect to Solvency II.

14. Termination of Status as Qualified and/or Reciprocal Jurisdiction

a. If the Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group finds the Qualified Jurisdiction to be out of compliance at any time with the requirements to be a Qualified
Jurisdiction, the specific reasons will be documented in a report to the jurisdiction under review. The Mutual Recognition of Jurisdictions (E) Working Group would then report any concerns to the Reinsurance (E) Task Force for further discussion and communication with appropriate federal and/or international authorities, and the status as a Qualified Jurisdiction may be placed on probation, suspended or revoked by the NAIC. If a Qualified Jurisdiction is also a Reciprocal Jurisdiction subject to a Covered Agreement, the Mutual Recognition of Jurisdictions (E) Working Group and the NAIC will initiate communications and consult with FIO, USTR and any other relevant federal and/or international authorities before any action is taken with respect to that Qualified Jurisdiction’s status.

b. Except for Reciprocal Jurisdictions entitled to automatic recognition, a jurisdiction’s status as a Reciprocal Jurisdiction may be placed on probation, suspended or revoked for good cause in the same manner as provided for Qualified Jurisdictions under paragraph 12. If cause is found to question the fitness of a Reciprocal Jurisdiction that is subject to an in-force Covered Agreement, or its compliance with applicable requirements of the covered agreement, the Qualified Jurisdiction Working Group would report any concerns to its parent the Reinsurance (E) Task Force for further discussion and communication with appropriate federal and/or international authorities. It is intended that compliance with the covered agreement will be addressed through the Joint Committee process established under the covered agreement, or through termination of the covered agreement by the parties to the covered agreement. The NAIC, individual state regulators and interested parties may raise these issues directly with FIO, USTR or other relevant federal authorities.

c. Both Qualified Jurisdictions and Reciprocal Jurisdictions that are not subject to a covered agreement are obligated to provide notice to the Mutual Recognition of Jurisdictions (E) Working Group of any applicable changes to their reinsurance supervisory system or changes to the assurances provided in the letter set forth in paragraph 13. States and U.S. ceding insurers may also provide notice of such changes to the Working Group. Upon notice of any such material changes, the Working Group will meet in regulator-only session to determine if these changes are in fact material to continuing recognition by the NAIC as either a Qualified or Reciprocal Jurisdiction. The Working Group will work directly with the jurisdiction to address any issues that have been identified. If these issues cannot be resolved through this regulator-only dialogue, then the Working Group will report its recommendation to the Reinsurance Task Force, which will consider a suspension of the jurisdiction’s status as a Qualified or Reciprocal Jurisdiction in open session. The Task Force will then make a recommendation to the NAIC Plenary on the action, if any, to be taken, which may include placing the Qualified or Reciprocal Jurisdiction’s status on probation, or suspending or revoking its status.

d. If a Qualified or Reciprocal Jurisdiction’s status is placed on probation by the NAIC, the material change will be noted in an update to its Summary of Finding and Determination in order to provide notice to the states and U.S. ceding insurers of this material change. If the NAIC decides to suspend or revoke its status, the jurisdiction may be given a reasonable time period, no more than 18 months, to rectify its noncompliance with the standards and return it to good standing. Once the NAIC’s suspension or revocation takes effect, it is expected that the same action will be taken by the respective states that have recognized the jurisdiction as a Qualified or Reciprocal Jurisdiction.
e. There is no administrative right to appeal the decision of the NAIC with respect to the revocation of status as a Qualified or Reciprocal Jurisdiction, but the jurisdiction can apply for reinstatement after a one-year period.

b.f. During the period in which a Qualified or Reciprocal Jurisdiction’s status has been suspended by a state, any new reinsurance assumed by a reinsurer domiciled in that jurisdiction from a ceding insurer domiciled in that state will not be eligible for credit unless the transaction qualifies for credit on the basis of security posted by the ceding insurer or some other basis that does not depend on recognition of the jurisdiction as a Qualified or Reciprocal Jurisdiction. However, suspension does not affect credit for reinsurance that was already in force.

g. If a Qualified or Reciprocal Jurisdiction’s status is revoked by a state, then those Certified Reinsurers and/or Reciprocal Jurisdiction Reinsurers domiciled in that jurisdiction lose no longer qualify for that status, which generally obligates them to post one hundred percent (100%) collateral on all their liabilities assumed from ceding insurers domiciled in that state. The state has the option to suspend a reinsurer’s certification indefinitely, in lieu of revocation, in which case the obligation to post collateral applies prospectively to all new, renewed and amended reinsurance agreements. If the reinsurer’s eligibility is revoked, it must be granted at least three months after the effective date of the revocation to cure any deficiency in collateral, unless exceptional circumstances make a shorter period necessary for policyholder and other consumer protection.

h. The factors used in the evaluation of Reciprocal Jurisdictions are not the same as are utilized in the evaluation of Qualified Jurisdictions. A Qualified Jurisdiction that has been approved by the NAIC as a Reciprocal Jurisdiction may have its status as a Reciprocal Jurisdiction either suspended or revoked but still meet the requirements to be a Qualified Jurisdiction. However, if a Reciprocal Jurisdiction that is not subject to a covered agreement has its status as a Qualified Jurisdiction revoked, it cannot maintain its status as a Reciprocal Jurisdiction, because it must be a Qualified Jurisdiction to meet the requirements of a Reciprocal Jurisdiction.

15. Passorting Process for Certified and Reciprocal Jurisdiction Reinsurers

a. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passorting” under which the commissioner has the discretion to defer to another state’s determination with respect to the requirements for both Certified Reinsurers and Reciprocal Jurisdiction Reinsurers. Passorting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passorting process. States are also encouraged to utilize the passorting process to reduce the amount of documentation filed with the states and reduce duplicate filings.

b. The passorting process is facilitated through the Reinsurance Financial Analysis (E) Working Group (ReFAWG). It is intended that ReFAWG will help facilitate multi-state recognition of Certified Reinsurers and Reciprocal Jurisdiction Reinsurers and address issues of uniformity among the states, both with respect to initial application and subsequent changes in rating or status. The ReFAWG Review Process is set forth in the ReFAWG Procedures Manual.
c. Section 9C(7) of the Credit for Reinsurance Model Regulation (#786) provides that the “assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis that the assuming insurer complies with the requirements set forth in Paragraphs (2) [i.e., minimum capital and surplus of no less than $250 million] and (3) [i.e., minimum solvency or capital ratio] of this subsection.” Section 9E(1) of Model #786 then provides that “The commissioner may accept financial documentation filed with another NAIC accredited jurisdiction or with the NAIC in satisfaction of the requirements of Subsection C.” A Reciprocal Jurisdiction may satisfy the requirements of Section 9C(7) of Model #786 either by providing the information required by Section 9C(7) itself, or by providing an assuming insurer domiciled in that Reciprocal Jurisdiction with a document confirming the required information, which the assuming insurer would file annually. With either filing method, in lieu of filing the required information directly with the domiciliary states of each of the reinsurer’s U.S. ceding companies, the information may be filed with either its Lead State or the NAIC, which will share this documentation with the other states through the ReFAWG Review Process in satisfaction of their respective filing requirements.
IV. Evaluation Methodology

The Evaluation Methodology was developed to be consistent with the provisions of the NAIC Credit for Reinsurance Models. It is intended to provide an outcomes-based comparison to financial solvency regulation under the NAIC Accreditation Program, adherence to international supervisory standards and relevant international guidance for recognition of reinsurance supervision. Although the methodology includes a comparison of the jurisdiction’s supervisory system to a number of key elements from the NAIC Accreditation Program, it is not intended as a prescriptive assessment under the NAIC Accreditation Program. Rather, the NAIC Accreditation Program simply provide the framework for the outcomes-based analysis. The NAIC will evaluate the appropriateness and effectiveness of the reinsurance supervisory system within the jurisdiction and consider the rights, benefits and the extent of reciprocal recognition afforded by the jurisdiction to reinsurers licensed and domiciled in the U.S. The determination of a Qualified Jurisdiction is based on the effectiveness of the entire reinsurance supervisory system within the jurisdiction.

The Evaluation Methodology consists of the following:

- Section A: Laws and Regulations
- Section B: Regulatory Practices and Procedures
- Section C: Jurisdiction’s Requirements Applicable to U.S.-Domiciled Reinsurers
- Section D: Regulatory Cooperation and Information Sharing
- Section E: History of Performance of Domestic Reinsurers
- Section F: Enforcement of Final U.S. Judgments
- Section G: Solvent Schemes of Arrangement

This information will be the basis for the Final Evaluation Report and the determination of whether the jurisdiction will be included on the NAIC List of Qualified Jurisdictions.
Section A: Laws and Regulations

The NAIC will review publicly available information, as well as information provided by an applicant jurisdiction with respect to its laws and regulations, in an effort to evaluate whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. This will include a review of elements believed to be basic building blocks for sound insurance/reinsurance regulation. A jurisdiction’s effectiveness under Section A may be demonstrated through law, regulation or established practice that implements the general authority granted to the jurisdiction, or any combination of laws, regulations or practices that meet the objective.

The Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group will initiate evaluation of a jurisdiction’s regulatory system by gathering and undertaking a review of the most recent FSAP Report, ROSC and any other publicly available information regarding the laws, regulations, practices and procedures applicable to the reinsurance supervisory system. The Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group will simultaneously invite each jurisdiction (or its designee) to provide information relative to Section A (and other sections, as relevant) to assist the NAIC in evaluating its laws and regulations. The NAIC will review this information in conjunction with Appendix A, which provides more detailed guidance with respect to elements the NAIC intends to consider on an outcomes basis in the evaluation under this section. Appendix A is not intended as a prescriptive checklist of requirements a jurisdiction must meet in order to be a Qualified Jurisdiction. Rather, it is provided in an effort to facilitate an outcomes-based comparison to financial solvency regulation under the NAIC Accreditation Program. An applicant jurisdiction is requested to address the following information, which the NAIC will consider, at a minimum, in determining whether the outcomes achieved by the jurisdiction’s laws and regulations meet an acceptable level of effectiveness for the jurisdiction to be included on the NAIC List of Qualified Jurisdictions:

1. Confirmation of the jurisdiction’s most recent FSAP Report, including relevant updates with respect to descriptions or elements of the FSAP Report in which changes have occurred since the assessment or where information might otherwise be outdated.

2. Confirmation of the jurisdiction’s ROSC, including relevant updates with respect to descriptions or elements of the ROSC in which changes have occurred since the report was completed or where information might otherwise be outdated.

3. If materials responsive to the topics under review have been provided in response to information exchanges between the jurisdiction under review and the NAIC, such prior responses may be cross-referenced provided updates are submitted, if required to address changes in laws or procedures.

4. Any other information, descriptions or responses the jurisdiction believes would be beneficial to the NAIC’s evaluation process in order to address, on an outcomes basis, the key elements described within Appendix A.

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3 The basic considerations under this section are derived from Model #786, Section 8C(2), which include: (a) the framework under which the assuming reinsurer is regulated; (b) the structure and authority of the jurisdiction’s reinsurance supervisory authority regarding solvency regulation requirements and financial surveillance; (c) the substance of financial and operating standards for reinsurers domiciled in the jurisdiction; and (d) the form and substance of financial reports required to be filed or made publicly available by reinsurers domiciled in the jurisdiction and the accounting principles used.
The NAIC will review the information provided by the applicant jurisdiction and determine whether it is adequate
to reasonably conclude whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in
an effective manner. After reviewing the initial submission, the NAIC may request that the applicant jurisdiction
submit supplemental information as necessary in order to make this determination. An applicant jurisdiction is
strongly encouraged to provide thorough, detailed and current information in its initial submission in order to
minimize the number and extent of supplemental information requests from the NAIC with respect to Section A of
this Evaluation Methodology. The NAIC will provide a complete description in the Final Evaluation Report of the
information provided in the Evaluation Materials, and any updates or other information that have been provided by
the applicant jurisdiction.

Section B: Regulatory Practices and Procedures

Section B is intended to facilitate an evaluation of whether the jurisdiction effectively employs baseline regulatory
practices and procedures to supplement and support enforcement of the jurisdiction’s financial solvency laws and
regulations described in Section A. This evaluation methodology recognizes that variation may exist in practices
and procedures across jurisdictions due to the unique situations each jurisdiction faces. Jurisdictions differ with
respect to staff and technology resources that are available, as well as the characteristics of the domestic industry
regulated. A determination of effectiveness may be achieved using various financial solvency oversight practices
and procedures. This evaluation is not intended to be prescriptive in nature.

The NAIC will utilize the information provided by the jurisdiction as outlined under Section A in completing this
section of the evaluation. The NAIC will review this information in conjunction with Appendix B, which provides
more detailed guidance with respect to elements the NAIC intends to consider on an outcomes basis in the evaluation
under this section. Appendix B is not intended as a prescriptive checklist of requirements a jurisdiction must meet
in order to be a Qualified Jurisdiction. Rather, it is provided in an effort to facilitate an outcomes-based comparison
to financial solvency regulation under the NAIC Accreditation Program. An applicant jurisdiction should also
provide any other information, descriptions or responses the jurisdiction believes would be beneficial to the NAIC’s
evaluation process in order to address, on an outcomes basis, the key elements described within Appendix B.

Section C: Jurisdiction’s Requirements Applicable to U.S. Domiciled Reinsurers

The jurisdiction is requested to describe and explain the rights, benefits and the extent of reciprocal recognition
afforded by the non-U.S. supervisory authority to reinsurers licensed and domiciled in the U.S.

Section D: Regulatory Cooperation and Information-Sharing

The Credit for Reinsurance Models require the supervisory authority to share information and cooperate with the
U.S. state insurance regulators with respect to all certified reinsurers domiciled within their jurisdiction. The
jurisdiction is requested to provide an explanation of the supervisory authority’s ability to cooperate, share
information and enter into an MOU with U.S. state insurance regulators and confirm that they are willing to enter
into an MOU. This should include information with respect to any existing MOU with U.S. state and/or federal
authorities that pertain to reinsurance. Both the jurisdiction and the states may rely on the IAIS MMoU to satisfy
this requirement, and any states that have not yet been approved by the IAIS as a signatory to the MMoU may rely
on an MOU entered into by a Lead State with the jurisdiction until such time that the state has been approved as a
signatory to the IAIS MMoU. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to this process.

**Section E: History of Performance of Domestic Reinsurers**

The jurisdiction is requested to provide a general description with respect to the historical performance of reinsurers domiciled in the jurisdiction. The NAIC does not intend to review confidential company-specific information under this section. Rather, it is intended that any information provided would be publicly available, unless specifically addressed with the jurisdiction under review. This discussion should address, at a minimum, the following information:

a. Number of reinsurers domiciled in the jurisdiction, and a list of any reinsurers domiciled in the jurisdiction that have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, of no less than $250,000,000.

b. Up to a 10-year history of any regulatory actions taken against specific reinsurers.

c. Up to a 10-year history listing any reinsurers that have gone through insolvency proceedings, including the size of each insolvency and a description of the related outcomes (e.g., reinsurer rehabilitated or liquidated, payout percentage of claims to priority classes, payout percentage of claims to domestic and foreign claimants).

d. Up to a 10-year history of any significant industry-wide fluctuations in capital or profitability with respect to domestic reinsurers.

**Drafting Note:** The NAIC will determine the appropriate time period for review on a case-by-case basis with respect to this information.

**Section F: Enforcement of Final U.S. Judgments**

The NAIC has previously collected information from a number of jurisdictions with respect to enforcement of final U.S. judgments. The jurisdiction is also requested to provide a current description or explanation of any restrictions with respect to the enforcement of final foreign judgments in the jurisdiction. Based on the foregoing information, the NAIC will make an assessment of the effectiveness of the ability to enforce final U.S. judgments in the jurisdiction. This will include a review of the status, interpretations, application and enforcement of various treaties, conventions and international agreements with respect to final judgments, arbitration and choice of law. The Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group will monitor the enforcement of final U.S. judgments and the Qualified Jurisdiction is requested to notify the NAIC of any developments in this area.

**Section G: Solvent Schemes of Arrangement**

The jurisdiction is requested to provide a description of any legal framework that allows reinsurers domiciled in the jurisdiction to propose or participate in any solvent scheme of arrangement or similar procedure. In addition, the jurisdiction is requested to provide a description of any solvent scheme of arrangement or similar procedure that a domestic reinsurer has proposed or participated in and the outcome of such procedure.
V. Appendices: Specific Guidance with Respect to Section A and Section B

It is important to note that Part IV, Section A: Laws and Regulations, and Part IV, Section B: Regulatory Practices and Procedures, are derived from the NAIC Financial Regulation Standards and Accreditation Program, which is intended to establish and maintain standards to promote sound insurance company financial solvency regulation among the U.S. states. As such, the NAIC Accreditation Program requires the states to employ laws, regulations and administrative policies and procedures substantially similar to the NAIC accreditation standards in order to be considered an accredited state.

However, it is not the intent of the Evaluation Methodology to require applicant jurisdictions to meet the standards required by the NAIC for accreditation. Instead, Section A and Section B (and their corresponding appendices) are intended to provide a framework to facilitate an outcomes-based evaluation by the NAIC and state insurance regulators of the effectiveness of the jurisdiction’s supervisory authority. This framework consists of a description of the jurisdiction’s laws, regulations, practices and procedures applicable to the supervision of its domestic reinsurers. The amount of detail provided within these appendices should not be interpreted as specific requirements that must be met by the applicant jurisdiction. Rather, the information is intended to provide direction to the applicant jurisdiction in an effort to facilitate a complete response and increase the efficiency and timeliness of the evaluation process.
Appendix A: Laws and Regulations

1. Examination Authority

Does the jurisdiction have the authority to examine its domestic reinsurers? This description should address the following:

a. Frequency and timing of examinations and reports.

b. Guidelines for examination.

c. Whether the jurisdiction has the authority to examine reinsurers whenever it is deemed necessary.

d. Whether the jurisdiction has the authority to have complete access to the reinsurer’s books and records and, if necessary, the records of any affiliated company.

e. Whether the jurisdiction has the authority to examine officers, employees and agents of the reinsurer when necessary with respect to transactions directly or indirectly related to the reinsurer under examination.

f. Whether the jurisdiction has the authority to share confidential information with U.S. state insurance regulatory authorities, provided that the recipients are required, under their law, to maintain its confidentiality.

2. Capital and Surplus Requirement

Does the jurisdiction have the authority to require domestic reinsurers to maintain a minimum level of capital and surplus to transact business? This description should address the following:

a. Whether the jurisdiction has the authority to require reinsurers to maintain minimum capital and surplus, including a description of such minimum amounts.

b. Whether the jurisdiction has the authority to require additional capital and surplus based on the type, volume and nature of reinsurance business transacted.

c. Capital requirements for reinsurers, including reports and a description of any specific levels of regulatory intervention.

3. Accounting Practices and Procedures

Does the jurisdiction have the authority to require domestic reinsurers to file appropriate financial statements and other financial information? This description should address the following:

a. Description of the accounting and reporting practices and procedures.

b. Description of any standard financial statement blank/reporting template, including description of content/disclosure requirements and corresponding instructions.

4. Corrective Action

Does the jurisdiction have the authority to order a reinsurer to take corrective action or cease and desist certain practices that, if not corrected or terminated, could place the reinsurer in a hazardous financial condition? This description should address the following:

a. Identification of specific standards which may be considered to determine whether the continued operation of the reinsurer might be hazardous to the general public.

b. Whether the jurisdiction has the authority to issue an order requiring the reinsurer to take corrective action when it has been determined to be in hazardous financial condition.
5. Regulation and Valuation of Investments

What authority does the jurisdiction have with respect to regulation and valuation of investments? This description should address the following:

a. Whether the jurisdiction has the authority to require a diversified investment portfolio for all domestic reinsurers as to type, issue and liquidity.

b. Whether the jurisdiction has the authority to establish acceptable practices and procedures under which investments owned by reinsurers must be valued, including standards under which reinsurers are required to value securities/investments.

6. Holding Company Systems

Does the jurisdiction have laws or regulations with respect to supervision of the group holding company systems of reinsurers? This description should address the following:

a. Whether the jurisdiction has access to information via the parent or other regulated group entities about activities or transactions within the group involving other regulated or non-regulated entities that could have a material impact on the operations of the reinsurer.

b. Whether the jurisdiction has access to consolidated financial information of a reinsurer’s ultimate controlling person.

c. Whether the jurisdiction has the authority to review integrity and competency of management.

d. Whether the jurisdiction has approval and intervention powers for material transactions and events involving reinsurers.

e. Whether the jurisdiction has authority to monitor, or has prior approval authority over:
   i. Change in control of domestic reinsurers.
   ii. Dividends and other distributions to shareholders of the reinsurer.
   iii. Material transactions with affiliates.

7. Risk Management

Does the jurisdiction have the authority to require its domestic reinsurers to maintain an effective risk-management function and practices? This description should address the following:

a. Whether the jurisdiction has Own Risk and Solvency Assessment (ORSA) requirements and reporting.

b. Any requirements regarding the maximum net amount of risk to be retained by a reinsurer for an individual risk based on the reinsurer’s capital and surplus.

c. Whether the jurisdiction has authority to monitor enterprise risk, including any activity, circumstance, event (or series of events) involving one or more affiliates of a reinsurer that, if not remedied promptly, is likely to have a material adverse effect on the financial condition or liquidity of the reinsurer or its insurance holding company system as a whole.

d. Whether the jurisdiction has corporate governance requirements for reinsurers.
8. **Liabilities and Reserves**

Does the jurisdiction have standards for the establishment of liabilities and reserves (technical provisions) resulting from reinsurance contracts? This description should address the following:

a. Liabilities incurred under reinsurance contracts for policy reserves, unearned premium, claims and losses unpaid, and incurred but not reported (IBNR) claims (including whether discounting is allowed for reserve calculation/reporting).

b. Liabilities related to catastrophic occurrences.

c. Whether the jurisdiction requires an opinion on reserves and loss and loss adjustment expense reserves by a qualified actuary or specialist for all domestic reinsurers, and the frequency of such reports.

9. **Reinsurance Ceded**

What are the jurisdiction’s requirements with respect to the financial statement credit allowed for reinsurance retroceded by its domestic reinsurers? This description should address the following:

a. Credit for reinsurance requirements applicable to reinsurance retroceded to domestic and non-domestic reinsurers.

b. Collateral requirements applicable to reinsurance contracts.

c. Whether the jurisdiction requires a reinsurance agreement to provide for insurance risk transfer (i.e., transfer of both underwriting and timing risk).

d. Requirements applicable to special purpose reinsurance vehicles and insurance securitizations.

e. Affiliated reinsurance transactions and concentration risk.

f. Disclosure requirements specific to reinsurance transactions, agreements and counterparties, if such information is not provided under another item.

10. **Independent Audits**

Does the jurisdiction require annual audits of domestic reinsurers by independent certified public accountants or similar accounting/auditing professional recognized in the applicant jurisdiction? This description should address the following:

a. Requirements for the filing of audited financial statements prepared in conformity with accounting practices prescribed or permitted by the supervisory authority.

b. Contents of annual audited financial reports.

c. Requirements for selection of auditor.

d. Allowance of audited consolidated or combined financial statements.

e. Notification of material misstatements of financial condition.

f. Supervisor’s access to auditor’s workpapers.

g. Audit committee requirements.

h. Requirements for reporting of internal control-related matters.

11. **Receivership**

Does the jurisdiction have a receivership scheme for the administration of reinsurers found to be insolvent? This should include a description of any liquidation priority afforded to policyholders and the liquidation priority of
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reinsurance obligations to domestic and non-domestic ceding insurers in the context of an insolvency proceeding of a reinsurer.

12. Filings with Supervisory Authority

Does the jurisdiction require the filing of annual and interim financial statements with the supervisory authority? This description should address the following:

a. The use of standardized financial reporting in the financial statements, and the frequency of relevant updates.

b. The use of supplemental data to address concerns with specific companies or issues.

c. Filing format (e.g., electronic data capture).

d. The extent to which financial reports and information are public records.

13. Reinsurance Intermediaries

Does the jurisdiction have a regulatory framework for the regulation of reinsurance intermediaries?

14. Other Regulatory Requirements with respect to Reinsurers

Any other information necessary to adequately describe the effectiveness of the jurisdiction’s laws and regulations with respect to its reinsurance supervisory system.
Appendix B: Regulatory Practices and Procedures

1. Financial Analysis

What are the jurisdiction’s practices and procedures with respect to the financial analysis of its domestic reinsurers? Such description should address the following:

   a. Qualified Staff and Resources
      The resources employed to effectively review the financial condition of all domestic reinsurers, including a description of the educational and experience requirements for staff responsible for financial analysis.

   b. Communication of Relevant Information to/from Financial Analysis Staff
      The process under which relevant information and data received by the supervisory authority are provided to the financial analysis staff and the process under which the findings of the financial analysis staff are communicated to the appropriate person(s).

   c. Supervisory Review
      How the jurisdiction’s internal financial analysis process provides for supervisory review and comment.

   d. Priority-Based Analysis
      How the jurisdiction’s financial analysis procedures are prioritized in order to ensure that potential problem reinsurers are reviewed promptly.

   e. Depth of Review
      How the jurisdiction’s financial analysis procedures ensure that domestic reinsurers receive an appropriate level or depth of review commensurate with their financial strength and position.

   f. Analysis Procedures
      How the jurisdiction has documented its financial analysis procedures and/or guidelines to provide for consistency and continuity in the process and to ensure that appropriate analysis procedures are being performed on each domestic reinsurer.

   g. Reporting of Material Adverse Findings
      The process for reporting material adverse indications, including the determination and implementation of appropriate regulatory action.

   h. Early Warning System/Stress Testing
      Whether the jurisdiction has an early warning system and/or stress testing methodology that is utilized with respect to its domestic reinsurers.
2. **Financial Examinations**

What are the jurisdiction’s practices and procedures with respect to the financial examinations of its domestic reinsurers? Such description should address the following:

a. **Qualified Staff and Resources**
   The resources employed to effectively examine all domestic reinsurers. This should include whether the jurisdiction prioritizes examination scheduling and resource allocation commensurate with the financial strength and position of each reinsurer, and a description of the educational and experience requirements for staff responsible for financial examinations.

b. **Communication of Relevant Information to/from Examination Staff**
   The process under which relevant information and data received by the supervisory authority are provided to the examination staff and the process under which the findings of the examination staff are communicated to the appropriate person(s).

c. **Use of Specialists**
   Whether the supervisory authority’s examination staff includes specialists with appropriate training and/or experience or whether the supervisory authority otherwise has available qualified specialists that will permit the supervisory authority to effectively examine any reinsurer.

d. **Supervisory Review**
   Whether the supervisory authority’s procedures for examinations provide for supervisory review.

e. **Examination Guidelines and Procedures**
   Description of the policies and procedures the supervisory authority employs for the conduct of examinations, including whether variations in methods and scope are commensurate with the financial strength and position of the reinsurer.

f. **Risk-Focused Examinations**
   Does the supervisory authority perform and document risk-focused examinations and, if so, what guidance is utilized in conducting the examinations? Are variations in method and scope commensurate with the financial strength and position of the reinsurer?

g. **Scheduling of Examinations**
   Whether the supervisory authority’s procedures provide for the periodic examination of all domestic reinsurers, including how the system prioritizes reinsurers that exhibit adverse financial trends or otherwise demonstrate a need for examination.

h. **Examination Reports**
   Description of the format in which the supervisory authority’s reports of examinations are prepared, and how the reports are shared with other jurisdictions under information-sharing agreements.

i. **Action on Material Adverse Findings**
   What are the jurisdiction’s procedures regarding supervisory action in response to the reporting of any material adverse findings.
3. **Information Sharing**

Does the jurisdiction have a process for the sharing of otherwise confidential documents, materials, information, administrative or judicial orders, or other actions with U.S. state regulatory officials, provided that the recipients are required, under their law, to maintain its confidentiality?

4. **Procedures for Troubled Reinsurers**

What procedures does the jurisdiction follow with respect to troubled reinsurers?

5. **Organization, Licensing and Change of Control of Reinsurers**

What processes does the supervisory authority use to identify unlicensed or fraudulent activities? The description should address the following:

   a. **Licensing Procedure**
      Whether the supervisory authority has documented licensing procedures that include a review and/or analysis of key pieces of information included in a primary licensure application.

   b. **Staff and Resources**
      The educational and experience requirements for staff responsible for evaluating company licensing.

   c. **Change in Control of a Domestic Reinsurer**
      Procedures for the review of key pieces of information included in filings with respect to a change in control of a domestic reinsurer.
To: Commissioner Scott A. White (VA), Financial Condition (E) Committee Chair  
From: Commissioner Marlene Caride (NJ), Financial Stability (E) Task Force Chair  
Date: July 27, 2021  
RE: Repurposing the Liquidity Assessment (E) Subgroup and its charges to an ongoing Macroprudential (E) Working Group

Earlier this year, the Financial Stability Task Force moved from the Executive Committee to the Financial Condition (E) Committee. As part of that move, the Task Force was charged with building out the NAIC macroprudential surveillance system. The current legal entity and group insurance surveillance system has been shaped over the last thirty years or so, while the Task Force is just beginning its work. We will need to assess the ability of the data and tools in that legal entity and group system to satisfy macroprudential surveillance needs. Modifications will likely need to be made, but new data and tools may also be needed in the future. There will be a significant amount of detail work involved in building this macroprudential surveillance system.

The Financial Stability Task Force also has some remaining Macro Prudential Initiative (MPI) work to complete for capital stress testing and counterparty disclosures. The MPI recovery and resolution item was addressed last year. Similarly, with the adoption of the 2020 Liquidity Stress Test (LST) Framework in May of this year, the liquidity risk MPI item has been addressed. However, the LST will be an ongoing activity managed by the Task Force.

To ensure the Financial Stability Task Force has appropriate support for this work, it adopted a motion to repurpose the Liquidity Assessment Subgroup to an ongoing Macroprudential Working Group with modified and expanded charges. The attached document shows the revised name and changes to the 2021 charges in track changes notation.
ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE

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Memorandum to Philip Barlow, Chair, Life Risk-Based Capital (E) Working Group, from Dale Bruggeman, Chair, Statutory Accounting Principles (E) Working Group, Dated May 20, 2021, Regarding SAPWG Response to the Life Real Estate Proposal (Attachment One-B1m) .................................................. 10-472
Memorandum to Dale Bruggeman, Chair, Statutory Accounting Principles (E) Working Group, from Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO), and Marc Perlman, Managing Investment Counsel, NAIC SVO, Dated May 1, 2021, Regarding Credit Tenant Loan Referral from the Statutory Accounting Principles (E) Working Group (Attachment One-B1n) .................................................................................................................. 10-476
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Blanks (E) Working Group Agenda Item Submission Form 2021-01BWG Modified; Effective Annual 2021; Add Reference to Health Care Receivables to Line 24 – Health Care and Other Amounts Receivable on the Asset Page, Change Description of Line 06999999 to Read Other Health Care Receivables on Exhibit 3 and Modify Column Headers for Exhibit 3A (Attachment Two-A1) ................................................................................ 10-493
Blanks (E) Working Group Agenda Item Submission Form 2021-02BWG Modified; Effective Annual 2021; Add Questions to General Interrogatories, Part 1 Regarding Depository Institution Holding Companies as it Pertains to the Group Capital Calculation; Modify the Terminology in the First Two Questions for Consistency with the New Questions (Attachment Two-A2) ................................................................................ 10-497
Blanks (E) Working Group Agenda Item Submission Form 2021-03BWG; Effective Annual 2021; Modify the Tables for Interrogatory Questions 1.01, 1.01A, 2.5 and 4.2 in the Separate Accounts General Interrogatories by Adding Category Lines to Reflect Additional Granularity in the Reporting on Those Tables (Attachment Two-A3)..........................................................................................10-499

Blanks (E) Working Group Agenda Item Submission Form 2021-04BWG Modified; Effective Annual 2021; Add Interrogatory Questions 24.1 and 24.2 to the General Interrogatories, Part 1 and Renumber Those Below Them; Renumber the Questions and Question References in the General Interrogatories, Part 1 to Match the Renumbering on the Blank Page (Attachment Two-A4)..............10-503

Blanks (E) Working Group Agenda Item Submission Form 2021-05BWG Modified; Effective Annual 2021; Modify the Instructions for Note 17B(4)b1(a) and Add a Table to the Illustrations to Data Capture the Disclosure (Attachment Two-A5)..........................................................................................10-513

Blanks (E) Working Group Agenda Item Submission Form 2021-06BWG; Effective Annual 2021; Add Crosschecks Between Form 5 and Form 1 for Columns 2, 3, 4, 6 and 7 of Form 5 (Attachment Two-A6)..........................................................................................10-518

Blanks (E) Working Group Agenda Item Submission Form 2021-07BWG; Effective Annual 2021; Add Additional Line Categories to the Instruction for Column 26 – Collateral Type to Capture Collateral Type Data for all RMBS, CMBS and LBSS Securities Regardless of Reporting Category (Attachment Two-A7)..........................................................................................10-521

Blanks (E) Working Group Agenda Item Submission Form 2021-08BWG Modified; Effective Annual 2021; Add a New Supplement Mortgage Guaranty Insurance Exhibit to Capture More Information from Mortgage Guaranty Insurers (Attachment Two-A8)..................................................................................10-525

Blanks (E) Working Group Editorial Revisions to the Blanks and Instructions Presented at the May 26, 2021, Meeting (Attachment Two-A9)..........................................................................................10-542

Blanks (E) Working Group Agenda Item Submission Form 2021-10BWG; Effective First Quarter 2022; Remove Language in Quarterly General Interrogatories Part 1, Line 4.1 That Requires Filing of a Quarterly Merger/History Form (Attachment Two-B)..................................................................................10-552

Blanks (E) Working Group Editorial Revisions to the Blanks and Instructions Presented at the July 22, 2021, Meeting (Attachment Two-C)..........................................................................................10-554

Memorandum to Jake Garn, Chair, Blanks (E) Working Group, from Marti Hooper, Chair, Health Actuarial (B) Task Force, Dated June 1, 2021, Regarding Health Actuarial Statement of Opinion Guidance for the 2021 Reporting Year (Attachment Two-D)..................................................................................10-556

Accounting Practices and Procedures (E) Task Force 2022 Proposed Charges (Attachment Three)..................................................................................10-557

Appendix G Implementation Guide (Guide) for the Annual Financial Reporting Model Regulation (#205) (Attachment Four)..................................................................................10-558
The Accounting Practices and Procedures (E) Task Force met July 27, 2021. The following Task Force members participated: Doug Slape, Chair, represented by Jamie Walker (TX); Trinidad Navarro, Vice Chair, represented by Ryllynn Brown (DE); Lori K. Wing-Heier and David Phifer (AK); Jim L. Ridling represented by Sheila Travis (AL); Evan G. Daniels represented by Kurt Regner (AZ); Alan McClain represented by Mel Anderson (AR); Ricardo Lara represented by Kim Hudson (CA); Andrew N. Mais represented by William Arfanis and Kathy Belfi (CT); Karima M. Woods represented by N. Kevin Brown (DC); David Almaier represented by Virginia Christy (FL); Doug Ommen represented by Kevin Clark (IA); Dean L. Cameron represented by Eric Fletcher (ID); Amy L. Beard represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Russell Coy (KY); James J. Donelon represented by Melissa Gibson (LA); Gary D. Anderson represented by John Turchi (MA); Eric A. Cioppa and Vanessa Sullivan (ME); Anita G. Fox represented by Judy Weaver (MI); Grace Arnold represented by Kathleen Orth (MN); Chlora Lindley-Myers represented by Shannon Schmoeger (MO); Mike Causey represented by Monique Smith (NC); Jon Godfread represented by Matt Fischer (ND); Dunning represented by Justin Schrader (NE); Chris Nicolopoulos represented by Doug Bartlett (NH); Linda A. Lacewell represented by Bob Kasinow (NY); Judith L. French represented by Dale Bruggeman (OH); Glen Mulready represented by Eli Snowberger (OK); Jessica K. Altman represented by Kimberly Rankin (PA); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Raymond G. Farmer represented by Daniel Morris (SC); Carter Lawrence represented by Hui Wattanaskolpant (TN); Jonathan T. Pike represented by Jake Garn (UT); Scott A. White represented by Doug Stolte and David Smith (VA); Michael S. Pieciak represented by Karen Ducharme and Dan Petterson (VT); Mike Kreidler represented by Tim Hays (WA); Mark Afable represented by Amy Malin (WI); James A. Dodrill represented by Jamie Taylor (WV); and Jeff Rude represented by Linda Johnson (WY).

1. Adopted its Spring National Meeting Minutes


Mr. Bruggeman provided the report of the Statutory Accounting Principles (E) Working Group, which conducted e-votes that concluded July 20, July 12, April 20. The Working Group also met May 20.

Mr. Bruggeman stated that during the July 20 e-vote, the Working Group exposed agenda item 2021-10: "Statement of Statutory Accounting Principles (SSAP) No. 32R—Clarification of Effective Call Price for a public comment period ending Aug. 6. He said that during the July 12 e-vote, the Working Group adopted its May 20, April 20, and Spring National Meeting minutes.

Mr. Bruggeman provided the action for the May 20 meeting. Mr. Bruggeman stated that the Working Group adopted the following nonsubstantive revisions to statutory accounting guidance:

A. **SSAP No. 26R—Bonds**: Revisions reject Accounting Standards Update (ASU) 2020-08, Codification Improvements to Subtopic 310-20, Receivables – Nonrefundable Fees and Other Costs for statutory accounting. (Ref #2021-02)

B. **SSAP No. 47—Uninsured Plans**: Revisions reject ASU 2021-02, Franchisors – Revenue from Contracts with Customers for statutory accounting. (Ref #2021-08)

C. **SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities**: Revisions incorporate disclosure elements and a data-capture template for where an entity has transferred assets but retains economic interest within the reporting entity, its related parties, or another member within the holding company group. (Ref #2021-03)

D. Adopted agenda items supporting disaggregated product identifiers to be used for each separate account product reported in the general interrogatories. This adoption does not result in statutory revisions, but it is reflected in the Working Group recommendation to support blanks proposal 2021-03BWG. (Ref #2020-37 and Ref #2020-38)
E. Interpretation (INT) 20-01: ASU 2020-04 – Reference Rate Reform: This interpretation provides optional guidance, allowing for the continuation of certain existing hedge relationships and thus does not require hedge redesignation for derivative instruments affected by changes to interest/reference rates due to reference rate reform. This interpretation is all-encompassing for “any hedging relationships” within the scope of INT 20-01 and captures all hedging transaction types, regardless of if the transaction occurred bilaterally or through a central clearing party. (Ref #2021-01)

F. INT 21-01: Accounting for Cryptocurrencies: This interpretation clarifies that directly held cryptocurrencies neither meet the definition of cash in SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments nor when directly held, meet the definition of an admitted asset per SSAP No. 4—Assets and Nonadmitted Assets. (Ref #2021-05)

G. Appendix D—Nonapplicable GAAP Pronouncements: Revisions reject ASU 2020-11, Financial Services – Insurance: Effective Date and Early Application as not applicable for statutory accounting. (Ref #2021-07)

H. Adopted the following editorial revisions (Ref #2021-06EP):


2. SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities: Revisions correct grammatical errors in paragraph 54.

3. SSAP Glossary: Revisions remove the footnote in the Glossary title and replace it as an opening paragraph with updated verbiage.

Mr. Bruggeman stated that the Working Group exposed the substantive proposed bond definition to be used for all securities in determining whether they qualify for reporting on Schedule D, Part 1 – Long-Term Bonds. The definition intends to reflect principal concepts to ensure appropriate consideration on whether a structure qualifies as an issuer credit obligation or an asset-backed security (ABS) prior to reporting as a bond. The public comment period for this agenda item ended July 15. (Ref #2019-21)

Mr. Bruggeman stated that the Working Group exposed nonsubstantive revisions to SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies and SSAP No. 97 to indicate that the equity method valuation reference in SSAP No. 97 can result in a negative equity valuation and to limit the statutory adjustments match in SSAP No. 97, paragraph 9. The exposure requests public comments on language suggested by interested parties that foreign insurance subsidiary, controlled and affiliated entities (SCAs) shall stop at zero (and thus not be subject to negative equity valuations) when applying paragraph 9 adjustments in cases where the foreign insurance subsidiary is not engaged in providing services to, or holding assets on behalf of, U.S. insurers. The public comment period for this agenda item ended July 15. (Ref #2021-04)

Mr. Bruggeman stated that the Working Group adopted a response to the Life Risk-Based Capital (E) Working Group on its referral request to consider accounting and reporting aspects of an American Council of Life Insurers (ACLI) proposal to modify the treatment of real estate in the life risk-based capital (RBC) formula. The adopted response identifies concerns on the reliability and consistency of fair value data to be considered before allowing reporting entities to reduce RBC through the reported fair value of real estate.

Mr. Bruggeman stated that the Working Group received an update on the following projects and referrals:

A. The Working Group directed a referral to be sent to the Life Actuarial (A) Task Force seeking input regarding whether the Task Force would consider changes to the reserve framework of fixed indexed annuity products, as its response will likely directly influence the accounting options for derivatives hedging these products. (Ref #2020-36)

B. SSAP No. 107—Risk-Sharing Provisions of the Affordable Care Act: The Working Group directed NAIC staff to develop additional revisions that expand the guidance to address the diversity in state Affordable Care Act (ACA) reinsurance programs identified in the industry comments. (Ref #2021-09)

C. INT 20-10: Reporting Nonconforming Credit Tenant Loans: Contingently exposed nonsubstantive revisions in anticipation of a Valuation of Securities (E) Task Force proposal to revise filing exempt (FE) requirements for credit tenant loans (CTLs). Subsequent to the Working Group meeting, on May 24, the Task Force did not expose the
anticipated revisions. Instead, the Task Force exposed edits to clarify that the reference to mortgage loans in the CTL definition pertains to items in scope of SSAP No. 37—Mortgage Loans and that the Accounting Practices and Procedures Manual (AP&P Manual) determines investment accounting and reporting. With this Task Force action, the revisions to INT 20-10 were not exposed. It is anticipated that the Working Group will review INT 20-10 after the Task Force concludes actions after their exposure.

D. Received a response from the Valuation of Securities (E) Task Force regarding CTLS and information regarding Securities Valuation Office (SVO) filings received.

Mr. Bruggeman stated that during the April 20 e-vote, the Working Group voted to update exposed agenda item 2021-03: SSAP No. 103R – Disclosures to reflect interested parties’ preliminary comments. While minor revisions were proposed to SSAP No. 103R disclosures, the primary changes from the original agenda item were reflected in the data capture template, which include instructions, updated capture fields, and column descriptions.

Mr. Bruggeman made a motion, seconded by Mr. Eft to adopt the report of the Statutory Accounting Principles (E) Working Group (Attachment One). The motion passed unanimously.


Mr. Garn provided the report of the Blanks (E) Working Group, which met July 22, 2021.

Mr. Garn stated the working Group adopted its May 26 minutes, which included the following action:

A. Mr. Garn stated the Working Group adopted its editorial listing and eight blanks proposals:

1. 2021-01 – add reference to health care receivables line in the Asset page.
2. 2021-02BWG – add questions to the General Interrogatories, Part 1 regarding depository institution holding companies as it pertains to the group capital calculation (GCC).
3. 2021-03BWG – add category lines to the Separate Accounts General Interrogatories for additional granularity.
4. 2021-04BWG – add a General Interrogatory to identify insurers that utilize third parties to pay agent commissions in which the amounts advanced by the third parties are not settled in full within 90 days.
5. 2021-05BWG – modify Note 17B(4) to reflect changes made by the Statutory Accounting Principles (E) Working Group reference number SAPWG 2021-03 regarding transferred assets.
6. 2021-06BWG – add crosschecks to the long-term care (LTC) reporting forms to gain consistency.
7. 2021-07BWG – add additional line categories to capture collateral type data for all residential mortgage-backed securities (RMBS), commercial mortgage-backed securities (CMBS), and loan-backed and structured securities (LBSS) regardless of reporting category.
8. 2021-08BWG – add a new supplement Mortgage Guaranty Insurance Exhibit to capture more information from mortgage guaranty insurers.

B. Exposed five proposals for public comment.

Mr. Garn stated that the Working Group adopted its editorial listing and 2021-10BWG – remove language in quarterly General Interrogatories Part 1, line 4.1 that requires filing of a quarterly merger/history form. The annual form shall still be required.

Mr. Garn stated that the Working Group adopted Health Actuarial Statement of Opinion Guidance for the 2021 reporting year.

Mr. Garn said the Working Group deferred four proposals for additional discussion for a 90-day public comment period ending Oct. 22.

Mr. Garn made a motion, seconded by Ms. Smith to adopt the report of the Blanks (E) Working Group (Attachment Two). The motion passed unanimously.
4. **Adopted its 2022 Proposed Charges**

Ms. Walker directed the Task Force to its 2022 proposed charges, noting that the proposed charges were previously distributed and are unchanged from last year.

Ms. Orth made a motion, seconded by Mr. Bruggeman, to adopt the Task Force’s 2022 proposed charges (Attachment Three). The motion passed unanimously.

5. **Adopted Revisions to the Model Audit Rule Implementation Guide**

Mr. Stolte, chair of the NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group, introduced the proposed additions to the NAIC’s Model Audit Rule Implementation Guide. He noted that the revisions, shown as tracked revisions beginning on page 10, were adopted via an e-vote of the NAIC/AICPA (E) Working Group that concluded May 17. He stated that the updated version of the Implementation Guide has been posted to the NAIC website with plans to be included in the 2022 publication of the AP&P Manual. In accordance with the instructions on page 1 of the Model Audit Rule Implementation Guide, the changes are subject to review and adoption by the Task Force.

Mr. Stolte stated that no comments were received during the Working Group’s last exposure of proposed changes. The revisions have been proposed to facilitate the collection of additional information on the external audit firm’s lead engagement partner through the “Communication of Internal Control Related Matters Noted in an Audit” filing provided to each insurer’s domestic regulator/NAIC each year.

Mr. Stolte stated that the purpose of the additional information is to allow for regulatory review and verification of compliance with audit partner rotation and qualification requirements. He said the information is being proposed for collection through the internal control letter as it receives confidential treatment from the NAIC and regulators, which preserves the lead audit partner’s personal information. The changes are proposed to be effective for audits as of Dec. 31, 2021, and thereafter.

Mr. Stolte made a motion, seconded by Mr. Hudson to adopt the revisions to the Model Audit Rule Implementation Guide (Attachment Four). The motion passed unanimously.

Having no further business, the Accounting Practices and Procedures (E) Task Force adjourned.
Virtual Meeting

STATUTORY ACCOUNTING PRINCIPLES (E) WORKING GROUP
July 20, 2021 / July 12, 2021 / May 20, 2021 / April 20, 2021

Summary Report


1. During the July 20 e-vote, the Working Group exposed agenda item 2021-10: SSAP No. 32R—Clarification of Effective Call Price for a public comment period ending Aug. 6 (Attachment One-A).

2. During the July 12 e-vote (Attachment One-B), the Working Group adopted its May 20, April 20, and Spring National Meeting minutes.

3. During the May 20 meeting, the Working Group:

   a. Adopted the following nonsubstantive revisions to statutory accounting guidance:

      1. Statement of Statutory Accounting Principles (SSAP) No. 26R—Bonds: Revisions reject Accounting Standards Update (ASU) 2020-08, Codification Improvements to Subtopic 310-20, Receivables – Nonrefundable Fees and Other Costs for statutory accounting. (Ref #2021-02)

      2. SSAP No. 47—Uninsured Plans: Revisions reject ASU 2021-02, Franchisors – Revenue from Contracts with Customers for statutory accounting. (Ref #2021-08)

      3. SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities: Revisions incorporate disclosure elements and a data-capture template for where an entity has transferred assets but retains economic interest within the reporting entity, its related parties, or another member within the holding company group. (Ref #2021-03)

4. Adopted agenda items supporting disaggregated product identifiers to be used for each separate account product reported in the general interrogatories. This adoption does not result in statutory revisions, but it is reflected in the Working Group recommendation to support blanks proposal 2021-03BWG. (Ref #2020-37 and Ref #2020-38)

5. Appendix B—Interpretations of Statutory Accounting Principles:

   i. Interpretation (INT) 20-01: ASU 2020-04 – Reference Rate Reform: This interpretation provides optional guidance, allowing for the continuation of certain existing hedge relationships and thus does not require hedge designation for derivative instruments affected by changes to interest/reference rates due to reference rate reform. This interpretation is all-encompassing for “any hedging relationships” within the scope of INT 20-01 and

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captures all hedging transaction types, regardless of if the transaction occurred bilaterally or through a central clearing party. (Ref #2021-01)

ii. INT 21-01: Accounting for Cryptocurrencies: This interpretation clarifies that directly held cryptocurrencies neither meet the definition of cash in SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments nor when directly held, meet the definition of an admitted asset per SSAP No. 4—Assets and Nonadmitted Assets. (Ref #2021-05)

6. Appendix D—Nonapplicable GAAP Pronouncements: Revisions reject ASU 2020-11, Financial Services – Insurance: Effective Date and Early Application as not applicable for statutory accounting. (Ref #2021-07)

b. Adopted the following editorial revisions (Ref #2021-06EP):

1. SSAP No. 53—Property Casualty Contracts—Premiums: Revisions retitle to SSAP No. 53—Property and Casualty Contracts—Premiums.

2. SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities: Revisions correct grammatical errors in paragraph 54.

3. SSAP Glossary: Revisions remove the footnote in the Glossary title and replace it as an opening paragraph with updated verbiage.

c. Exposed the substantive proposed bond definition to be used for all securities in determining whether they qualify for reporting on Schedule D, Part 1 – Long-Term Bonds. The definition intends to reflect principal concepts to ensure appropriate consideration on whether a structure qualifies as an issuer credit obligation or an asset-backed security (ABS) prior to reporting as a bond. The public comment period for this agenda item ends July 15. (Ref #2019-21)

d. Exposed nonsubstantive revisions to SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies and SSAP No. 97 to indicate that the equity method valuation reference in SSAP No. 97 can result in a negative equity valuation and to limit the statutory adjustments match in SSAP No. 97, paragraph 9. The exposure requests public comments on language suggested by interested parties that foreign insurance subsidiary, controlled and affiliated entities (SCAs) shall stop at zero (and thus not be subject to negative equity valuations) when applying paragraph 9 adjustments in cases where the foreign insurance subsidiary is not engaged in providing services to, or holding assets on behalf of, U.S. insurers. The public comment period for this agenda item ends July 15. (Ref #2021-04)

e. Adopted a response to the Life Risk-Based Capital (E) Working Group on its referral request to consider accounting and reporting aspects of an American Council of Life Insurers (ACLI) proposal to modify the treatment of real estate in the life risk-based capital (RBC) formula. The adopted response identifies concerns on the reliability and consistency of fair value data to be considered before allowing reporting entities to reduce RBC through the reported fair value of real estate.
f. Received an update on the following projects and referrals:

1. The Working Group directed a referral to be sent to the Life Actuarial (A) Task Force seeking input regarding whether the Task Force would consider changes to the reserve framework of fixed indexed annuity products, as its response will likely directly influence the accounting options for derivatives hedging these products. (Ref #2020-36)

2. SSAP No. 107—Risk-Sharing Provisions of the Affordable Care Act: The Working Group directed NAIC staff to develop additional revisions that expand the guidance to address the diversity in state Affordable Care Act (ACA) reinsurance programs identified in the industry comments. (Ref #2021-09)

3. INT 20-10: Reporting Nonconforming Credit Tenant Loans: Contingently exposed nonsubstantive revisions in anticipation of a Valuation of Securities (E) Task Force proposal to revise filing exempt (FE) requirements for credit tenant loans (CTLs). Subsequent to the Working Group meeting, on May 24, the Task Force did not expose the anticipated revisions. Instead, the Task Force exposed edits to clarify that the reference to mortgage loans in the CTL definition pertains to items in scope of SSAP No. 37—Mortgage Loans, and that the Accounting Practices and Procedures Manual determines investment accounting and reporting. With this Task Force action, the revisions to INT 20-10 were not exposed. It is anticipated that the Working Group will review INT 20-10 after the Task Force concludes actions after their exposure.

4. Received a response from the Valuation of Securities (E) Task Force regarding CTLs and information regarding Securities Valuation Office (SVO) filings received.

4. During the April 20 e-vote, the Working Group voted to update exposed agenda item 2021-03: SSAP No. 103R – Disclosures to reflect interested parties’ preliminary comments. While minor revisions were proposed to SSAP No. 103R disclosures, the primary changes from the original agenda item were reflected in the data capture template, which include instructions, updated capture fields, and column descriptions.

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The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force conducted an e-vote that concluded July 20, 2021. The following Working Group members participated: Dale Bruggeman, Chair (OH); Kevin Clark, Vice Chair (IA); Kim Hudson (CA); William Arfanis (CT); Eric Moser (IL); Stewart Guerin (LA); Judy Weaver (MI); Doug Bartlett (NH); Melissa Greiner (PA); David Smith (VA); and Amy Malm (WI).

1. Exposed Agenda Item 2021-10

The Working Group conducted an e-vote to consider exposure of agenda item 2021-10: SSAP No. 32R – Clarification of Effective Call Price. This agenda item proposes revisions to Statement of Statutory Accounting Principles No. 32R—Preferred Stock to clarify that the “effective call price” valuation limitation for all instruments within scope of the standard shall only apply if the call is currently exercisable by the issuer or if the issuer has announced that the instrument will be redeemed or called. This agenda item has an exposure deadline of Aug. 6.

Mr. Guerin made a motion, seconded by Mr. Hudson, to expose agenda item 2021-10. The motion passed unanimously.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force conducted an e-vote that concluded July 12, 2021. The following Working Group members participated: Dale Bruggeman, Chair (OH); Kevin Clark, Vice Chair (IA); Kim Hudson (CA); William Arfanis (CT); Eric Moser (IL); Stewart Guerin (LA); Judy Weaver (MI); Doug Bartlett (NH); Bob Kasinow (NY); Melissa Greiner (PA); Jamie Walker (TX); David Smith (VA); and Amy Malm (WI).

1. **Adopted its May 20, April 20, and March 15 Minutes**

The Working Group conducted an e-vote to consider adoption of its May 20, April 20, and March 15 minutes. Mr. Clark made a motion, seconded by Ms. Walker, to adopt the Working Group’s May 20 (Attachment One-B1), April 20 (Attachment One-B2), and March 15 (see *NAIC Proceedings – Spring 2021, Accounting Practices and Procedures (E) Task Force, Attachment One*) minutes. The motion passed unanimously.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force met May 20, 2021. The following Working Group members participated: Dale Bruggeman, Chair (OH); Carrie Mears and Kevin Clark, Co-Vice Chairs (IA); Richard Ford (AL); Kim Hudson (CA); William Arfanis and Michael Estabrook (CT); Rylynn Brown and Steve Kinion (DE); Eric Moser and Kevin Fry (IL); Stewart Guerin and Melissa Gibson (LA); Judy Weaver (MI); Doug Bartlett (NH); Bob Kasinow (NY); Melissa Greiner and Kimberly Rankin (PA); Jamie Walker (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI).

1. Adopted Non-Contested Positions

The Working Group held a public hearing to review comments (Attachment One-B1a) on previously exposed items.

Mr. Hudson made a motion, seconded by Ms. Malm, to adopt the statutory accounting revisions detailed below, which were non-contested by commenters. The motion passed unanimously.

a. Agenda Items 2020-37 and 2020-38

Mr. Bruggeman directed the Working Group to agenda item 2020-37: Separate Account Product Mix (Attachment One-B1b) and agenda item 2020-38: Pension Risk Transfer Disclosure (Attachment One-B1c). Jim Pinegar (NAIC) stated that these agenda items were drafted at the request of state insurance regulators due to the recent growth of pension risk transfers (PRTs) and registered index-linked annuities (RILAs). These agenda items initially requested input on the degree of product identifying details in the separate account blanks. Mr. Pinegar stated that because of the prior exposure, interested parties suggested separate general interrogatory reporting of PRTs and RILAs, and state insurance regulators have requested additional reporting granularity in the separate account general interrogatories. He stated that based on these comments, a Blanks (E) Working Group proposal (2021-03BWG) was concurrently exposed. The blanks proposal requires the addition of PRT and RILA reporting categories, and it modified the general interrogatory instructions to require disaggregated product reporting, using unique product identifiers for each product represented. Mr. Pinegar stated that aggregation in reporting can still occur if the products are under the same product filing or policy form; otherwise, the instructions require disaggregation in reporting. He noted that agenda items 2020-37 and 2020-38 do not result in any statutory accounting revisions; however, the Statutory Accounting Principles (E) Working Group can adopt the recommendation detailing the proposed blank template revisions to indicate support for adoption of the blanks revisions by the Blanks (E) Working Group.

b. Agenda Item 2021-02

Mr. Bruggeman directed the Working Group to agenda item 2021-02: ASU 2020-08 – Premium Amortization on Callable Debt Securities (Attachment One-B1d). Mr. Pinegar stated that this nonsubstantive agenda item rejects Accounting Standards Update (ASU) 2020-08 in the Statement of Statutory Accounting Principles (SSAP) No. 26R—Bonds for statutory accounting. He stated that ASU 2020-08 clarifies the amortization of premium associated with callable debt securities, and while the guidance closely mimics existing statutory accounting’s yield-to-worst concept in SSAP No. 26R, there may be scenarios where application of the yield-to-worst concept will result in a lower asset value than amortizing callable debt premium in accordance with ASU 2020-08. As such, the revisions detailed in this agenda item recommend rejection of ASU 2020-08.

c. Agenda Item 2021-03

Mr. Bruggeman directed the Working Group to agenda item 2021-03: SSAP No. 103R – Disclosures (Attachment One-B1e). Mr. Pinegar stated that this nonsubstantive agenda item was drafted because of ongoing discussions with industry and state insurance regulators regarding the SSAP No. 43R—Loan-Backed and Structured Securities project. One of the topics discussed was the state insurance regulators’ desire to identify situations in which a reporting entity has entered into a securitization, asset-backed financing, or similar transfer transaction where a significant economic interest in the transferred asset is retained by the reporting entity. Mr. Pinegar stated that one of the primary concerns is when an asset has been self-securitized, but the economic benefits have been retained. This agenda item proposes additional disclosures and the data capturing of certain existing disclosures being required in SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of
Liabilities. Mr. Pinegar stated that after the Working Group’s initial exposure, interested parties offered several initial comments and questions for clarification. In response to these inquiries, the Working Group exposed a revised recommendation as jointly collaborated with by Iowa, interested parties and NAIC staff. Mr. Pinegar stated that the revised proposal included additional disclosure elements, but it primarily resulted in significant changes to a blanks proposal (2021-05BWG), which included an updated data-capture template combined with supplemental reporting instructions. He stated that the revised disclosures and updated data-capture template will permit state insurance regulators to have the ability to perform system inquiries to identify which reporting entities have such transactions and the extent to which they occur.

d. Agenda Item 2021-06EP

Mr. Bruggeman directed the Working Group to agenda item 2021-06EP: Editorial Updates (Attachment One-B1f). Jake Stultz (NAIC) stated that this agenda item provides nonsubstantive editorial corrections in accordance with the maintenance process. The revisions propose a minor update to the title of SSAP No. 53—Property Casualty Contracts–Premiums, correct grammatical errors in SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, and relocate an existing footnote in the Glossary.

e. Agenda Item 2021-07

Mr. Bruggeman directed the Working Group to agenda item 2021-07: ASU 2020-11 – Financial Services – Insurance: Effective Date (Attachment One-B1g). Mr. Stultz stated that this nonsubstantive agenda item rejects ASU 2020-11 as not applicable for statutory accounting, as it updates the effective dates for other ASUs, which have previously been rejected for statutory accounting. Reference to ASU 2020-11 will be reflected in Appendix D—Nonapplicable GAAP Pronouncements.

f. Agenda Item 2021-08

Mr. Bruggeman directed the Working Group to agenda item 2021-08: ASU 2021-02 – Franchisors – Revenue from Contracts with Customers (Attachment One-B1h). Mr. Stultz stated that this nonsubstantive agenda item rejects ASU 2021-02 in SSAP No. 47—Uninsured Plans. Rejection in SSAP No. 47 is consistent with the Working Group’s rejection of several other ASUs related to revenue recognition.

2. Reviewed Comments on Exposed Items

The Working Group held a public hearing to review comments (Attachment One-B1a) on previously exposed items.

a. Agenda Item 2020-36

Mr. Bruggeman directed the Working Group to agenda item 2020-36: Derivatives Hedging Fixed Indexed Products. Julie Gann (NAIC) stated that this agenda item was drafted to address the accounting and reporting of derivatives that effectively hedge the growth in interest credited for fixed indexed products (e.g., fixed indexed annuities [FIAs] and fixed indexed universal life [IUL] products) reported in the general account. She stated that NAIC staff continue to work with interested parties regarding various methods for future Working Group consideration. As one of the possible solutions may require a change in the reserve framework of fixed annuity products, a formal referral to the Life Actuarial (A) Task Force was recommended, as its response will likely influence the accounting options for derivatives hedging these products. After the referral, NAIC staff will continue to work in the interim with interested parties on potential accounting and reporting solutions.

Michael Monahan (American Council of Life Insurers—ACLI) inquired regarding the referral process, asking to whom the referral would be addressed. Mr. Bruggeman responded that the chair of the Life Actuarial (A) Task Force would be the direct recipient, with support staff receiving a copy. Rosemarie Albrizio (Equitable), representing interested parties, agreed with the referral to the Task Force, as some of the approaches being considered would require a change in the reserves; and accordingly, the appetite for a reserve modification will influence options presented for Working Group consideration.

In response to an inquiry from Mr. Bruggeman, the Working Group did not object to sending a formal referral to the Life Actuarial (A) Task Force.
b. Agenda Item 2021-01

Mr. Bruggeman directed the Working Group to agenda item 2021-01: *ASU 2021-01 – Reference Rate Reform*. Mr. Pinegar stated that in March 2020, the Financial Accounting Standards Board (FASB) issued *ASU 2020-04 – Reference Rate Reform (Topic 848): Facilitation of the Effects of Reference Rate Reform on Financial Reporting*. He stated that the Working Group adopted ASU 2020-04 in its entirety, where applicable, through its adoption of Interpretation (INT) 20-01: *ASU 2020-04 – Reference Rate Reform*. ASU 2020-04 and INT 20-01 provide temporary, optional and expedient relief in that a qualifying contract modification (because of reference rate reform) should not be considered an event that requires contract remeasurement. This exception guidance applies to both general business and derivative contracts. Mr. Pinegar stated that since the issuance of ASU 2020-04, questions have arisen regarding the accounting for changes in reference rates, which do not specifically reference the London Interbank Offered Rate (LIBOR) or another rate that is expected to be discontinued, that are specifically used for margining, discounting, or contract price alignment. He stated that these items are generally referred to as “basis swaps,” and basis swaps were specifically addressed by the Working Group through *INT 20-09: Basis Swaps as a Result of the LIBOR Transition*. However, ASU 2021-01 directs that basis swaps and other derivative instruments affected by changes to the interest rates from reference rate reform are eligible for the optional relief provided for in ASU 2020-04. Mr. Pinegar stated that interested parties also proposed additional clarifying edits to ensure that derivative transactions that do not qualify for hedge accounting and replication (synthetic asset) transactions could be accounted for as a continuation of the existing contract even when the legal form of the modification is a termination of the original contract, which is replaced with a new reference rate reform contract. He stated that interested parties also proposed edits to clarify that in-scope modifications to centrally cleared swap contracts would also be permitted, as these changes will likely result in a new legal form contract. He stated that in response to the edits proposed by interested parties, the revisions slightly differ from U.S. generally accepted accounting principles (GAAP). However, for statutory accounting, the revisions do not change the measurement method, as these items would still be reported at fair value. For the non-highly effective hedges, the proposed edits address a flow of funds issue and prevent gains/losses from being realized through net income because of reference rate reform when the derivative structure has not matured or otherwise been terminated. By ensuring that these items receive the relief provided in INT 20-01, these derivative transactions will remain as outstanding in the financial statements and thus not require redesignation. The changes in fair value will continue as unrealized until the termination/maturity date of the derivative. He stated that NAIC staff recommend that the Working Group adopt the previously exposed edits to INT 20-01 and incorporate the additional edits as proposed by interested parties.

Ms. Albrizio stated that interested parties support adoption of INT 20-01 as recommended by NAIC staff and do not request an exposure. Mr. Monahan stated that the ACLI also supports adoption and does not request an exposure.

Mr. Arfánis made a motion, seconded by Mr. Hudson, to adopt agenda item 2021-01 (Attachment One-B1i) and the exposed revisions to INT 20-01 (Attachment One-B1j), including the edits received from interested parties during the exposure period. The motion passed unanimously.

c. Agenda Item 2021-04

Mr. Bruggeman directed the Working Group to agenda item 2021-04: SSAP No. 97 – Valuation of Foreign Insurance SCAs. Fatima Sediqzad (NAIC) stated that this agenda item originated from comments received during the development of agenda item 2018-26: SCA Loss Tracking – Accounting Guidance, which adopted revisions in SSAP No. 97 to state that reported equity method losses of an investment in a subsidiary, controlled or affiliated entity (SCA) would not create a negative value in an SCA investment; thus, equity method losses would stop at zero. However, the agenda item 2018-26 also clarified that to the extent that there was a financial guarantee or commitment, it would require recognition under SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets. In November 2020, the Working Group adopted agenda item 2020-18: SSAP No. 97 Update, which removed a lingering, superseded reference regarding negative equity method loss valuations. Ms. Sediqzad stated that SSAP No. 97 requires a specific limited statutory basis of accounting adjustments to paragraph 8.b ii. (insurance-related SCA) and paragraph 8.b.iv. (foreign insurance SCA) entities. These adjustments are to prevent assets held by an SCA from receiving more favorable accounting treatment than had they been held directly by the insurer. It was during the Working Group’s discussion of agenda item 2020-18 that industry requested consideration of whether paragraph 8.b.iv. entities should continue to be subject to the long-standing SSAP No. 97 provisions, specifically if the limited statutory basis of accounting adjustments should result in a negative SCA valuation. Interested parties’ initial response was that foreign insurance operations are subject to foreign jurisdictions and should be allowed to stand independently of a domestic insurer; thus, in the absence of a guarantee or commitment, equity valuation should not go negative. Industry discussion then expanded to include certain investments in scope of SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies and whether the limited
statutory adjustments, as required in SSAP No. 97, of certain SSAP No. 48 entities should apply in the absence of a required U.S. GAAP audit.

Ms. Sediqzad stated that in response to comments received, NAIC staff requested state insurance regulator input on the industry comments, particularly regarding whether the limited statutory adjustments should not result in a negative valuation for foreign SCA, specifically in circumstances where the SCA does not provide services or hold assets on behalf of a U.S. insurer. Additionally, NAIC staff have proposed additional clarifying edits to SSAP No. 48, stating that the equity method of accounting remains required in the event of a negative equity valuation, as the equity method of accounting is independent from the limited statutory accounting adjustment requirements.

Angelica Tamayo-Sanchez (New York Life), representing interested parties, stated that the intent of the proposed edits from interested parties is to ensure proper accounting treatment for foreign SCAs while providing adequate safeguards. She stated that interested parties support exposure of agenda item 2021-04, which proposes exceptions to the negative equity valuation of foreign SCAs as a result of limited statutory accounting adjustments required in SSAP No. 97.

Mr. Bruggeman stated that examples provided by interested parties demonstrate anticipated equity diminishment in a rising interest rate environment. The translation between U.S. GAAP and statutory accounting causes potential valuation differences; however, the foreign SCA is subject to the solvency requirements of the local jurisdiction. Mr. Bruggeman asked the Working Group if an exception to the potential negative equity valuation resulting from the limited statutory accounting adjustments should be considered. Mr. Clark stated support for the exposure as an environment of prolonged rising interest rates. Foreign SCAs could experience dramatic decreases in equity valuations, and the exposure will permit multiple options for Working Group consideration.

Mr. Clark made a motion, seconded by Mr. Kasinow, to expose agenda item 2021-04 with proposed language in: 1) SSAP No. 48 to clarify that equity method calculations may result in a negative equity valuation regardless of if the investment is supported by a U.S. GAAP audit; and 2) SSAP No. 97 to detail that the limited statutory basis of accounting adjustments will not result in a negative equity valuation of foreign SCAs under certain, limited circumstances. The motion passed unanimously.

d. Agenda Item 2021-05

Mr. Bruggeman directed the Working Group to agenda item 2021-05: Accounting for Cryptocurrencies. Mr. Stultz stated that this agenda item was drafted in response to inquiries received regarding the statutory accounting treatment for cryptocurrencies, specifically whether Bitcoin is an admitted asset and within the definition of SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments. He stated that the agenda item proposed INT 21-01T: Accounting for Cryptocurrencies to clarify that cryptocurrencies neither meet the definition of cash in SSAP No. 2R, nor meet the definition of an admitted asset per SSAP No. 4—Assets and Nonadmitted Assets. He stated that in response to comments received, NAIC staff updated INT 21-01T to clarify that this nonadmission only refers to directly held cryptocurrencies. Accordingly, as INT 21-01T only directly affects held cryptocurrencies, NAIC staff did not recommend revisions to SSAP No. 30R—Unaffiliated Common Stock, SSAP No. 48, or SSAP No. 97. Mr. Bruggeman stated that while the proposed INT 21-01T addresses cryptocurrencies in a holistic perspective, any state regulation would take precedence over any action taken by the Working Group.

Mr. Kinion stated support for the edits to reflect that only directly held cryptocurrencies are affected by INT 21-01T. Additionally, the captive insurance market currently utilizes indirectly held cryptocurrency investments and believes its acceptance as an investment will expand to other entities. Mr. Kinion stated that Delaware recommends that the Working Group continue to monitor the development and innovation regarding cryptocurrency acceptance.

James Newman (Massachusetts Mutual Life Insurance), on behalf of interested parties, stated that they agree with the edits as proposed by NAIC staff stating that only directly held cryptocurrencies are nonadmitted assets.

Mr. Hudson made a motion, seconded by Ms. Weaver, to adopt agenda item 2021-05 (Attachment One-B1k) and the nonsubstantive interpretive guidance in INT 21-01 (Attachment One-B1l), which clarifies that cryptocurrencies neither meet the definition of cash in SSAP No. 2R, nor when directly held, meet the definition of an admitted asset per SSAP No. 4. The motion passed unanimously.
Mr. Bruggeman directed the Working Group to agenda item 2021-09: State ACA Reinsurance Programs. Robin Marcotte (NAIC) stated that this agenda item proposed revisions to SSAP No. 107—Risk-Sharing Provisions of the Affordable Care Act to include state Affordable Care Act (ACA) reinsurance programs using Section 1332 waivers. The intent of the revisions was to ensure that the state programs continue to follow the SSAP No. 107 hybrid approach for state ACA programs. In general, these programs provide funding to insurance plans in the individual market that incur high claims costs for enrollees, and they often require assessments from group insurance plans. Ms. Marcotte stated that the hybrid accounting approach has three categories: 1) individual products that pay a reinsurance funding contribution and are eligible to receive reinsurance distributions would be accounted for in a manner similar to an involuntary reinsurance pool, as described in SSAP No. 62—Underwriting Pools; 2) health products that are not eligible for reinsurance distributions under the terms of the state ACA reinsurance program would treat the amounts as assessments reported in taxes, licenses and fees similar to treatment under SSAP No. 35R—Guaranty Funds and Other Assessments; and 3) liabilities should be recognized when they meet the definition of a liability pursuant to SSAP No. 5R; reimbursement for claims costs should reduce claims incurred; 2) payments should be reflected as assessment if a plan is only based revisions to address the diversity in state programs with the following preliminary recommendations: 1) program reimbursements for claims costs should reduce claims incurred; 2) payments should be reflected as assessment if a plan is only eligible to be a payer; 3) liabilities should be recognized when they meet the definition of a liability pursuant to SSAP No. 5R; 4) the state ACA reinsurance programs admissibility guidance should be similar to the SSAP No. 107 federal receivables guidance.

Tom Finnell (America’s Health Insurance Plans—AHIP) stated support for the continued efforts to address the variations in state plans and offered to assist NAIC staff in developing additional recommendations for Working Group consideration.

In response to an inquiry from Mr. Bruggeman, the Working Group did not object to directing NAIC staff to continue efforts on this topic.

3. Considered Maintenance Agenda – Pending Listing – Exposures
   a. Agenda Item 2019-21

Mr. Bruggeman directed the Working Group to agenda item 2019-21: SSAP No. 43R. Ms. Gann stated that this agenda item was in part a continuation of the “Investment Classification Project,” which intended to undertake a comprehensive project to review the investment SSAPs. Since the origination of the project, the Working Group has adopted substantive revisions to SSAP No. 26R, SSAP No. 30R, and SSAP No. 32R—Preferred Stock. She stated that in March 2020, the Working Group exposed a preliminary issue paper to present potential options for consideration when assessing investments within the scope of SSAP No. 43R, particularly focusing on different types of investments based on their characteristics. In response to the initial exposure, interested parties commented that the investment characteristics of focus in the SSAP No. 43R exposure overlap with investments in scope of SSAP No. 26R. After this assessment, the Working Group elected to pursue a principles-based approach to define investments that are eligible for reporting on Schedule D-1: Long-Term Bonds to encompass investments within the scope of both SSAP No. 26R and SSAP No. 43R.

Ms. Gann stated that since the Fall 2020 exposure, interested parties, Iowa regulators and NAIC staff have developed a proposed bond definition that intends to reflect principles that focus on substance over form to determine eligibility for reporting on Schedule D-1. In summary, a bond must represent a creditor relationship in substance and can be issued as either a direct issuer obligation or an asset-backed security (ABS). Creditor relationships with equity-linked characteristics or that represent ownership interest in substance are neither bonds, nor investments that rely on equity return cash flows. The proposed guidance includes a rebuttable presumption that investments that rely on equity return cash flows are not bonds; however, the presumption may be overcome through documented analysis supporting the recharacterization of the underlying equity risks into bond risk through the structuring and diversification of collateral.

Ms. Gann stated that issuer obligations are primarily supported by the general creditworthiness of an operating entity, and additional examples of these instruments have been included in the proposed definition. The other investments eligible for Schedule D-1 reporting are ABSs, which are defined as instruments issued by entities that have a primary purpose of raising

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Mr. Clark stated that the summary adequately described the proposed bond definition, and he expressed his appreciation of both NAIC staff and industry for their collaborative efforts. He stated that the definition proposes a set of concepts to define the substance of a bond, and it can be applied to all debt securities that are in substance a bond (regardless of legal form). The agenda item eliminates the opportunity to characterize risks that are not reflective of a bond risk as a bond and thus reduce non-bond items from Schedule D-1.

Michael Reis (Northwestern Mutual), representing interested parties, acknowledged the importance of the project and stated that all parties came to the table with meaningful collaboration, which resulted in the proposed bond definition for exposure. He stated that interested parties will evaluate their investment holdings in the interim to determine what investments may no longer qualify for bond reporting, and they will report back during the comment period. Caleb Brainerd (Athene) stated that Athene appreciates the efforts of state insurance regulators and NAIC staff in the development of this project, and he said he is willing to assist in the development of the standard.

Mr. Clark made a motion, seconded by Mr. Fry, to expose the proposed bond definition for a public comment period ending July 15. The motion passed unanimously.

4. Discussed Other Matters

a. Life Risk-Based Capital (E) Working Group Referral and Draft Response

Ms. Gann stated that the Life Risk-Based Capital (E) Working Group sent a referral to the Statutory Accounting Principles (E) Working Group requesting consideration on the accounting and reporting aspects of an ACLI proposal to modify the treatment of real estate in the life risk-based capital (RBC) formula. The proposal included the incorporation of an adjustment to the factor applied based, in part, on the fair value of real estate reported in the annual statements. Ms. Gann stated that NAIC staff drafted a response that noted a number of concerns for property reported on Schedule A – Part 1: Real Estate Owned that included: 1) fair value has historically only been a supplemental disclosure and is not subject to audit or verification procedures; 2) fair value has historically only been used to determine whether an other-than-temporary impairment (OTTI) assessment is required not for the evaluation of unrealized gains; 3) the statutory accounting requirements for five-year appraisals does not include property that is owner-occupied. She highlighted that there were a significant number of instances in which the reported book/adjusted carrying value (BACV) was the same as the fair value, or where the fair value reported was left blank. She stated that additional concerns were noted for investments captured in scope of SSAP No. 48 and reported on Schedule BA: Other Long-Term Invested Asset as having underlying characteristics of real estate that included: 1) the classification of investments reported on BA as having “underlying characteristics of real estate” is subjective. As a result, property reported elsewhere may be reclassified to this category for RBC benefit; 2) SSAP No. 48 investments follow U.S. GAAP, which has options for permissible valuations, and these different valuations could affect the difference in fair value, resulting in the underlying U.S. GAAP option affecting the extent to which RBC is affected; and 3) real estate reported on Schedule BA is not subject to appraisal requirements.
Ms. Gann stated that the memo details two potential recommendations for consideration that include delaying the adjustment factors until at least 2022 to ensure that examiners have adequate time to assess the reported real estate values or restrict fair values used for RBC to the “lesser of” current or prior year reported fair values, or possibly averaging reported fair values across multiple years. The later recommendation will prevent the inflation of fair values in situations where a reporting entity needs RBC relief. Mr. Bruggeman stated that the concerns noted are primarily based on the reliability and consistency of data across all reporting entities. He stated that larger entities likely have the resources to determine fair value; however, the opportunity for benefit should apply equally among all life entities. If implemented, companies will likely have an increased incentive to report inflated fair values, and state insurance regulators do not want situations where fair values are increased solely for RBC benefit.

Mr. Monahan stated his appreciation for the detailed review and that the ACLI does not disagree with the conclusion to defer the implementation of the adjustments based on fair values until there has been a review and possible modification to the accounting requirements, exam and audit procedures. He stated that the ACLI supports submitting the response to the Life Risk-Based Capital (E) Working Group. Mr. Bruggeman noted that his concern was less with the concept and more with using fair value numbers that do not drive surplus.

In response to an inquiry from Mr. Bruggeman, the Working Group did not object to directing NAIC staff to send the response to the Life Risk-Based Capital (E) Working Group (Attachment One-B1m).

b. CTLs – Valuation of Securities (E) Task Force Response

Ms. Gann stated that in January 2021, the Working Group sent a referral to the Valuation of Securities (E) Task Force pursuant to the discussion regarding credit tenant loans (CTLs). The referral posed several inquiries and included a question as to whether it is appropriate to revisit the 5% residual asset risk threshold as a restriction for conforming CTLs. She stated that the Task Force response was recently received (Attachment One-B1n), and NAIC staff will continue to review and assess the response. John Garrison (Lease-Backed Securities Working Group) inquired as to whether the Working Group would receive public comments regarding the referral response. Mr. Bruggeman stated that while comments are generally reserved for exposures, comments may be sent to NAIC staff.

c. INT 20-10

Ms. Gann stated that the Valuation of Securities (E) Task Force is considering edits to the filing exemption (FE) requirements for CTLs. In advance of any potential action by the Task Force, edits have been proposed to INT 20-10: Reporting Nonconforming Credit Tenant Loans to clarify that temporary reporting eligibility permitted in INT 20-10 does not require Securities Valuation Office (SVO)-assigned NAIC designations beyond what is required in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual). Ms. Gann stated that as the Working Group is discussing this item prior to the Task Force meeting, it is recommended to expose the edits to INT 20-10 contingently upon anticipated exposure or adoption of the Task Force. If the Task Force takes differing action, a Working Group exposure will not occur. Mr. Fry stated that the subject matter proposed by the Task Force requires exposure, and he said he would support an exposure of INT 20-10, with an exposure period to match that of the Task Force.

In response to an inquiry from Mr. Bruggeman, Charles Therriault (NAIC) stated that the proposed revisions for FE classification with a 50% residual risk threshold do not reflect any mitigants, such as a residual risk insurance policy. He stated that assessment of credit quality can occur for any level of residual risk; however, the determination of an appropriate residual risk threshold is a determination that cannot be made by the SVO.

Mr. Fry made a motion, seconded by Mr. Clark, to expose INT 20-10 dependent on an anticipated corresponding exposure by the Valuation of Securities (E) Task Force. If exposed by the Task Force, the exposure period of INT 20-10 will match that of the Task Force. The motion passed unanimously.

After the Working Group’s May 24 meeting, the Valuation of Securities (E) Task Force did not expose the proposed revisions to modify the residual risk threshold in determining whether a security could be FE. This exposure did not occur, as it was identified that the changes to the residual risk threshold for “filing exemptions” (e.g., permitting credit rating provider (CRP) ratings as equivalents to NAIC designations) would also inadvertently modify the structural requirements in classifying mortgage loans in scope of SSAP No. 37—Mortgage Loans as CTLs permitted to be reported on Schedule D-1. In addition to revising the structural requirements for mortgage loans, the original proposed edits would also alter the requirement for these mortgage loan structures to be assessed by the SVO. After considering these concerns, the Task Force instead exposed minor
edits, that differ from what was anticipated. The revised edits reflect a proposal as sent by the chair and vice chair of the Working Group on May 21 (Attachment One-B1o), to clarify that the definition of CTLs as mortgage loans pertains to investments in scope of SSAP No. 37. This edit clarifies that the Accounting Practices and Procedures Manual (AP&P Manual) determines the investment accounting and reporting schedule, and it reiterates that security structures should be classified in accordance with those provisions. If the exposed edits are adopted, it was identified that INT 20-10 may no longer be needed; therefore the Working Group will subsequently consider INT 20-10 after the Task Force concludes consideration on this issue.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.

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April 29, 2021

Dale Bruggeman
Chair, Statutory Accounting Principles (E) Working Group
National Association of Insurance Commissioners

Re: INT 21-01T: Accounting for Cryptocurrencies; Exposure Ref #2021-05

Dear Chairman Bruggeman:

On behalf of Insurance Commissioner Navarro, please accept this letter as a recommendation that the Statutory Accounting Principles (E) Working Group (SAPWG) expand the scope of Exposure 2021-05 regarding INT 21-01T to consider the investment in cryptocurrency mutual funds by insurers. Thus far, the exposure is limited to insurers directly investing in cryptocurrencies. The exposure should expand to consider investments in mutual and other securities funds that may have cryptocurrencies within their portfolios.

Today there are approximately 4,000 different cryptocurrencies available on about 200 different cryptocurrency exchanges. Cryptocurrencies have seen significant price volatility and have experienced an extreme increase in value over the past year, with the value of total outstanding cryptocurrencies nearing $1 trillion as of February 2021. The Delaware Insurance Department’s captive insurance program already has captive insurers investing in such funds. If captive insurers are doing so, it is very possible that commercial insurers are either already or considering doing the same.

SAPWG determined that if an insurer directly invests in cryptocurrencies, the investment is non-admitted under statutory accounting because cryptocurrencies are not cash under Statement of Statutory Accounting Principles (SSAP) No. 2R. 1 Cryptocurrencies are not cash under this SSAP because cryptocurrencies are not a medium of exchange that a bank or other similar financial institution will accept for deposit and allow an immediate credit to the depositor’s account.

1 National Association of Insurance Commissioners (March 2021), Statutory Statement of Accounting Principles No. 2R – Cash, Cash Equivalents, Drafts, and Short-Term Investments.
The SAPWG’s decision to only consider insurers directly investing in cryptocurrencies and not indirect investments via mutual funds reveals an important distinction between what is an admitted versus non-admitted asset. SSAP No. 30R\(^2\) does not limit an insurer’s investments in mutual funds. Specifically, paragraph 4(c) includes Securities and Exchange Commission (SEC) registered funds regardless of the fund’s mix or type of securities owned. If the mutual fund is not SEC registered, per SSAP No. 48\(^3\) the investment receives treatment as a joint venture. Consequently, an insurer may indirectly invest in cryptocurrencies through a mutual fund and hold the investment as an admitted asset.

The use of cryptocurrencies is evolving. PayPal now allows users to buy, sell and hold some cryptocurrencies, but it is important to note that PayPal is not recognized as a bank. In addition to Bitcoin, some banks have shown interest in stablecoins, which trade like cryptocurrencies but are pegged to existing government-backed currencies, such as the U.S. dollar. Because the Delaware Insurance Department has experience with this evolution via captive insurers investing in cryptocurrency funds, it offers its experience to assist the working group. Captive insurers typically adopt Generally Accepted Accounting Principles (GAAP) as opposed to Statutory Accounting Principles for financial reporting. Accordingly, captive insurers report mutual fund investments at market value under GAAP. Despite this significant accounting difference, there is commonality between captive and commercial insurers for how they may invest in cryptocurrencies.

Thank you for considering this letter and the Delaware Insurance Department looks forward to assisting the SAPWG.

Sincerely,

Steve W. Kinion
Director

\(^2\) National Association of Insurance Commissioners (March 2021), Statutory Statement of Accounting Principles No. 30R – Unaffiliated Common Stock.

\(^3\) National Association of Insurance Commissioners (March 2021), Statutory Statement of Accounting Principles No. 48 – Joint Ventures, Partnerships, and Limited Liability Companies.
April 30, 2021

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Items Exposed for Comment by the Statutory Accounting Principles Working Group on March 15, 2021 with Comments due April 30, 2021

Dear Mr. Bruggeman:

Interested parties appreciate the opportunity to comment on the exposure drafts released for comment by the NAIC Statutory Accounting Principles (E) Working Group (the Working Group). We offer the following comments:

**Ref #2020-36: Derivatives Hedging Fixed Indexed Products**

On November 12, 2020, the Working Group moved this item to the active listing, categorized as substantive, and exposed the agenda item to solicit comment from state insurance regulators and industry on establishing accounting and reporting guidance for derivatives hedging the growth in interest for fixed indexed products. In addition to the two general options presented in the agenda item, the Working Group is open for additional commentary and suggestions, and directed NAIC staff to work with industry throughout the process similar to the collaborative efforts that occurred when developing the guidance in *SSAP No. 108—Derivatives Hedging Variable Annuity Guarantees*. With this exposure, notification to the Life Actuarial (E) Task Force will occur.

On March 15, 2021, the Working Group re-exposed this agenda item to provide additional time for interested parties to develop a proposal. NAIC staff will work with interested parties in the interim to discuss this agenda item and potential options.

Interested parties would like to thank the Working Group for the opportunity to comment on the exposed Ref #2020-36, Derivatives Hedging Fixed Indexed Products.

We continue our work assessing the proposal and evaluating potential variances to the exposure. As noted in 2020-36, “With this exposure, notification to the Life Actuarial (E) Task Force (LATF) will occur”. We would request that a referral be made to LATF, as to whether there is interest in changing the reserve framework to accommodate the derivative approach as this may influence our view on the approach to recommend.
Interested parties are committed to working with NAIC staff and SAPWG on this very complicated and important topic, so far meeting with NAIC staff to share initial views

**Ref #2020-37: Separate Account – Product Identifiers**

On November 12, 2020, the Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed the agenda item to solicit comments from state insurance regulators and industry regarding the degree of product identifying details needed to adequately assess the product features and reserve liabilities in the separate account. In particular, feedback was requested on how to obtain increased product identifier reporting granularity in question 1.01 (product mix) of the separate account general interrogatories (GI 1.01). Additionally, feedback was requested regarding if a threshold should be established for when aggregate reporting would be permitted.

On March 15, 2021, the Working Group exposed this agenda item with details of a proposed blanks change, which was also concurrently exposed with the Blanks (E) Working Group. With the proposed blanks changes, there were no proposed revisions to statutory accounting principles.

Consideration of this item will occur during an interim call so that the blanks changes may be reflected in the statutory financials for year-end 2021. Pursuant to this agenda item and regulator comments received, the Working Group is sponsoring blanks agenda item (2021-03BWG) to modify the current General Interrogatory instructions and require that a distinct disaggregated product identifier be used for each product represented. The disaggregation will require that each separate account product filing or policy form be separately identified. For example, if a company has 5 different separate account group annuities, each annuity shall be separately reported. Additionally, the instructions will indicate that companies may eliminate proprietary information (e.g., such as XYZ company Pension Plan), however such elimination will still require the use of a unique reporting identifiers (such as PRT #1). This disaggregation of reporting will be utilized for all applicable General Interrogatories (e.g., 1.01, 2.4, 4.1) and was at the direct request of regulators and will assist in regulator review so that each product, primarily those in which may potentially expose the general account to funding risk, may be independently examined.

NAIC staff also noted that there is inconsistency in the current reporting of the separate account general interrogatories, as some companies aggregate based on overall product type and other companies already include a disaggregation of all separate account products. With the clarification that “each product” shall be captured, the regulators will have the information necessary to complete assessments and improve consistency in reporting.

Interested parties supports the re-exposure to add pension risk transfer (PRT) and registered indexed linked annuity (RILA) product totals in the interrogatory and with the disaggregation required for each separate account product filing to be separately identified.

**Ref #2020-38: Pension Risk Transfer – Separate Account Disclosure**

Working Group exposed this agenda item with details of a proposed blanks change, which will also be concurrently exposed with the Blanks (E) Working Group. With the proposed blanks changes, there are no proposed revisions to statutory accounting principles.
Consideration of this item will occur during an interim call so that the blanks changes may be reflected in the statutory financials for year-end 2021. Pursuant to this agenda item and regulator comments received, the Working Group is sponsoring blanks agenda item (2021-03BWG) to modify the current General Interrogatory instructions and require that a distinct disaggregated product identifier be used for each product represented. The disaggregation will require that each separate account product filing or policy form to be separately identified. For example, if a company has 5 different separate account group annuities, each annuity shall be separately reported. Additionally, the instructions will indicate that companies may eliminate proprietary information (e.g., such as XYZ company Pension Plan), however such elimination will still require the use of a unique reporting identifiers (such as PRT #1). This disaggregation of reporting will be utilized for all applicable General Interrogatories (e.g., 1.01, 2.4, 4.1) and was at the direct request of regulators and will assist in regulator review so that each product, primarily those in which may potentially expose the general account to funding risk, may be independently examined.

NAIC staff also notes that there is inconsistency in the current reporting of the separate account general interrogatories, as some companies aggregate based on overall product type and other companies already include a disaggregation of all separate account products. With the clarification that “each product” shall be captured, the regulators will have the information necessary to complete assessments and improve consistency in reporting.

The blanks proposal includes a distinct disaggregated product identifier to be used for each product and shall be used consistently throughout the interrogatory. Disaggregation of reporting shall be such that each product filing or policy form is separately identified. For example, if a company has 5 different separate group annuities, each annuity shall be separately reported. (Companies may eliminate proprietary information however such elimination will require the use of unique reporting identifiers).

Interested parties supports the re-exposure, noting that it will provide additional detail for pension risk transfer (PRT) products in the General Interrogatories.

**Ref #2021-01: ASU 2021-01, Reference Rate Reform**

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed temporary (optional) expedient and exception interpretative guidance, with an expiration date of December 31, 2022. These optional expediens would expand the current exception guidance provided by INT 20-01: ASU 2020-04 – Reference Rate Reform. With this guidance, derivative instruments affected by changes to interest/reference rates because of reference rate reform (regardless of whether they reference LIBOR or another rate that is expected to be is discontinued), in which are used for discounting, margining or contract price alignment would be in scope of the exception guidance afforded in INT 20-01. This exception would allow for continuation of the existing hedge relationship and thus not requiring hedge designdation.

Interested parties agree with the revisions proposed in INT 20-01 to address related FASB guidance in ASU 2021-01 and we believe that it will provide significant relief to all companies that have entered into contracts that reference LIBOR (or another reference rate expected to be discontinued due to reference rate reform).
Other Comments

During the reference rate reform period there has been discussion amongst industry participants related to derivative contract modification market mechanisms and the potential unique impact on statutory accounting. Although the overarching principle of ASU 2020-04 and ASU 2021-01 and thus INT 20-01 is that contracts within scope that are modified due to reference rate reform can be accounted for as a continuation of the existing contract, the guidance only specifically addresses derivatives in the context of qualifying hedging relationships. Neither derivatives used in hedging relationships that do not qualify for hedge accounting (i.e., non-qualifying relationships) nor replication (synthetic asset) transactions (RSAT) are specifically addressed.

Addressing modifications associated with derivatives used in non-qualifying relationships or RSATs is not necessary for generally accepted accounting principles (GAAP) because under GAAP these transactions are always accounted for at market value and both unrealized and realized gains/losses are recorded within the same income statement line. Under SAP, however, gains/losses on these transactions may have different financial statement geography or may not be recognized in the income statement, for example, depending on whether they are unrealized or realized. Further, statutory reporting guidance requires detailed disclosure, through Schedule DB, of each held and terminated derivative transaction.

Exacerbating the need for clarity on this issue is the standard market mechanism for centrally cleared swaps. While bilateral derivative contracts can be amended without termination, it is typical market convention that a cleared derivative contract would be terminated and replaced with an off-market contract in order to amend terms associated with reference rate reform. Without relief, it is standard practice that these amendments would be treated as terminations within statutory accounting and reporting, with resulting impacts on the financial statements.

Although interested parties believe it is the intention of the Working Group and NAIC staff to allow all derivative contract amendments, including non-qualifying relationships and RSATs, associated with reference rate reform to be accounted for and reported as continuations under INT 20-01, we request that clarifying language be included to address the concern of industry participants. We believe this addition will provide statutory accounting and reporting clarity and ensure operational relief for all derivatives as companies plan and begin reference rate modifications.

We believe the most effective way to provide this requested clarity is the addition of the following language as subsection “e” within section 12 of the exposed revision to INT 20-01(changes noted in underline):

For all derivatives (those qualifying for hedge accounting, those that do not qualify for hedge accounting and RSAT’s), allow a reporting entity to account for and report modifications (that are within the scope of INT 20-01) as a continuation of the existing contract even when the legal form of the modification is a termination of the original contract and its replacement with a new reference rate reform contract. This includes in-scope modifications of centrally cleared swap contracts whether they are automatically transitioned at a cessation date or voluntarily executed prior to cessation.
We believe this additional language within INT 20-01 will provide statutory accounting and reporting clarity to companies as they prepare and begin to transition both bilateral and cleared derivatives as part of reference rate reform.

**Ref #2021-02: ASU 2020-08 – Premium Amortization on Callable Debt Securities**

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to *SSAP No. 26R—Bonds* to reject ASU 2020-08, *Codification Improvements to Subtopic 310-20, Receivables – Nonrefundable Fees and Other Costs* for statutory accounting. While ASU 2020-08 closely mirrors existing guidance in SSAP No. 26R (amortizing applicable debt premium to the next effective call price), it does preclude statutory accounting’s yield-to-worst concept, which requires amortizing premiums to the call or the maturity value/date which produces the lowest asset value. There may be scenarios, for statutory accounting, in which premiums amortized to the maturity value/date will yield a lower asset value than simply amortizing applicable premium to the next effective call date (as is required in ASU 2020-08).

Interested parties support the rejection of ASU 2020-08 as insurers are using the yield-to-worst concept for statutory reporting.

**Ref #2021-03: SSAP No. 103R – Disclosures**

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to *SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities* to propose 1) new disclosure elements, and 2) a data-capture template for existing disclosures in SSAP No. 103R to capture disclosures for when a reporting entity has transferred (or sold) assets but still retains a material participation. A blanks proposal is anticipated to be concurrently exposed.

Interested parties thank NAIC staff for working with us in clarifying the purpose of the proposal and the requirements themselves. It was very good collaboration and we support the revised draft.

**Ref #2021-04: SSAP No. 97 – Valuation of Foreign Insurance SCAs**

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed the intent to move this agenda item to the disposal listing without statutory edits. Industry is requested to submit comments on any prevalent examples of a negative equity valuation in a foreign insurance subsidiary, controlled or affiliated (SCA) investment with detailed information for assessment.

As described in the exposure draft, the Working Group does not believe that any changes to SSAP No. 97 are necessary at this point. As such, the reporting entity should record negative equity in an 8.b.iv foreign insurance subsidiary if negative equity arises from the application of the SSAP No. 97 paragraph 9 adjustments even if there is no financial guarantee or commitment by the reporting entity. This approach applies the same treatment to 8.b.iv foreign insurance subsidiaries and 8.b.ii non-insurance subsidiaries.
As stated in our previous comment letter on this topic dated September 18, 2020, interested parties agree with the current accounting guidance, which requires 8.b.ii entities to report negative equity. This is because 8.b.ii entities are considered an extension of the insurance company and since 8.b.ii entities may own assets that would not be admitted if owned by the insurer, it is reasonable to require the insurer to report negative equity in those subsidiaries if negative equity arises due to the non-admission of certain assets.

Interested parties, however, do not agree that the application of the paragraph 9 adjustments should ever result in the insurer’s investment in a foreign insurance subsidiary being reported at an amount less than zero. Foreign insurance subsidiaries have a true business purpose, independent from the parent insurer and are subject to significant regulations in the foreign jurisdiction in which they operate (including with respect to how they invest, the assets they are allowed to own, and the amount of capital they are required to hold). In this way, foreign insurance subsidiaries operate similarly to domestic insurance subsidiaries, and are subject to comparable levels of oversight. It does not appear reasonable to treat a foreign insurance subsidiary differently from the way a domestic insurance subsidiary is treated whereby losses are floored at zero unless the reporting entity has guaranteed obligations or is otherwise committed to provide further financial support for the domestic insurance subsidiary, as stated in SSAP No. 97, paragraph 14e.

We agree with the comments included in the exposure draft regarding the fact that in the past few years, there probably have not been instances of insurers recording negative equity in their foreign insurance subsidiaries. However, we believe that regardless of whether or not this is a common occurrence, the accounting standards should reflect the appropriate accounting treatment and provide guidance for this circumstance, which might arise in the future. As mentioned in our previous comment letter, negative equity could arise due to the non-allowance of deferred acquisition costs recorded by the foreign insurer. Since GAAP allows the explicit recognition of a DAC asset, the gross GAAP reserves are usually higher than statutory reserves, which have an implicit credit for acquisition expenses. As a result, when applying the SSAP No. 97 adjustments to non-admit DAC, we end up with a reserve that is more conservative than statutory rules. One of the reasons why this has not resulted in negative equity in the past is due to the current interest rate environment, which has caused most insurers’ fixed income portfolios to be in a sustained unrealized gain position. If interest rates rise and these unrealized gains reverse out over time, it will likely result in a negative equity position.

Assuming rates stay as low as they are today, negative equity will also be very likely to occur once a foreign insurer uses the new U.S. GAAP standard on long-duration insurance contracts in the paragraph 8.b.iv valuation, since insurance liabilities will increase due to the required market value adjustment under the new standard. Under this scenario, having to report insurance liabilities at market value will then negate any unrealized gains on an insurer’s bond portfolio. This change will go into effect in 2025 for non-public life insurance companies.

Finally, not all foreign insurance companies receive audited GAAP financial statements. In these situations, the investment in the foreign insurance subsidiary (cost basis) is non-admitted, and no results are reflected in surplus until the foreign insurance company distributes earnings to the parent insurance company. If a parent insurance company decides to obtain an audit of its foreign insurance company, it should not result in an impact to surplus that is worse than non-admitting the investment.
We are able and willing to work with NAIC staff to draft potential amendments to SSAP No. 97 to modify the accounting and reporting requirements of foreign insurers to address the negative equity issue.

**Ref #2021-05: Accounting for Cryptocurrencies**

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed the interpretative guidance in INT 21-01T: *Statutory Accounting Treatment for Cryptocurrencies* to clarify that cryptocurrencies do not meet the definition of cash in SSAP No. 2R—*Cash, Cash Equivalents, Drafts, and Short-Term Investments* and are nonadmitted assets for statutory accounting. With the exposure, information from industry is requested per the above recommendation.

Interested parties would like to thank the Working Group for the opportunity to comment on Reference No. 2021-05 – *Accounting for Cryptocurrencies* and related INT 21-01T: *Statutory Accounting Treatment for Cryptocurrencies*, (together the “Exposure”).

Interested parties agree that cryptocurrencies (e.g., Bitcoin) currently do not meet the definition of cash under SSAP No. 2R *Cash, Cash Equivalents, Drafts, and Short-Term Investments*. However, based on our understanding of how cryptocurrencies work, we believe that cryptocurrencies do meet the definition of an asset. As stated in SSAP No. 4 *Assets and Non-Admitted Assets*, an asset is defined as “having future economic benefits obtained or controlled by a particular entity as a result of past transactions or events.” Cryptocurrencies certainly have a future economic benefit as this asset can be sold for cash or exchanged for goods and services in markets that accept cryptocurrencies as payment. In addition, to be an admitted asset, an asset needs to be readily marketable. Interested parties note that there is an active market for cryptocurrencies as they can be purchased and/or redeemed in an open market at readily determinable fair values.

Based on interested parties’ understanding, the overall extent of direct and indirect cryptocurrency ownership is unknown. We do not believe that insurers are directly investing in cryptocurrencies, nor are we aware of any companies that are currently transacting with cryptocurrencies for goods or services. However, we are aware of a very small number of insurers that are currently considering whether to directly hold cryptocurrency for purposes of investment. In addition, some companies have indicated they are interested in potentially using cryptocurrencies to transact business in the future.

Most insurers’ involvement in this asset class so far seems to be limited to investments in private funds set up as limited partnerships/limited liability companies, which invest in cryptocurrency. The funds, for U.S. GAAP purposes, are generally classified as investment companies. Therefore, these funds carry their investments at fair value, and the carrying value under the statutory equity method is essentially fair value. Since the reporting entity’s investment is held by a fund, the investment also results in an equity-based capital charge.

The general level of interest for future investment is difficult to gauge, however, based on what’s transpiring in the financial services market and beyond, cryptocurrencies continue to gain mainstream
traction as an investment\(^1\) and accepted medium of exchange\(^2\), with Bitcoin being the predominant cryptocurrency chosen. The level of interest for holding or transacting with cryptocurrencies may increase as blockchain technology applications are developed and deployed in the years to come. Interest may also increase as companies look to diversify their portfolios. Bitcoin can potentially be a good source of diversification as so far bitcoin appears not to have a strong correlation with the performance of other assets that are impacted by interest rate movements and government regulation for example. In addition, bitcoin may act as an inflation hedge. The supply of traditional currencies is set by a central bank or a similar institution that can run the printing presses, which can cause hyperinflation caused by the printing of too much money. In contrast, the supply of Bitcoin is set as strong incentives provide assurances that there will likely be no more than 21 million bitcoin ever created.

Ref #2021-06: NAIC Accounting Practices and Procedures Manual Editorial and Maintenance Update

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed editorial revisions to SSAP No. 53—Property Casualty Contracts, SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities and the SSAP Glossary.

Interested parties have no comment on the revisions.

Ref #2021-07: ASU 2020-11, Financial Services—Insurance: Effective Date and Early Application

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2020-11, Financial Services – Insurance: Effective Date and Early Application as not applicable for statutory accounting.

Interested parties have no comment on this item.

Ref #2021-08: ASU 2021-02, Franchisors—Revenue from Contracts with Customers (Subtopic 952-606)

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 47—Uninsured Plans to reject ASU 2021-02, Franchisors – Revenue from Contracts with Customers.

Interested parties have no comment on this item.

Ref #2021-09: State ACA Reinsurance Programs

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 107—Risk-Sharing Provisions of the Affordable Care Act. The revisions

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\(^1\) https://www.cnbc.com/2021/03/31/bitcoin-goldman-is-close-to-offering-bitcoin-to-its-richest-clients.html
include State ACA reinsurance programs which are using Section 1332 waivers in scope of SSAP No. 107 and will provide guidance to follow the hybrid accounting approach for the state ACA programs as they operate in a similar manner.

In summary, the view of interested parties is that the principles underlying the exposure draft are appropriate. However, there are important variances among the state ACA Reinsurance Programs as to how they are funded and operate, much more so than was apparently contemplated in the drafting of the proposed guidance in the exposure draft. The significance of such variances requires additional context and guidance to assure that health plans report activity related to any particular state’s ACA Reinsurance Program in a consistent manner. These points are described below, along with suggestions for such additional context and guidance for Working Group’s consideration.

The proposed guidance suggested by the exposure draft is largely prefaced on the following statement therein (emphasis added):

To date, most of the states that have sought 1332 waivers did so to implement state ACA reinsurance programs which have the goal of using the reinsurance programs to lower individual health insurance premium in the jurisdiction. As these programs seek to operate to cover higher individual health claims in a manner similar to the transitional reinsurance program, the initial recommendation is to provide guidance that such state programs should follow the guidance in SSAP No. 107 to the extent the state program has similar terms.

While interested parties agree that the goal of the various state ACA Reinsurance Programs is to lower individual health insurance premiums, the second sentence in the above passage is based on a faulty premise. In fact, the various state ACA Reinsurance Programs aim to achieve that goal in ways that differ operationally in important ways, not just from the former Federal ACA Reinsurance Program, but also from each other.

As a result of those differences, it would be difficult to apply the guidance as proposed in the exposure draft which largely mirrors the current text in SSAP No. 107 applicable to the former Federal ACA Reinsurance Program to the State ACA Reinsurance Programs. It is likely that different health plans could reach different conclusions on how to report any particular state’s ACA Reinsurance Program activity notwithstanding a common set of facts and circumstances about how that state’s program operates. Likewise, independent auditors and state examiners could also reach different interpretations and conclusions.

This is not to suggest that the principles from SSAP No. 107 which the exposure draft proposes to apply as well to state ACA Reinsurance Programs are necessarily flawed, rather that additional context and guidance is needed to assure that statutory accounting will be more uniformly applied by health plans with respect to the same facts and circumstances involving a particular state’s ACA Reinsurance Program.

For the former Federal ACA Reinsurance Program, SSAP No. 107 recognized that additional guidance was needed, noting that:
“… the term “reinsurance” does not represent actual reinsurance between licensed insurers as defined by SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance. This program is similar to an involuntary pool in SSAP No. 63—Underwriting Pools for the individual insured health products subject to the 2014 ACA market reforms.”

Despite the failure of the former Federal ACA Reinsurance Program to clearly meet all the requirements of SSAP No. 61R or SSAP No. 63, SSAP No. 107 nonetheless included clarifying language to deem certain aspects of the program to be reinsurance and to be accounted for as such for statutory reporting. With subject health plans participating in a single federal program for which No. SSAP No. 107 deemed the activity as reinsurance, uniformity in reporting by health plans was more assured.

However, uniformity in reporting by health plans for their activity with the various state ACA Reinsurance Programs would not be similarly assured under the current text of the exposure draft, as each such state plan differs from the former Federal ACA Reinsurance Program – as well as from each other – in various ways. Some examples of those operational differences follow:

- Unlike the former Federal ACA Reinsurance Program, many of the state ACA Reinsurance Programs charge a single assessment that funds many other elements of healthcare affordability within the state and administration of the program, in addition to funding the reinsurance program itself. Other states may fund their program through use of existing premium taxes and have appropriated certain amounts within the state’s general fund to support the reinsurance program and its administration.
- The foregoing differences in funding sources also result in differences in the amount of funding for a state’s ACA Reinsurance Program that is ultimately paid by the participating health plans. In most cases, participating health plans fund a minority of the total program costs. For some state ACA Reinsurance Programs, none of the cost is borne by participating health plans. An anomalous outcome therefore is where a health plan pays very little if any of the state ACA Reinsurance Program’s cost, includes no provision for such cost in its rates, and therefore does not report any premium that it could “cede” but nonetheless reports ceded claims.
- For some state ACA Reinsurance Programs, the state does not itemize the use of assessments. Application of the current proposed guidance may therefore be operationally onerous for organizations and, in some cases, may not be possible without the state providing a specific itemization of the use of the assessments. This may cause health plans to have to estimate the ceded portion versus the expense portion of payments resulting in unintended diversity in practice in treatment for the assessments, potentially reducing comparability in reporting across health plans with respect to their participation in the same state ACA Reinsurance Program.
- The assessments or fees charged are to fund more than just the reinsurance program (distributions and administration of the program); they may also include amounts related to other affordability initiatives.
- The attachment points, coinsurance, and payment caps may be more favorable to the insurer than that of the federal program particularly in the context where the fees might be lower (because the fee charged pay for more than the reinsurance program, or the fact there may be no fee at all).
SSAP No. 107, as well as the current text of the exposure draft, provides principle-based guidance that is intended to help health plans determine which of the following accounting treatments is appropriate, depending on the facts and circumstances:

- As a reinsurance cession following reinsurance accounting in accordance with SSAP No. 61R, Life, Deposit-Type and Accident and Health Reinsurance
- As an involuntary assessment consistent with SSAP No. 35R, Guaranty Fund and Other Assessments
- As an assessment made on behalf of self-insured plans which are administered by the reporting entity following the guidance of SSAP No. 47—Uninsured Plans

Interested parties support a similar conceptual structure to determine the appropriate statutory accounting treatment for state ACA Reinsurance Programs. However, and as a practical matter based on what is known about such programs currently in effect, reinsurance accounting would not seem to be appropriate in most cases. This is because relatively little of the cost is paid by health plans for most of the state ACA Reinsurance Programs (even zero in some cases).

That would leave as remaining options either accounting pursuant to SSAP No. 35R (assessment) or SSAP No. 47 (uninsured plan). However, for some state ACA Reinsurance Programs, the facts and circumstances may not be sufficiently clear to determine which of those would necessarily be appropriate, e.g., in the case of a state ACA Reinsurance Program for which the funding is used for a variety of health-related initiatives and which would vary by nature and amount each year based on legislative action.

As a result, it may be appropriate for the text in the exposure draft to be amended to include additional context and guidance. AHIP offers the following suggestions for the Working Group’s consideration:

- Additional context to inform readers as to the nature, extent, and significance of the various ways in which state ACA Reinsurance Programs differ from the former Federal ACA Reinsurance Program, as well as from each other.
- Section 1332 Waivers should be reviewed by health plans and their auditors to see if traditional reinsurance under SSAP No. 61R would apply. Again, based on the operational aspects of the state ACA Reinsurance Programs currently in place, reinsurance accounting would not appear to be appropriate in most instances.
- If it is determined that reinsurance accounting criteria is not met, then a determination should be made as to whether the guidance of SSAP No. 47 for uninsured plans (e.g., like that under INT 05-05 for Medicare Part D), or of SSAP No. 35R (assessment reporting) would apply.
- In cases where reinsurance accounting is then not deemed appropriate, and where the facts and circumstances do not clearly indicate which of SSAP No. 35R or SSAP No. 47 should apply, include a default provision as to which of those should then apply (e.g., SSAP No. 35R). The assessments under the state ACA Reinsurance Programs are generally unavoidable if the insurer writes business within the state which is more characteristic of a business tax or similar assessment. Insurers are generally required to reduce their rates if the state reinsurance programs
are in effect, and therefore, recording all of the assessment to expense is unlikely to meaningfully distort any underwriting ratios.

**Timing and recognition of assessments.** The updates in SSAP No. 107 currently do not address the timing of accounting recognition for the assessments. Because state ACA Reinsurance Programs vary operationally as described above, assessments may be charged such that the current year assessment is based on prior year premiums (i.e., a premium-based assessment); this could lead to diversity in practice if health plans operating in the same state have varying views of when to recognize the assessment in the absence of specific guidance.

Additional guidance could be provided to clarify when the assessment should be recognized and recorded, e.g., by referencing within SSAP No. 107 the accounting model in SSAP No. 35R, paragraph 4a-c, and providing clarity as to how to apply the recognition criteria to the State Reinsurance assessments.

**Treatment of receivables from state-based reinsurance plans as admitted assets.** Under the former federal reinsurance program, SSAP No. 107 provided the following guidance:

“All receivables from the transitional reinsurance program are subject to the 90-day non-admission rule beginning from when program receivables are due to be disbursed by the government or a government-sponsored entity. That is, the 90-day rule begins when governmental receivables are due, not from the date of initial accrual. The announced governmental or government-sponsored entity distribution date shall be the contractual due date similar to Appendix A-791, paragraph 2.h., which requires that payments due from the reinsurer are made in cash within ninety (90) days of the settlement date. The receivable is also subject to impairment analysis.”

Since most of the existing state ACA Reinsurance Programs are funded by large measure based on state budgetary authority, similar guidance should apply to receivables from such programs.

* * *

Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell  
Rose Albrizio

cc: NAIC staff  
Interested parties
April 30, 2021

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: New York Life’s Comments on Item 2021-04 SSAP No. 97 – Valuation of Foreign Insurance SCAs

Dear Mr. Bruggeman:

New York Life (“NYL”) appreciates the opportunity to provide comments on Item 2021-04 (the “Exposure”), which was exposed by the Statutory Accounting Principles (E) Working Group (the “SAPWG”) on March 15, 2021. We write to request SAPWG pursue the changes to SSAP No. 97 we detail below. We should note that we recognize amending SSAP No. 97 could bring potential unintended consequences. With that in mind, while we offer some suggested language to address such issues later in this letter, we are committed to working with SAPWG on any additional language changes deemed necessary.

As described in the Exposure, SAPWG does not believe that any changes to SSAP No. 97 are necessary at this point. As such, the reporting entity should record negative equity in an 8.b.iv foreign insurance subsidiary if negative equity arises from the application of the SSAP No. 97 paragraph 9 adjustments even if there is no financial guarantee or commitment by the reporting entity. This approach applies the same treatment to 8.b.iv foreign insurance subsidiaries and 8.b.ii non-insurance subsidiaries.

As stated in our previous comment letter on this topic dated October 27, 2020 (attached), there are significant differences between 8.b.ii and 8.b.iv subsidiaries, which, in our view, warrant different accounting treatment. 8.b.ii entities generally operate as an extension of the insurance company and own assets that for the most part would not be admitted if owned by the insurer. In those circumstances, recording negative equity makes sense. In contrast, foreign insurance subsidiaries have a true business purpose, independent from the parent insurer, and are subject to significant regulations in the foreign jurisdiction in which they operate (including with respect to how they invest and the assets they own). In this way, foreign insurance subsidiaries operate similarly to domestic insurance subsidiaries, and are subject to comparable levels of oversight. It does not appear reasonable to treat a foreign insurance subsidiary differently from the way a domestic insurance subsidiary is treated whereby losses are floored at zero unless the reporting entity has guaranteed obligations or is otherwise committed to provide further financial support for the domestic insurance subsidiary, as stated in SSAP No. 97, paragraph 14e.

Furthermore, if the foreign insurer is solvent and has positive capital on a local statutory basis, recording negative equity only due to the SSAP No. 97 paragraph 9 adjustments does not appear to provide the right accounting result. We agree with the comments included in the Exposure regarding the fact that in the past few years, there probably have not been instances of insurers recording negative equity in their foreign insurance subsidiaries. However, just because it hasn’t happened recently, does not mean it cannot happen in the future under very realistic scenarios. Accordingly, we believe the accounting standards should reflect the appropriate accounting treatment and provide guidance for this likely circumstance.

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As mentioned in our previous comment letter, negative equity could arise due to the non-allowance of deferred acquisition costs (“DAC”) recorded by the foreign insurer. Since GAAP allows the explicit recognition of a DAC asset, the gross GAAP reserves are usually higher than statutory reserves, which have an implicit credit for acquisition expenses. As a result, when applying the SSAP No. 97 adjustments to non-admit DAC, we end up with a reserve that is more conservative than statutory rules. One of the reasons why this has not resulted in negative equity in the past is due to the current interest rate environment, which has caused most insurers’ fixed income portfolios to be in a sustained unrealized gain position. If interest rates rise and these unrealized gains reverse out over time, it will likely result in a negative equity position. We have included an example below to illustrate the sensitivity to interest rates of certain foreign insurers’ fixed income portfolios. It is possible that other foreign insurers might have different interest rate sensitivity due to differences in their current GAAP equity and underlying portfolios. This example is based on a sensitivity analysis performed by NYL using certain assumptions regarding asset composition. Based on our analysis, an increase of as little as 50 basis points in the 10-year treasury rate can deplete about $200 million of unrealized gains.

<table>
<thead>
<tr>
<th>Reconciliation from U.S. GAAP to statutory admitted equity (in millions)</th>
<th>Admitted equity at 12/31/20</th>
<th>Assumes a 0.5% increase in the 10-year treasury rate</th>
<th>Assumes a 1.5% increase in the 10-year treasury rate</th>
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<tr>
<td>SCA GAAP Equity*</td>
<td>1,300</td>
<td>1,100</td>
<td>700</td>
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<tr>
<td>Less para. 9 adjustments</td>
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<td>DAC</td>
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<tr>
<td>Other non-admitted assets</td>
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<td>Goodwill</td>
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<td><strong>Adjusted Equity</strong></td>
<td><strong>596</strong></td>
<td><strong>396</strong></td>
<td><strong>(4)</strong></td>
</tr>
</tbody>
</table>

*GAAP equity includes $900 million of unrealized gains on the foreign insurer's bond portfolio at 12/31/20

In light of the fact that negative equity can occur realistically in the near term, we believe that changes are needed to the accounting standards to address this issue. At the same time, we understand the need to protect against potential abuses that could arise if SSAP No. 97 is updated to remove the negative equity concept for a foreign insurance subsidiary. As suggested in our previous comment letter, we have crafted the below underlined language, which we would propose inserting into the last sentence of paragraph 9:

Note that the outcome of these adjustments can result in a negative equity valuation of the investment for all 8.b.ii SCA entities. For an 8.b.iv SCA entity, the application of these adjustments will not result in negative equity unless either of the following circumstances arises:

1) The reporting entity has guaranteed obligations of the 8.b.iv SCA entity or is otherwise committed to provide further financial support for the 8.b.iv SCA entity. In this case, accounting for the equity pick-up after application of the paragraph 9 adjustments, should be based on the guidance in SSAP No. 97, paragraph 14e;

2) The 8.b.iv SCA entity provides services to, or holds assets on behalf of, the reporting entity. In this case, negative equity has to be recorded.

Note – if there are any reinsurance transactions between the reporting entity and the foreign insurance subsidiary, the adjustments required in paragraph 8.b.iv of SSAP No. 97 must be followed.
We believe this language addresses the two competing interests described above: (1) reflect the appropriate accounting for an 8.b.iv entity and (2) prevent potential abuses from allowing an 8.b.iv entity’s equity to be floored at zero. However, we are open to any other language SAPWG believes would help distinguish true operating foreign insurance subsidiaries that are independent from the U.S. insurer and have a true business purpose from entities that operate to shield the reporting entity from U.S. statutory accounting rules. Our intent is not to amend SSAP No. 97 in a way that creates loopholes – instead we want to incorporate changes that contain sufficient guardrails while also appropriately accounting for foreign insurance subsidiaries. We will be happy to work with you on re-drafting our proposal to address potential loopholes and prevent any abuses from occurring.

We would also like to take this opportunity to raise another issue related to the accounting and reporting of foreign insurance subsidiaries. Due to the high cost of implementing new U.S. GAAP standards related to credit losses and long duration insurance contracts, NYL has decided to discontinue the preparation of financial statements on a U.S. GAAP basis in 2023, which will include our Mexican subsidiary. Once that occurs, it is unclear to us which accounting basis to use to record our investment in the foreign insurance subsidiary, which would then be non-admitted since there is no U.S. GAAP audit. In that scenario, we would have to record our investment at cost or local statutory equity. To that end, we would appreciate the opportunity to engage in a conversation with you and SAPWG staff regarding the ability to potentially allow for foreign insurance subsidiaries without U.S. GAAP financial statements to be admitted and to be carried at the lower of cost or local audited statutory equity, adjusted for paragraph 9 requirements, but flooring those adjustments at zero if negative equity arises. Our understanding of the current guidance in SSAP No. 97 paragraph 8.b.iv is that we are allowed to use audited foreign statutory basis financial statements of the foreign insurer, but the foreign insurer’s financial statements still need to include a reconciliation to U.S. GAAP, which means that U.S. GAAP books and records still need to be prepared.

Thank you for considering our comments on this topic. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

Robert M. Gardner
Senior Vice President and Controller

Douglas A. Wheeler
Senior Vice President, Office of Governmental Affairs
October 27, 2020

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: New York Life’s Comments on Item 2020-18 SSAP 97 Update

Dear Mr. Bruggeman:

New York Life (“NYL”) appreciates the opportunity to provide comments on Item 2020-18 (the "Exposure"), which was exposed by the Statutory Accounting Principles (E) Working Group (the "Working Group") during the NAIC 2020 Summer National Meeting.

NYL agrees with the comments provided in the September 18, 2020 Interested Party letter. This letter provides additional background on those comments as well as a potential path to resolution by suggesting wording changes that could be incorporated into SSAP No. 97 Investments in Subsidiaries, Controlled and Affiliated Entities to address the issues that have been identified.

NYL has been closely watching SAPWG’s exposure of revisions to SSAP No. 97, including the most recent exposure that makes some updates to the last sentence of paragraph 9. That exposure caused us to re-examine our understanding of the SSAP and the potential for a foreign insurance subsidiary to record negative equity in the future. As expressed in the Interested Parties comment letter, we believe that it makes sense for SSAP No. 97 to differentiate in its treatment of 8.b.iv foreign insurance subsidiaries and 8.b.ii SCAs.

At a high level, 8.b.ii entities generally operate as an extension of the insurance company and own assets that for the most part would not be admitted if owned by the insurer. In those circumstances, recording negative equity makes sense. In contrast, foreign insurance subsidiaries have a true business purpose, independent from the parent insurer, and are subject to significant regulations in the foreign jurisdiction in which they operate. From our perspective, foreign insurance subsidiaries are closer to 8.b.iii subsidiaries in that they are real operating companies that are independent of the domestic insurer.

While the circumstances that could cause an insurer to record negative equity in a foreign insurance subsidiary are probably not very common, they could come to pass in the future. This could be due to the non-allowance of deferred acquisition costs recorded by the foreign insurer, while still requiring the foreign insurer subsidiary to hold the higher gross GAAP reserve that has no implicit credit for acquisition expenses that is inherent in statutory reserves. Therefore, we believe that changes are needed to prevent this situation from occurring in the future.
At the same time, we want to prevent against any potential abuses that could arise if SSAP No. 97 is updated to remove the negative equity concept for a foreign insurance subsidiary. We have therefore crafted the below underlined language, which we would propose inserting into the last sentence of paragraph 9:

Note that the outcome of these adjustments can result in a negative equity valuation of the investment for all 8.b.ii SCA entities. For an 8.b.iv SCA entity, recording negative equity depends on whether or not the parent insurer has issued a guarantee to fund losses of the 8.b.iv SCA entity or whether the 8.b.iv entity provides services to the parent or affiliated insurer. If the parent insurer has committed to fund losses of the 8.b.iv SCA entity, the accounting described in paragraph 13e should be followed. If the 8.b.iv SCA entity does not provide services to, or holds assets on behalf of, the parent insurer or affiliate, the valuation of the investment in the SCA would be floored at zero if negative equity arises due to the application of these adjustments. For an 8.b.iv SCA entity that provides services to, or holds assets on behalf of, the parent insurer or affiliate, negative equity has to be recorded due to the application of these adjustments for the total amount of the non-admitted assets used to provide services to, or held on behalf of, the parent insurer or affiliate.

We believe this language addresses the two competing interests described above. Thank you for considering our comments on this topic. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

Robert M. Gardner
Senior Vice President and Controller

Douglas A. Wheeler
Senior Vice President, Office of Governmental Affairs
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Separate Account – Product Identifiers

Check (applicable entity):

<table>
<thead>
<tr>
<th>Modification of Existing SSAP</th>
<th>P/C</th>
<th>Life</th>
<th>Health</th>
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</thead>
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<td>☒</td>
<td>☒</td>
</tr>
<tr>
<td>New Issue or SSAP</td>
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</tr>
<tr>
<td>Interpretation</td>
<td></td>
<td>☒</td>
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</tbody>
</table>

Description of Issue:
This agenda item proposes increased product identifier reporting granularity in question 1.01 (product mix) of the separate account general interrogatories (GI 1.01). At the request of regulators, primarily in response to the recent growth of pension risk transfer (PRT) transactions and registered indexed linked annuity (RILA) products that are generally held in insulated separate accounts, improved reporting was requested so regulators can more readily identify and review the products captured in the separate account. This agenda item does not anticipate modifications to SSAP No. 56—Separate Accounts, however if supported by the Working Group, would likely result in a proposal to the Blanks (E) Working Group for annual statement instruction modifications.

For example, upon review of the 2019 separate account annual statements filed with the NAIC, it was found that while some reporting entities included reporting details such as “XYZ Company Pension Risk Transfer” (a preferred method of disclosure), most entities grouped their separate account products in 3-4 broad categories. Common categories included variable life, variable annuity, indexed annuity and group variable annuity (the latter of which is likely where PRT’s would be captured).

SSAP No. 56 requires several disclosure elements separated by “product identifier.” These situations include:

- 1.01 – Separate account assets by SEC registration, guarantees, seed money, etc.
- 1.01A – Identification of private placement variable annuities / life insurance (PPVA or PPLI)
- 2.5 – Risk charges
- 4.2 – Investment Process and their treatment (e.g., to policyholder, to GA, or retained in SA)

As detailed in the separate account instructions, “a distinct product identifier shall be used for each product and shall be used consistently throughout the interrogatory.” Even with this direction, most reporting entities appear to be aggregating product types for reporting. This has made it difficult to assess the reserve requirements or guarantees for the specific products. Additionally, regulators have indicated that upon their examination of the product mix general interrogatory in which the assets reflect if they are supported with a guarantee from the general account, due to the broad grouping of products, some products which do not have guarantees were grouped with those that did have guarantees.

Existing Authoritative Literature:

The disclosures for separate account assets are detailed in SSAP No. 56—Separate Accounts:

36. The Separate Account Annual Statement Blank shall include detailed information on the characteristics of the separate account assets, specifically categorizing separate account assets in accordance with the following characteristics:
a. Identification of separate account assets that are legally insulated from the general account and those which are not legally insulated.

b. Aggregation of separate account assets from products registered with the SEC and separate account assets from products excluded from registration. In addition to the overall aggregation, this disclosure shall specifically identify separate account assets from private placement variable annuities (PPVA) and private placement life insurance (PPLI). The disclosures in this paragraph (36.b.) are effective December 31, 2018.

c. Amount of separate account assets that represent seed money, other fees and expenses due to the general account, and additional required surplus amounts. This disclosure shall include the amount of seed money and other fees and expenses currently included in the separate account, as well as the amount of seed money received and repaid to the general account during the current year. This disclosure shall also include information on insulation (if applicable), the time duration for which seed money and other fees and expenses due the general account are retained in the separate account, and information on how whether seed money is invested pursuant to general account directives or in accordance with stated policies and procedures.

d. Identification of the separate account assets in which the investment directive is not determined by a contractholder. (In most instances, having multiple investment choices at the option of a contractholder would be considered a situation in which the investment directive is determined by a contractholder. This is not true for situations in which the asset is invested in a manner that mirrors the investment directives of the general account.) Situations in which the investment directive is not determined by the contractholder (and situations in which the reporting entity is the contractholder) shall include disclosure regarding whether the investments of the respective separate account assets, if included within the general account investments, would have resulted with the reporting entity exceeding any investment limitations imposed on the general account.

e. Identification of the separate account assets in which less than 100% of investment proceeds are attributed to a contractholder. This shall include identification of the separate account investment income attributed to the reporting entity during the reporting period and whether such income was transferred to the general account or reinvested within the separate account. Instances in which such income is reinvested within the separate account shall include disclosure on whether the subsequent investments, if categorized with investments in the general account, would have exceeded investment limitations imposed on the general account.

39. Identify all products reported as a separate account product under statutory accounting principles and identify whether each product was classified differently under GAAP. For products that resulted with different classifications between GAAP and SAP, identify the characteristic(s) of the product that prevented it from receiving a separate account classification under GAAP. This disclosure is applicable for all reporting entities. Thus, if GAAP financial statements were not filed, the reporting entity should complete this disclosure as if GAAP financials had been completed.
The annual statement instructions as well as an example of note 1.01 are below.

As the product identifier is used throughout the interrogatory, examples of other items potentially impacted are as follows:

1.01A For the products (and related assets) that are not registered with the SEC, identify whether the products are considered private placement variable annuity products or private placement life insurance.

<table>
<thead>
<tr>
<th>Product Identifier</th>
<th>Not Registered with SEC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Private Placement Variable Annuity</td>
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<tr>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Totals</td>
<td>$</td>
</tr>
</tbody>
</table>

Allocation of Investment Proceeds of Separate Account Activity

4.1 Does the reporting entity have separate account assets in which less than 100% of investment proceeds (net of contract fees and assessments) are attributed to a contract holder? (This should identify any situations where there is a ceiling on investment performance results.)

4.2 If yes, provide detail on the net investment proceeds that were attributed to the contract holder, transferred to the general account and reinvested within the separate account:

<table>
<thead>
<tr>
<th>Product Identifier</th>
<th>Net Investment Proceeds</th>
<th>Attributed to Contract Holder</th>
<th>Transferred to General Account</th>
<th>Reinvested Within the Separate Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
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<td>Totals</td>
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</tbody>
</table>

8.3 Identify all separate account products and identify whether each product was classified within a separate account for GAAP reporting purposes. (For non-GAAP filers, this disclosure should reflect whether the GAAP classification would have been the same if GAAP financials had been completed.) For products that were (or would have been) reported differently, identify which SOP 03-1 condition prevented separate account GAAP classification for that particular product.

<table>
<thead>
<tr>
<th>Product Identifier</th>
<th>Same as GAAP / Condition that Requires GAAP General Account Reporting</th>
</tr>
</thead>
</table>

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): N/A

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): N/A

Staff Recommendation:
NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose the agenda item to solicit comments from state insurance regulators and industry regarding the degree of product identifying details needed to adequately assess the product features and reserve liabilities. Additionally, feedback is requested regarding if a threshold should be established for when aggregate reporting would be permitted.
Staff Review Completed by:
Jim Pinegar - NAIC Staff, October 2020

Status:
On November 12, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed the agenda item to solicit comments from state insurance regulators and industry regarding the degree of product identifying details needed to adequately assess the product features and reserve liabilities in the separate account. Particularly, this is requesting feedback on how to obtain increased product identifier reporting granularity in question 1.01 (product mix) of the separate account general interrogatories (GI 1.01). Additionally, feedback is requested regarding if a threshold should be established for when aggregate reporting would be permitted.

On March 15, 2021, the Statutory Accounting Principles (E) Working Group exposed this agenda item with details of a proposed blanks change, which will also be concurrently exposed with the Blanks (E) Working Group. With the proposed blanks changes, there are no proposed revisions to statutory accounting principles.

Consideration of this item will occur during an interim call so that the blanks changes may be reflected in the statutory financials for year-end 2021. Pursuant to this agenda item and regulator comments received, the Working Group is sponsoring blanks agenda item (2021-03BWG) to modify the current General Interrogatory instructions and require that a distinct disaggregated product identifier be used for each product represented. The disaggregation will require that each separate account product filing or policy form be separately identified. For example, if a company has 5 different separate account group annuities, each annuity shall be separately reported. Additionally, the instructions will indicate that companies may eliminate proprietary information (e.g., such as XYZ company Pension Plan), however such elimination will still require the use of a unique reporting identifiers (such as PRT #1). This disaggregation of reporting will be utilized for all applicable General Interrogatories (e.g., 1.01, 2.4, 4.1) and was at the direct request of regulators and will assist in regulator review so that each product, primarily those in which may potentially expose the general account to funding risk, may be independently examined.

NAIC staff also notes that there is inconsistency in the current reporting of the separate account general interrogatories, as some companies aggregate based on overall product type and other companies already include a disaggregation of all separate account products. With the clarification that “each product” shall be captured, the regulators will have the information necessary to complete assessments and improve consistency in reporting.

An excerpt from the blanks proposal is shown below:

A distinct disaggregated product identifier shall be used for each product and shall be used consistently throughout the interrogatory. Disaggregation of reporting shall be such that each product filing or policy form is separately identified. For example, if a company has 5 different separate group annuities, each annuity shall be separately reported. (Companies may eliminate proprietary information however such elimination will require the use of unique reporting identifiers).

<table>
<thead>
<tr>
<th>1</th>
<th>Separate Account Assets</th>
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<td>Product Identifier</td>
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<td>3</td>
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<td>Fees and Expenses Due to the General Account</td>
<td>Additional Required Surplus Amounts</td>
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<tr>
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</tr>
</tbody>
</table>

© 2021 National Association of Insurance Commissioners
On May 20, 2021, the Statutory Accounting Principles (E) Working Group adopted a recommendation that supports adoption of the corresponding exposure (2021-03BWG) by the Blanks (E) Working Group. This agenda item does not result in statutory accounting revisions.

The blanks agenda item modifies the current General Interrogatory instructions and requires that a distinct disaggregated product identifier be used for each product represented. The disaggregation will require that each separate account product filing or policy form to be separately identified. Additionally, the instructions will indicate that companies may eliminate proprietary information, however, such elimination will still require the use of a unique reporting identifier. This disaggregation of reporting will be utilized for all applicable General Interrogatories (e.g., 1.01, 2.4, 4.1) and was at the direct request of regulators and will assist in regulator review so that each product, primarily those in which may potentially expose the general account to funding risk, may be independently examined.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Pension Risk Transfer – Separate Account Disclosure

Check (applicable entity):
- Modification of Existing SSAP
- New Issue or SSAP
- Interpretation

Description of Issue:
This agenda item proposes increased product identification and disclosure of pension risk transfer (PRT) transactions in the separate account financial statements. At the request of regulators, in response to the recent growth of PRT, improved reporting is sought so regulators can more readily identify and analyze such transactions. Regulators requested several enhancements, including separated PRT reporting and improved PRT disclosure regarding reserves, associated assets, and general account exposure.

As a brief background, a pension risk transfer is when a defined-benefit pension provider seeks to remove some or all of its obligation to pay guaranteed retirement income to plan participants. In these transactions, the pension providers will generally transfer assets to an insurer, for which the insurer assumes the annuity risk for plan participants. According to AM Best, there were over 500 single premium pension contract buyouts totaling $28 billion in 2019. Due to organizations wanting to alleviate their pension liability, it is expected that PRT transactions will not subside in the near future.

Currently, the most specific details concerning PRT transactions are generally captured/disclosed in question 1.01 (product mix) of the separate account general interrogatories (GI 1.01). For reference, GI 1.01 is shown below:

<table>
<thead>
<tr>
<th>Product Identifier</th>
<th>Separate Account Assets</th>
<th>4 Guarantees Associated with the Product Yes/No</th>
<th>5 Seed Money</th>
<th>6 Fees and Expenses Due to the General Account</th>
<th>7 Additional Required Surplus Amounts</th>
</tr>
</thead>
<tbody>
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<td>Registered with SEC</td>
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<td>$</td>
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<tr>
<td>Not Registered with SEC</td>
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<td>Total</td>
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</table>

Upon review of the 2019 separate account annual statements filed with the NAIC, it was found that most entities did not individually detail PRT activity, but rather broadly combine this product into other product categories (i.e. group variable annuity).

While other details of the broadly categorized products are captured in various other general interrogatories (as shown below in Existing Authoritative Literature), this agenda item, at the request of regulators, proposes enhanced detailed reporting requirements for pension risk transfer products and transactions in the scope of SSAP No. 56—Separate Accounts.
Existing Authoritative Literature:

There are numerous disclosure elements in SSAP No. 56—Separate Accounts that would be applicable for PRT transactions (the most relevant disclosures have been bolded below). However as described above, PRTs are generally reported in an aggregated manner with other similar products, thus the disclosures below do not currently provide the level of detail sought by regulators.

Disclosures

31. The general account financial statement shall include detailed information on the reporting entity’s separate account activity. These disclosures shall include:
   a. A narrative of the general nature of the reporting entity’s separate account business.
   b. Identification of the separate account assets that are legally insulated from the general account claims.
   c. Identification of the separate account products that have guarantees backed by the general account. This shall include:
      i. Amount of risk charges paid by the separate account to the general account for the past five (5) years as compensation for the risk taken by the general account; and
      ii. Amount paid by the general account due to separate account guarantees during the past five (5) years.
   d. Discussion of securities lending transactions within the separate account, separately including the amount of any loaned securities within the separate account, and if policy and procedures for the separate account differ from the general account.

32. For each grouping (as detailed in paragraph 33), the following shall be disclosed:
   a. Premiums, considerations or deposits received during the year;
   b. Reserves by the valuation basis of the investments supporting the reserves at the financial statement date. List reserves for separate accounts whose assets are carried at fair value separately from those whose assets are carried at amortized cost/book value;
   c. Reserves by withdrawal characteristics, including whether or not the separate account is subject to discretionary withdrawal. For reserves subject to discretionary withdrawal, the below categories are included if applicable:
      i. With market value adjustment;
      ii. at book value without market value adjustment and with surrender charge of 5% or more;
      iii. at fair value;
      iv. at book value without market value adjustment and with surrender charge of less than 5%;
Reserves for asset default risk, as described in paragraph 18.b., that are recorded in lieu of AVR.

33. For the disclosures required in paragraph 32, separate accounts shall be addressed in the following groupings (which are the same as those used for risk-based capital):

a. **Separate Accounts with Guarantees**:

i. Indexed separate accounts, which are invested to mirror an established index which is the basis of the guarantee;

ii. Nonindexed separate accounts, with reserve interest rate at no greater than 4% and/or fund long-term interest guarantee in excess of a year that does not exceed 4%;

iii. Nonindexed separate accounts, with reserve interest rate at greater than 4% and/or fund long-term interest guarantee in excess of a year that exceeds 4%.

b. Nonguaranteed Separate Accounts—Variable separate accounts, where the benefit is determined by the performance and/or fair value of the investments held in the separate account. Include variable accounts with incidental risks, nominal expense, and minimum death benefit guarantees.

34. **Provide a reconciliation of the amount reported as transfers to and from separate accounts in the Summary of Operations of the separate accounts statement and the amount reported as net transfers to or from separate accounts in the Summary of Operations of the general accounts statement.**

35. The disclosures in SSAP No. 51R—Life Contracts, and SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance related to the withdrawal characteristics of products include separate account products and shall be completed in the general account disclosures.

36. The Separate Account Annual Statement Blank shall include detailed information on the characteristics of the separate account assets, specifically categorizing separate account assets in accordance with the following characteristics:

a. **Identification of separate account assets that are legally insulated from the general account and those which are not legally insulated.**

b. **Aggregation of separate account assets from products registered with the SEC and separate account assets from products excluded from registration.** In addition to the overall aggregation, this disclosure shall specifically identify separate account assets from private placement variable annuities (PPVA) and private placement life insurance (PPLI). The disclosures in this paragraph (36.b.) are effective December 31, 2018.

c. Amount of separate account assets that represent seed money, other fees and expenses due to the general account, and additional required surplus amounts. This disclosure shall include the amount of seed money and other fees and expenses currently included in the separate account, as well as the amount of seed money received and repaid to the general account during the current year. This disclosure shall also include information on insulation (if applicable), the time duration for which seed money and other fees and expenses due the general account are retained in the separate account, and information on how whether seed money is invested pursuant to general account directives or in accordance with stated policies and procedures.
d. Identification of the separate account assets in which the investment directive is not determined by a contractholder. (In most instances, having multiple investment choices at the option of a contractholder would be considered a situation in which the investment directive is determined by a contractholder. This is not true for situations in which the asset is invested in a manner that mirrors the investment directives of the general account.) Situations in which the investment directive is not determined by the contractholder (and situations in which the reporting entity is the contractholder) shall include disclosure regarding whether the investments of the respective separate account assets, if included within the general account investments, would have resulted with the reporting entity exceeding any investment limitations imposed on the general account.

e. Identification of the separate account assets in which less than 100% of investment proceeds are attributed to a contractholder. This shall include identification of the separate account investment income attributed to the reporting entity during the reporting period and whether such income was transferred to the general account or reinvested within the separate account. Instances in which such income is reinvested within the separate account shall include disclosure on whether the subsequent investments, if categorized with investments in the general account, would have exceeded investment limitations imposed on the general account.

37. For all separate account assets not reported at fair value, indicate the measurement basis (amortized cost or other method) for each asset (or asset class) and whether the measurement method was grandfathered in under the transition guidance in this SSAP, or whether the measurement method is allowed under a prescribed or permitted practice. This disclosure shall include a comparison of the assets’ reported value to fair value with identification of the resulting unrealized gain/loss that would have been recorded if the assets had been reported at fair value.

38. For all separate accounts that include securities lending transactions, disclose the reporting entity’s use and policy of securities lending within the separate account, including the amount of loaned securities from the separate account at the reporting date, the percentage of separate account assets lent as of that date, a description for which type of accounts (e.g., book value accounts, market value account accounts) are lent, if the separate account policyholder is notified or approves of such practices, the policy for requiring collateral, whether the collateral is restricted and the amount of collateral for transactions that extend beyond one year from the reporting date. This disclosure requires the entity to provide the following information as of the date of the statement of financial position: (1) the aggregate amount of contractually obligated open collateral positions (aggregate amount of securities at current fair value or cash received for which the borrower may request the return of on demand) and the aggregate amount of contractually obligated collateral positions under 30-day, 60-day, 90-day, and greater than 90-day terms, (2) the aggregate fair value of all securities acquired from the sale, trade and use of the accepted collateral (reinvested collateral), and (3) information about the sources and uses of that collateral.

39. Identify all products reported as a separate account product under statutory accounting principles and identify whether each product was classified differently under GAAP. For products that resulted with different classifications between GAAP and SAP, identify the characteristic(s) of the product that prevented it from receiving a separate account classification under GAAP. This disclosure is applicable for all reporting entities. Thus, if GAAP financial statements were not filed, the reporting entity should complete this disclosure as if GAAP financials had been completed.
As previously shown, GI 1.01 is the primary interrogatory which capture PRT transactions, however additional details are captured in the following tables.

1.01A For the products (and related assets) that are not registered with the SEC, identify whether the products are considered private placement variable annuity products or private placement life insurance.

<table>
<thead>
<tr>
<th>Product Identifier</th>
<th>Not Registered with SEC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Private Placement Variable Annuity</td>
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<tr>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Totals</td>
<td>$</td>
</tr>
</tbody>
</table>

Allocation of Investment Proceeds of Separate Account Activity

4.1 Does the reporting entity have separate account assets in which less than 100% of investment proceeds (net of contract fees and assessments) are attributed to a contract holder? (This should identify any situations where there is a ceiling on investment performance results.)

4.2 If yes, provide detail on the net investment proceeds that were attributed to the contract holder, transferred to the general account and reinvested within the separate account:

<table>
<thead>
<tr>
<th>Product Identifier</th>
<th>Net Investment Proceeds</th>
<th>Attributed to Contract Holder</th>
<th>Transferred to General Account</th>
<th>Reinvested Within the Separate Account</th>
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</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>Totals</td>
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<td>$</td>
<td>$</td>
<td>$</td>
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8.3 Identify all separate account products and identify whether each product was classified within a separate account for GAAP reporting purposes. (For non-GAAP filers, this disclosure should reflect whether the GAAP classification would have been the same if GAAP financials had been completed.) For products that were (or would have been) reported differently, identify which SOP 03-1 condition prevented separate account GAAP classification for that particular product.

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Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): N/A

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): N/A

Staff Recommendation:
NAIC staff recommends that the Working Group move this item to the active listing, categorized as non-substantive to solicit comments from state insurance regulators and industry regarding possible modifications to SSAP No. 56—Separate Accounts. Depending upon the feedback received, the Working...
Group would have several options available including, but not limited to, requiring the separate identification of pension risk transfer products (including transactions, guarantees, reserve assumptions, etc.) within existing disclosure requirements or the addition of a new general interrogatory (and perhaps new separate accounting reporting schedules / exhibits) to separate specific product detail that was previously reported in an aggregated format. NAIC staff is open for additional commentary and suggestions, and requests to work with industry and regulators throughout this and any subsequent exposure.

Staff Review Completed by:
Jim Pinegar - NAIC Staff, October 2020

Status:
On November 12, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed the agenda item to solicit comments from state insurance regulators and industry regarding possible modifications to SSAP No. 56—Separate Accounts specific to pension risk transfer (PRT) products. Depending upon the feedback received, the Working Group would have several options available including, but not limited to, requiring the separate identification of pension risk transfer products (including transactions, guarantees, reserve assumptions, etc.) within existing disclosure requirements or the addition of a new general interrogatory (and perhaps new separate accounting reporting schedules / exhibits) to separate specific product detail that was previously reported in an aggregated format.

On March 15, 2021, the Statutory Accounting Principles (E) Working Group exposed this agenda item with details of a proposed blanks change, which will also be concurrently exposed with the Blanks (E) Working Group. With the proposed blanks changes, there are no proposed revisions to statutory accounting principles.

Consideration of this item will occur during an interim call so that the blanks changes may be reflected in the statutory financials for year-end 2021. Pursuant to this agenda item and regulator comments received, the Working Group is sponsoring blanks agenda item (2021-03BWG) to modify the current General Interrogatory instructions and require that a distinct disaggregated product identifier be used for each product represented. The disaggregation will require that each separate account product filing or policy form be separately identified. For example, if a company has 5 different separate account group annuities, each annuity shall be separately reported. Additionally, the instructions will indicate that companies may eliminate proprietary information (e.g., such as XYZ company Pension Plan), however such elimination will require the use of a unique reporting identifiers (such as PRT #1). This disaggregation of reporting will be utilized for all applicable General Interrogatories (e.g., 1.01, 2.4, 4.1) and was at the direct request of regulators and will assist in regulator review so that each product, primarily those in which may potentially expose the general account to funding risk, may be independently examined.

NAIC staff also notes that there is inconsistency in the current reporting of the separate account general interrogatories, as some companies aggregate based on overall product type and other companies already include a disaggregation of all separate account products. With the clarification that “each product” shall be captured, the regulators will have the information necessary to complete assessments and improve consistency in reporting.

An excerpt from the blanks proposal is shown below:

A distinct disaggregated product identifier shall be used for each product and shall be used consistently throughout the interrogatory. Disaggregation of reporting shall be such that each product filing or policy form is separately identified. For example, if a company has 5 different separate group annuities, each annuity shall be separately reported. (Companies may eliminate proprietary information however such elimination will require the use of unique reporting identifiers).
On May 20, 2021, the Statutory Accounting Principles (E) Working Group adopted a recommendation that supports adoption of the corresponding exposure (2021-03BWG) by the Blanks (E) Working Group. This agenda item does not result in statutory accounting revisions.

The blanks agenda item modifies the current General Interrogatory instructions and requires that a distinct disaggregated product identifier be used for each product represented. The disaggregation will require that each separate account product filing or policy form to be separately identified. Additionally, the instructions will indicate that companies may eliminate proprietary information, however, such elimination will still require the use of a unique reporting identifier. This disaggregation of reporting will be utilized for all applicable General Interrogatories (e.g., 1.01, 2.4, 4.1) and was at the direct request of regulators and will assist in regulator review so that each product, primarily those in which may potentially expose the general account to funding risk, may be independently examined.

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<table>
<thead>
<tr>
<th>Product Identifier</th>
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<tr>
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<td>Yes/No</td>
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Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

**Issue:** ASU 2020-08 – Premium Amortization on Callable Debt Securities

**Check (applicable entity):**

<table>
<thead>
<tr>
<th>Modification of Existing SSAP</th>
<th>P/C</th>
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<th>Health</th>
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<tbody>
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<td>New Issue or SSAP</td>
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<tr>
<td>Interpretation</td>
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**Description of Issue:** In October 2020, the Financial Accounting Standards Board (FASB) issued ASU 2020-08, Codification Improvements to Subtopic 310-20, Receivables – Nonrefundable Fees and Other Costs to clarify the amortization of premium associated with callable debt securities. In summary, ASU 2020-08 requires that to the extent the amortized cost basis of a callable debt security exceeds the amount repayable by the issuer, any associated premium (above the call price) is to be amortized to the next effective call price/date. For example, if a reporting entity held a bond at $104 in which could be called at $102 in a year, the $2 excess premium would be amortized over that particular year. Once amortized to $102, the reporting entity would then reassess for any excess premium to the next effective call price/date. If there is no remaining premium or further call dates, the effective yield is reset using the payment terms of the debt security.

**Existing Authoritative Literature:** The amortization of premiums related to debt securities is referenced in SSAP No. 26R—Bonds. While the requirements in ASU 2020-08 are very similar to statutory accounting guidance, SSAP No. 26R also requires the application of a yield-to-worst concept. With this concept, premium is amortized in a manner to produce the lowest asset value. Relevant guidance has been bolded below.

**Amortized Cost**

9. **Amortization of bond premium or discount shall be calculated using the scientific (constant yield) interest method taking into consideration specified interest and principal provisions over the life of the bond.** Bonds containing call provisions (where the issue can be called away from the reporting entity at the issuer’s discretion), except “make-whole” call provisions, shall be amortized to the call or maturity value/date which produces the lowest asset value (yield-to-worst). Although the concept for yield-to-worst shall be followed for all callable bonds, make-whole call provisions, which allow the bond to be callable at any time, shall not be considered in determining the timeframe for amortizing bond premium or discount unless information is known by the reporting entity indicating that the issuer is expected to invoke the make-whole call provision.

**Application of Yield-to-Worst**

10. **For callable bonds, the first call date after the lockout period (or the date of acquisition if no lockout period exists) shall be used as the “effective date of maturity” for reporting in Schedule D, Part 1.** Depending on the characteristics of the callable bonds, the yield-to-worst concept in paragraph 9 shall be applied as follows:

   a. **For callable bonds with a lockout period, premium in excess of the next call price (subsequent to acquisition and lockout period) shall be amortized proportionally over the length of the lockout period. After each lockout period (if more than one), remaining premium shall be amortized to the call or maturity value/date which produces the lowest asset value.**

   b. **For callable bonds without a lockout period, the book adjusted carrying value (at the time of acquisition) of the callable bonds shall equal the lesser of the next call price (subsequent...**
remaining premium shall then be amortized to the call or maturity value/date which produces the lowest asset value.

c. For callable bonds that do not have a stated call price, all premiums over par shall be immediately expensed. For callable bonds with a call price at par in advance of the maturity date, all premiums shall be amortized to the call date.

Balance Sheet Amount

11. Bonds, as defined in paragraph 3, shall be valued and reported in accordance with this statement, the Purposes and Procedures Manual of the NAIC Investment Analysis Office, and the designation assigned in the NAIC Valuations of Securities product prepared by the NAIC Securities Valuation Office (SVO).

a. Bonds, except for mandatory convertible bonds: For reporting entities that maintain an asset valuation reserve (AVR), the bonds shall be reported at amortized cost, except for those with an NAIC designation of 6, which shall be reported at the lower of amortized cost or fair value. For reporting entities that do not maintain an AVR, bonds that are designated highest-quality and high-quality (NAIC designations 1 and 2, respectively) shall be reported at amortized cost; all other bonds (NAIC designations 3 to 6) shall be reported at the lower of amortized cost or fair value.

b. Mandatory convertible bonds: Mandatory convertible bonds are subject to special reporting instructions and are not assigned NAIC designations or unit prices by the SVO. The balance sheet amount for mandatory convertible bonds shall be reported at the lower of amortized cost or fair value during the period prior to conversion. This reporting method is not impacted by NAIC designation or information received from credit rating providers (CRPs). Upon conversion, these securities will be subject to the accounting guidance of the statement that reflects their revised characteristics. (For example, if converted to common stock, the security will be in scope of SSAP No. 30R—Unaffiliated Common Stock, if converted to preferred stock, the security will be in scope of SSAP No. 32R—Preferred Stocks.)

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): N/A

Staff Recommendation:
NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 26R—Bonds to reject ASU 2020-08 for statutory accounting. While ASU 2020-08 closely mimics existing guidance in SSAP No. 26R (amortizing applicable debt premium to the next effective call price), it does preclude statutory accounting’s yield-to-worst concept, which requires amortizing premiums to the call or the maturity value/date in which produces the lowest asset value. There may be scenarios, for statutory accounting, in which premiums amortized to the maturity value/date will yield a lower asset value than simply amortizing applicable premium to the next effective call date (as is required in ASU 2020-08).
Proposed Revisions to SSAP No. 26R

33. This statement rejects the GAAP guidance for debt securities, which is contained in ASU 2020-08, Codification Improvements to Subtopic 310-20, Receivables—Nonrefundable Fees and Other Costs, ASU 2018-03, Recognition and Measurement of Financial Assets and Financial Liabilities, ASU 2017-08, Premium Amortization on Purchased Callable Debt Securities, ASU 2016-01, Financial Instruments—Overall, FASB Statement No. 115, Accounting for Certain Investments in Debt and Equity Securities, FASB Statement No. 91, Accounting for Nonrefundable Fees and Costs Associated with Originating or Acquiring Loans and Initial Direct Costs of Leases, FASB Emerging Issues Task Force No. 89-18, Divestitures of Certain Investment Securities to an Unregulated Commonly Controlled Entity under FIRREA, and FASB Emerging Issues Task Force No. 96-10, Impact of Certain Transactions on Held-to-Maturity Classifications Under FASB Statement No. 115.

Staff Review Completed by: Jim Pinegar, NAIC Staff – January 2021

Status:
On March 15, 2021, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 26R—Bonds to reject ASU 2020-08, Codification Improvements to Subtopic 310-20, Receivables—Nonrefundable Fees and Other Costs for statutory accounting. While ASU 2020-08 closely mimics existing guidance in SSAP No. 26R (amortizing applicable debt premium to the next effective call price), it does preclude statutory accounting’s yield-to-worst concept, which requires amortizing premiums to the call or the maturity value/date which produces the lowest asset value. There may be scenarios, for statutory accounting, in which premiums amortized to the maturity value/date will yield a lower asset value than simply amortizing applicable premium to the next effective call date (as is required in ASU 2020-08).

On May 20, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to SSAP No. 26R—Bonds, as illustrated above, to reject ASU 2020-08, Codification Improvements to Subtopic 310-20, Receivables—Nonrefundable Fees and Other Costs for statutory accounting. While ASU 2020-08 closely mimics existing guidance in SSAP No. 26R (amortizing applicable debt premium to the next effective call price), it does preclude statutory accounting’s yield-to-worst concept, which requires amortizing premiums to the call or the maturity value/date which produces the lowest asset value. There may be scenarios, for statutory accounting, in which premiums amortized to the maturity value/date will yield a lower asset value than simply amortizing applicable premium to the next effective call date (as is required in ASU 2020-08).
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

**Issue:** SSAP No. 103R – Disclosures

**Check (applicable entity):**

<table>
<thead>
<tr>
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<th>P/C</th>
<th>Life</th>
<th>Health</th>
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<tr>
<td>Modification of existing SSAP</td>
<td>✗</td>
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<tr>
<td>New Issue or SSAP</td>
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<tr>
<td>Interpretation</td>
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**Description of Issue:**
This agenda item has been drafted to propose additional disclosures and to data-capture certain existing disclosure elements in SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities. The additional disclosures proposed herein are in response to the Working Group’s continued deliberation of agenda item 2019-21: SSAP No. 43R – Equity Instruments. Agenda item 2019-21 is a substantive project to consider what investments fall within scope of SSAP No. 43R—Loan-Backed and Structured Securities and on Oct. 13, 2020, this project was expanded to include a review of the investments eligible for reporting on Schedule D-1: Long Term Bonds. During the continued work on this project, regulators expressed a desire to identify situations in which a reporting entity has entered into a securitization, asset-backed financing or similar transfer transaction where a significant economic interest in the transferred assets is retained by the reporting entity, its related parties or another member within the holding company group.

The existing disclosures discussed (and proposed for data-capture) are currently completed in a narrative (pdf) format. With the proposal to data-capture certain disclosures, regulators can utilize system inquiries to determine which reporting entities have a securitization, asset-backed financing arrangement, or other similar transfers that have been accounted for as a sale when the transferor has continued involvement.

Note – the disclosures discussed below are only required in the event a reporting entity as entered into a securitization, asset-backed financing arrangement or other similar transfer in which it also retains a continuing involvement with the transferred financial asset. Due to the numerous circumstances that may require disclosure, data-capture of most of the applicable disclosures would not sufficiently relay the particular characteristics or circumstances of the transaction – as is required in SSAP No. 103R. However, the need for regulators to have the ability to query the global population regarding the nature of these transactions remains a primary reason for this agenda item. Nonetheless, certain consistent numerical disclosures are suitable for data-capture, which will significantly assist with regulator’s ability to identify which reporting entities have such transactions, at which time further analysis of the narrative disclosures can be performed.

**Existing Authoritative Literature:**

SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities.

28. A reporting entity shall disclose the following:

g. For securitizations, asset-backed financing arrangements, and similar transfers accounted for as sales when the transferor has continuing involvement (as defined in the glossary) with the transferred financial assets:

i. For each income statement presented:
(a) The characteristics of the transfer (including a description of the transferor’s continuing involvement with the transferred financial assets, the nature and initial fair value of the assets obtained as proceeds and the liabilities incurred in the transfer, and the gain or loss from sale of transferred financial assets. For initial fair value measurements of assets obtained and liabilities incurred in the transfer, the following information:

1. The level within the fair value hierarchy in which the fair value measurements in their entirety fall, segregating fair value measurements using quoted prices in active markets for identical assets or liabilities (Level 1), significant other observable inputs (Level 2), and significant unobservable inputs (Level 3)

2. The key inputs and assumptions used in measuring the fair value of assets obtained and liabilities incurred as a result of the sale that relate to the transferor’s continuing involvement (including, at a minimum, but not limited to, and if applicable, quantitative information about discount rates, expected prepayments including the expected weighted-average life of prepayable financial assets, and anticipated credit losses, including expected static pool losses).

(b) Cash flows between a transferor and transferee, including proceeds from new transfers, proceeds from collections reinvested in revolving-period transfers, purchases of previously transferred financial assets, servicing fees, and cash flows received from a transferor’s beneficial interests.

ii. For each statement of financial position presented, regardless of when the transfer occurred:

(a) Qualitative and quantitative information about the transferor’s continuing involvement with transferred financial assets that provides financial statement users with sufficient information to assess the reasons for the continuing involvement and the risks related to the transferred financial assets to which the transferor continues to be exposed after the transfer and the extent that the transferor’s risk profile has changed as a result of the transfer (including, but not limited to, credit risk, interest rate risk, and other risks), including:

1. The total principal amount outstanding, the amount that has been derecognized, and the amount that continues to be recognized in the statement of financial position.

2. The terms of any arrangements that could require the transferor to provide financial support (for example, liquidity arrangements and obligations to purchase assets) to the transferee or its beneficial interest holders, including a description of any events or circumstances that could expose the transferor to loss and the amount of the maximum exposure to loss.

3. Whether the transferor has provided financial or other support during the periods presented that it was not previously contractually required to provide to the transferee or its beneficial interest holders, including when the transferor assisted the transferee or its beneficial interest holders in obtaining support, including:

   (i.) The type and amount of support

   (ii.) The primary reasons for providing the support
Information is encouraged about any liquidity arrangements, guarantees, and/or other commitments provided by third parties related to the transferred financial assets that may affect the transferor’s exposure to loss or risk of the related transferor’s interest.

(b) The entity’s accounting policies for subsequently measuring assets and liabilities that relate to the continuing involvement with the transferred financial assets;

(c) The key inputs and assumptions used in measuring the fair value of assets or liabilities that relate to the transferor’s continuing involvement (including, at a minimum, but not limited to, and if applicable, quantitative information about discount rates, expected prepayments including the expected weighted-average life of prepayable financial assets, and anticipated credit losses, including expected static pool losses);

(d) For the transferor’s interests in the transferred financial assets, a sensitivity analysis or stress test showing the hypothetical effect on the fair value of those interests (including any servicing assets or servicing liabilities) of two or more unfavorable variations from the expected levels for each key assumption that is reported under paragraph 28.g.ii.(c) independently from any change in another key assumption, and a description of the objectives, methodology, and limitations of the sensitivity analysis or stress test;

(e) Information about the asset quality of transferred financial assets and any other assets that it manages together with them. This information shall be separated between assets that have been derecognized and assets that continue to be recognized in the statement of financial position. This information is intended to provide financial statement users with an understanding of the risks inherent in the transferred financial assets as well as in other assets and liabilities that it manages together with transferred financial assets. For example, information for receivables shall include, but is not limited to:

(i.) Delinquencies at the end of the period; and

(ii.) Credit losses, net of recoveries, during the period.

Current Annual Statement Illustrations for Completing Disclosures:

Note 17: Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

For securitizations, asset-backed financing arrangements and similar transfers accounted for as sales when the transferor has continuing involvement (as defined in the glossary of the Accounting Practices and Procedures Manual) with the transferred financial assets:

a. For each income statement presented:

1. The characteristics of the transfer including a description of the transferor’s continuing involvement with the transferred financial assets, the nature and initial fair value of the assets obtained as proceeds and the liabilities incurred in the transfer, and the gain or loss from the sale of transferred financial assets. For initial fair value measurements of assets obtained and liabilities incurred in the transfer, the following information:

(a) The level within the fair value hierarchy in which the fair value measurements in their entirety fall, segregating fair value measurements using quoted prices in
active markets for identical assets or liabilities (Level 1), significant other observable inputs (Level 2) and significant unobservable inputs (Level 3).

(b) The key inputs and assumptions used in measuring the fair value of assets obtained and liabilities incurred as a result of the sale that relate to the transferor’s continuing involvement (including, at a minimum, but not limited to, and if applicable, quantitative information about discount rates; expected prepayments, including the expected weighted-average life of prepayable financial assets; and anticipated credit losses, including expected static pool losses)

- If an entity has aggregated multiple transfers during a period, it may disclose the range of assumptions.

- The weighted-average life of prepayable assets in periods (for example, months or years) can be calculated by multiplying the principal collections expected in each future period by the number of periods until that future period, summing those products, and dividing the sum by the initial principal balance.

- Expected static pool losses can be calculated by summing the actual and projected future credit losses and dividing the sum by the original balance of the pool of assets.

2. Cash flows between a transferor and transferee, including proceeds from new transfers, proceeds from collections reinvested in revolving-period transfers, purchases of previously transferred financial assets, servicing fees and cash flows received from a transferor’s beneficial interests.

b. For each statement of financial position presented, regardless of when the transfer occurred:

1. Qualitative and quantitative information about the transferor’s continuing involvement with transferred financial assets that provides financial statement users with sufficient information to assess the reasons for the continuing involvement and the risks related to the transferred financial assets to which the transferor continues to be exposed after the transfer and the extent that the transferor’s risk profile has changed as a result of the transfer (including, but not limited to, credit risk, interest rate risk and other risks), including:

   (a) The total principal amount outstanding, the amount that has been derecognized and the amount that continues to be recognized in the statement of financial position.

   (b) The terms of any arrangements that could require the transferor to provide financial support (for example, liquidity arrangements and obligations to purchase assets) to the transferee or its beneficial interest holders, including a description of any events or circumstances that could expose the transferor to loss and the amount of the maximum exposure to loss.

   (c) Whether the transferor has provided financial or other support during the periods presented that it was not previously contractually required to provide to the transferee or its beneficial interest holders, including when the transferor assisted the transferee or its beneficial interest holders in obtaining support, including:
The type and amount of support.

The primary reasons for providing the support.

(d) Information is encouraged about any liquidity arrangements, guarantees and/or other commitments provided by third parties related to the transferred financial assets that may affect the transferor’s exposure to loss or risk of the related transferor’s interest.

2. The entity’s accounting policies for subsequently measuring assets and liabilities that relate to the continuing involvement with the transferred financial assets.

3. The key inputs and assumptions used in measuring the fair value of assets or liabilities that relate to the transferor’s continuing involvement (including, at a minimum, but not limited to, and if applicable, quantitative information about discount rates; expected prepayments, including the expected weighted-average life of pre-payable financial assets; and anticipated credit losses, including expected static pool losses).

4. For the transferor’s interests in the transferred financial assets, a sensitivity analysis or stress test showing the hypothetical effect on the fair value of those interests (including any servicing assets or servicing liabilities) of two or more unfavorable variations from the expected levels for each key assumption that is reported per SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities independently from any change in another key assumption, and a description of the objectives, methodology and limitations of the sensitivity analysis or stress test.

5. Information about the asset quality of transferred financial assets and any other assets that it manages together with them. This information shall be separated between assets that have been derecognized and assets that continue to be recognized in the statement of financial position. This information is intended to provide financial statement users with an understanding of the risks inherent in the transferred financial assets, as well as in other assets and liabilities that it manages together with transferred financial assets. For example, information for receivables shall include, but is not limited to:

- Delinquencies at the end of the period.
- Credit losses, net of recoveries, during the period.

Activity to Date (issues previously addressed by the Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): N/A

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS) and U.S. GAAP: N/A

Staff Recommendation: NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive to 1) expose new disclosure elements and 2) propose data-capture templates for existing disclosures in SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities. A blanks proposal exposure is anticipated to occur concurrently with the Working Group’s exposure. With inclusion of the data templates, narrative (pdf) reporting shall still occur to provide additional
information regarding transfers accounted for as a sale when the transferor maintains continuing involvement in the transferred financial assets. The purpose of the data-capture templates is so regulators can perform system inquiries to identify which reporting entities have such transactions, at which time further analysis of the narrative disclosures can be performed.

**Proposed disclosures to SSAP No. 103R**

28. A reporting entity shall disclose the following:

   g. For securitizations, asset-backed financing arrangements, and similar transfers accounted for as sales when the transferor has continuing involvement (as defined in the glossary) with the transferred financial assets:

   i. For each income statement presented:

   (a) The characteristics of the transfer (including a description of the transferor’s continuing involvement with the transferred financial assets, the nature and initial fair value of the assets obtained as proceeds and the liabilities incurred in the transfer, and the gain or loss from sale of transferred financial assets. For initial fair value measurements of assets obtained and liabilities incurred in the transfer, the following information:

   (1) The level within the fair value hierarchy in which the fair value measurements in their entirety fall, segregating fair value measurements using quoted prices in active markets for identical assets or liabilities (Level 1), significant other observable inputs (Level 2), and significant unobservable inputs (Level 3)

   (2) The key inputs and assumptions used in measuring the fair value of assets obtained and liabilities incurred as a result of the sale that relate to the transferor’s continuing involvement (including, at a minimum, but not limited to, and if applicable, quantitative information about discount rates, expected prepayments including the expected weighted-average life of prepayable financial assets, and anticipated credit losses, including expected static pool losses).

   (b) Cash flows between a transferor and transferee, including proceeds from new transfers, proceeds from collections reinvested in revolving-period transfers, purchases of previously transferred financial assets, servicing fees, and cash flows received from a transferor’s beneficial interests.

   ii. For each statement of financial position presented, regardless of when the transfer occurred:

   (a) Qualitative and quantitative information about the transferor’s continuing involvement with transferred financial assets that provides financial statement users with sufficient information to assess the reasons for the continuing involvement and the risks related to the transferred financial assets to which the transferor continues to be exposed after the transfer and the extent that the transferor’s risk profile has changed as a result of the transfer (including, but not limited to, credit risk, interest rate risk, and other risks), including:

   (1) The total original principal amount outstanding, the amount that has been derecognized, and the outstanding amount that continues to be
recognized in the statement of financial position. The percentage of original principal held in the company group and the percentage of derecognized principal held by related parties.

(2) The terms of any arrangements that could require the transferor to provide financial support (for example, liquidity arrangements and obligations to purchase assets) to the transferee or its beneficial interest holders, including a description of any events or circumstances that could expose the transferor to loss and the amount of the maximum exposure to loss.

(3) Whether the transferor has provided financial or other support during the periods presented that it was not previously contractually required to provide to the transferee or its beneficial interest holders, including when the transferor assisted the transferee or its beneficial interest holders in obtaining support, including:

(iii.) The type and amount of support

(iv.) The primary reasons for providing the support

(4) Information is encouraged about any liquidity arrangements, guarantees, and/or other commitments provided by third parties related to the transferred financial assets that may affect the transferor’s exposure to loss or risk of the related transferor’s interest.

Proposed Data Capture Template:

This data template includes aspects from SSAP No. 103R paragraphs 28g.i.(a & b), and 28.g.iii(a) as well as the new proposed disclosure elements. (While the entire proposed data capture template was new, only the additional proposed SSAP No. 103R disclosures were shown as tracked changes in the March 15th exposure, as shown immediately below).

Proposed Data Capture Template:

Each Material Transaction Listed Separately:

(Identification of each transaction should be consistent so that the circumstances for each item are adequately associated with the applicable transaction)

<table>
<thead>
<tr>
<th>Identification of Transaction</th>
<th>Original Principal</th>
<th>% of Original Principal held within the company group</th>
<th>Amount Derecognized</th>
<th>% of derecognized principal held by related parties</th>
<th>Outstanding Amount still recognized in the statement of financial position</th>
<th>Net cashflows between transferor and transferee</th>
<th>FV of proceeds received</th>
<th>Gain/loss from sale of transferred assets</th>
</tr>
</thead>
</table>

Staff Review Completed by: Jim Pinegar – January 2021
Status:
On March 15, 2021, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities to propose 1) new disclosure elements, and 2) a data-capture template for existing disclosures in SSAP No. 103R to capture disclosures for when a reporting entity has transferred (or sold) assets but still retains a material participation. A blanks proposal is anticipated to be concurrently exposed.

On April 20, 2021, the Statutory Accounting Principles (E) Working Group exposed updated revisions to SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities. The updated exposure was drafted after receiving preliminary comments from interested parties and proposes 1) new disclosure elements, and 2) a data-capture template for certain existing disclosures in SSAP No. 103R to detail instances where a reporting entity has transferred (or sold) assets but still retains a material participation. An updated blanks proposal is anticipated to be concurrently exposed.

April 20, 2021 Updated Exposure and Disclosure Template:

Drafting Note: Subsequent to March exposure of this agenda item, Working Group representatives, NAIC staff and interested parties discussed regulator’s desire to identify situations in which a reporting entity has entered into a securitization, asset-backed financing or similar transfer transaction where a significant economic interest in the transferred asset is retained by the reporting entity, its related parties or another member within the holding company group. Through this discussion, refinement and explanatory language which was updated and exposed by the Working Group on April 20, has been collaboratively proposed. The updated SSAP No. 103R disclosure recommendation and the blanks proposal are shown below.

Updated Exposed Revisions to SSAP No. 103R – April 20, 2021:

SSAP No. 103R, paragraph 28.g.ii

ii. For each statement of financial position presented, regardless of when the transfer occurred:

(a) Qualitative and quantitative information about the transferor’s continuing involvement with transferred financial assets that provides financial statement users with sufficient information to assess the reasons for the continuing involvement and the risks related to the transferred financial assets to which the transferor continues to be exposed after the transfer and the extent that the transferor’s risk profile has changed as a result of the transfer (including, but not limited to, credit risk, interest rate risk, and other risks), including:

(1) The total principal amount outstanding (BACV), the amount that has been derecognized, and the amount that continues to be recognized in the statement of financial position. The amount recognized (allocated fair value) by the reporting entity for the acquired participation in the transferred assets. The reporting schedules of both the transferred and reacquired assets. The percentage of beneficial interests from the reporting entity’s transferred assets acquired by affiliated entities.
Updated Exposed Data Capture Template – April 20, 2021:

Instructions:
The purpose of this table is to provide a data capture template for certain disclosures required in SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, paragraph 28g. As detailed in paragraph 28.g.ii, disclosure is required for each statement of financial position presented, regardless of when the transfer occurred. Determination of continuing involvement shall be applied in accordance with the definition reflected in SSAP No. 103, Appendix A.

Columns requesting information that results in a null result (i.e., if column 5 results in a zero balance as 100% of the asset was transferred), shall indicate zero (0). In the event a column is not applicable, (i.e., if affiliated entities did not acquire an interest in the transferred asset), the column shall be referenced as zero (0).

In circumstances where an entity has multiple assets associated with a sale (i.e., several limited partnerships are sold as a single transaction), the assets should be aggregated and reported as a single transaction.

<table>
<thead>
<tr>
<th>Identification of Transaction</th>
<th>BACV Prior to Transfer</th>
<th>Original Reporting Schedule of the Transferred Assets</th>
<th>Amount Derecognized from Sale Transaction</th>
<th>Amount that continues to be recognized in the statement of financial position</th>
<th>BACV of acquired interests in transferred assets</th>
<th>Reporting Schedule of Acquired Interests</th>
<th>Percentage of interests of a reporting entity’s transferred assets acquired by affiliated entities</th>
</tr>
</thead>
</table>

Column 1 – Identification of each material transaction. Identification should be consistent across reporting periods so that the circumstances for each item are adequately associated with the applicable transaction.

Column 2 – The aggregate book value, at the time of transfer, of all assets associated with the transaction.

Column 3 – The investment schedule(s) in which the transferred assets were reported, immediately prior to the transfer. If the transferred assets were reported on multiple schedules, all reporting schedules shall be identified.

Column 4 – The aggregate book value derecognized from the investment schedules as a result of the transfer. If the assets were transferred in their entirety, Column 4 will equal Column 2.

Column 5 – The amount that continues to be recognized in the statement of financial position. This should equal Column 2 less Column 4.

Column 6 – The original BACV reported for acquired beneficial interests (or any other interest) in the previously transferred asset. (BACV for these transactions is often the allocated fair value associated with the transaction.)

Column 7 – The reporting schedule of the acquired beneficial interest reported in Column 6.

Column 8 - The percentage of interest of a reporting entity’s transferred assets acquired by an affiliate as defined in SSAP No. 25—Affiliates and Other Related Parties.
On May 20, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, revisions to SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, as illustrated above, to incorporate additional disclosure elements and a data-capture template for certain disclosures in SSAP No. 103R. The disclosures and data-capture template will assist regulators in their assessment of situations where an entity has transferred (or sold) assets but a significant economic interest in the transferred asset is retained by the reporting entity, its related parties or another member within the holding company group.
Maintenance updates provide revisions to the *Accounting Practices and Procedures Manual*, such as editorial corrections, reference changes and formatting.

<table>
<thead>
<tr>
<th>SSAP/Appendix</th>
<th>Description/Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSAP No. 53</td>
<td>Minor modification to the SSAP title to be consistent with similar SSAP titles.</td>
</tr>
<tr>
<td>SSAP No. 97</td>
<td>Corrects grammatical errors in paragraph 54 of SSAP No. 97—<em>Investments in Subsidiary, Controlled and Affiliated Entities</em>.</td>
</tr>
<tr>
<td>SSAP Glossary</td>
<td>Removes the footnote noted in the <em>Glossary to the Statements of Statutory Accounting Principles</em> and replaces it as an opening paragraph with updated verbiage.</td>
</tr>
</tbody>
</table>

**Recommendation:**
NAIC staff recommend that the Statutory Accounting Principles (E) Working Group move this agenda item to the active listing, categorize as nonsubstantive, and expose editorial revisions as illustrated below.

**Status:**
On March 15, 2021, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed editorial revisions to *SSAP No. 53—Property Casualty Contracts*, *SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities* and the SSAP Glossary as detailed below.

On May 20, 2021, the Statutory Accounting Principles adopted, as final, the exposed editorial revisions to *SSAP No. 53—Property Casualty Contracts*, *SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities* and the SSAP Glossary, as illustrated below.

**SSAP No. 53—Property Casualty Contracts – Premiums**

Retitle to *SSAP No. 53—Property and Casualty Contracts – Premiums*. This minor modification will title SSAP No. 53 in a consistent manner with other SSAPs (i.e., *SSAP No. 62R—Property and Casualty Reinsurance*).

**SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities**

54. The purpose of a Sub 1 filing is to gather basic information about the SCA. If the NAIC determines that the reported transaction meets the tests specified, it will complete the filing in the VISION database. If the NAIC determines that the transaction does not meet the tests specified, it shall not complete the filing in the VISION database and instead shall notify the reporting insurance company and the state of domicile in writing of its determination.
SSAP Glossary

1) Remove the footnote in the SSAP Glossary title:
GLOSSARY to the Statements of Statutory Accounting Principles (FN)
FN – Note that some SSAPs may have terminology that is specific to that topic. Refer to the SSAP for clarification. Accordingly, they are not intended to be applied to other topics.

2) Add an opening paragraph:
The terms in this Glossary are common in most SSAPs. Some SSAPs may have terminology that is topic-specific and not intended to be applied to other topics.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

**Issue:** ASU 2020-11, Financial Services—Insurance: Effective Date and Early Application

**Check (applicable entity):**

- Modification of Existing SSAP: P/C ☒, Life ☐, Health ☒
- New Issue or SSAP: ☐
- Interpretation: ☐

**Description of Issue:** FASB issued ASU 2020-11, Financial Services—Insurance: Effective Date and Early Application, which updates guidance on the effective date of the amendments in ASU 2019-09, Financial Services—Insurance and ASU 2018-12, Targeted Improvements to the Accounting for Long-Duration Contracts because of COVID-19.

**Existing Authoritative Literature:** Both ASU 2019-09 and 2018-12 were rejected for statutory accounting.

**Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):** None.

**Information or issues (included in Description of Issue) not previously contemplated by the Working Group:** None

**Convergence with International Financial Reporting Standards (IFRS):** None

**Staff Recommendation:**
NAIC staff recommends the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2020-11, Financial Services—Insurance: Effective Date and Early Application as not applicable for statutory accounting. This ASU was issued to only address the effective dates of ASU 2019-09 and ASU 2018-12, which were both previously rejected by the Working Group.

**Staff Review Completed by Jake Stultz, January 2021**

**Status:**
On March 15, 2021, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2020-11, Financial Services—Insurance: Effective Date and Early Application as not applicable for statutory accounting.

On May 20, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2020-11, Financial Services—Insurance: Effective Date and Early Application as not applicable for statutory accounting.
Statutory Accounting Principles (E) Working Group  
Maintenance Agenda Submission Form  
Form A

Issue: **ASU 2021-02, Franchisors—Revenue from Contracts with Customers (Subtopic 952-606)**

<table>
<thead>
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<td>New Issue or SSAP</td>
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**Description of Issue:**

In January 2021, the Financial Accounting Standards Board (FASB) issued *ASU 2021-02, Franchisors—Revenue from Contracts with Customers (Subtopic 952-606)*, slightly amending the guidance which was issued in *ASU 2014-09, Revenue from Contracts with Customers*, as it relates to franchisors. As a reminder, the revenue recognition updates were the result of a joint project between FASB and the International Accounting Standards Board (IASB). This project clarified the principles for recognizing revenue and develop a common revenue standard for U.S. GAAP and IFRS (the IASB issued *IFRS 15 – Revenue from Contracts with Customers*) and FASB created ASC Topic 606 – Revenue from Contracts with Customers.

In 2018, the Working Group rejected the guidance in ASU 2014-09 and several other ASUs related to Revenue Recognition in *SSAP No. 47—Uninsured Plans*. Since 2018, all additional ASUs related to revenue recognition have been reviewed by NAIC staff and have been rejected for statutory accounting. The guidance in ASU 2021-02 provides updates and clarifications to the guidance for franchisors, which include several unique accounting concepts that were not fully covered by ASU 2014-09 and ASC Topic 606.

The updates in ASU 2021-02 apply to entities that are not public business entities that are within the scope of Topic 952, which includes all entities that meet the definition of franchisor, that is, the party who grants business rights (the franchise) to the party (the franchisee) who will operate the franchised business. The amendments in this ASU were intended to reduce the cost and complexity of applying Topic 606 to pre-opening services for franchisors that are not public business entities by providing a practical expedient for applying Topic 606 to pre-opening services.

**Existing Authoritative Literature:**

Premium revenue recognition is detailed throughout the SSAPs, including the following: *SSAP No. 51—Life Contracts; SSAP No. 53—Property Casualty Contracts – Premiums; SSAP No. 54—Individual and Group Accident and Health Contracts and SSAP No. 57—Title Insurance*. The ASUs related to ASC Topic 606 have been rejected in SSAP No. 47.

**Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):** Agenda item 2016-19 and 2017-37 address the main ASUs related to ASC Topic 606 and there have been several other agenda items for minor updates to revenue recognition guidance.

**Information or issues (included in Description of Issue) not previously contemplated by the Working Group:**

None
Convergence with International Financial Reporting Standards (IFRS): ASC Topic 606 and IFRS 15 are the result of the joint project between the FASB and IASB to improve financial reporting by creating common revenue recognition guidance.

Staff Recommendation:
NAIC staff recommends the Working Group move this agenda item to the active listing, categorized as nonsubstantive and expose revisions to reject ASU 2021-02 in SSAP No. 47—Uninsured Plans. This recommendation is consistent with how the prior ASUs related to Topic 606 have been treated.

Staff Review Completed by: Jake Stultz, February 2021

Proposed Revisions to SSAP No. 47:

15. This statement rejects ASU 2014-09, Revenue from Contracts with Customers; ASU 2015-14, Revenue From Contracts With Customers; ASU 2016-08, Revenue From Contracts with Customers: Principal versus Agent Considerations (Reporting Revenue Gross versus Net); ASU 2016-10, Revenue from Contracts with Customers: Identifying Performance Obligations and Licensing; ASU 2016-12, Revenue from Contracts with Customers: Narrow-Scope Improvements and Practical Expedients; ASU 2016-20, Technical Corrections and Improvements to Topic 606, Revenue from Contracts with Customers; and ASU 2018-18, Collaborative Arrangements (Topic 808), Clarifying the Interaction between Topic 808 and Topic 606, and ASU 2021-02, Franchisors—Revenue from Contracts with Customers.

Status:
On March 15, 2021, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 47—Uninsured Plans to reject ASU 2021-02, Franchisors – Revenue from Contracts with Customers.

On May 20, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to SSAP No. 47—Uninsured Plans, as illustrated above, to reject ASU 2021-02, Franchisors—Revenue from Contracts with Customers for statutory accounting.
Issue: **ASU 2021-01, Reference Rate Reform**

**Check (applicable entity):**

- Modification of Existing SSAP: P/C, Life, Health
- New Issue or SSAP: P/C, Life, Health
- Interpretation: P/C, Life, Health

**Description of Issue:**
In March 2020, the Financial Accounting Standards Board (FASB) issued *ASU 2020-04, Reference Rate Reform (Topic 848) Facilitation of the Effects of Reference Rate Reform on Financial Reporting* to ensure the financial reporting of hedging relationships would reflect a continuation of the original contract and hedging relationship during the period of the market-wide transition to alternative reference rates – commonly referred to as “reference rate reform.” Reference rate reform typically refers to the transition away from referencing the London Interbank Offered Rate (LIBOR), and other interbank offered rates (IBORs), and moving toward alternative reference rates that are more observable or transaction based. In July 2017, the governing body responsible for regulating LIBOR announced it would no longer require banks to continue rate submissions after 2021 – thus, likely sunsetting both the use and publication of LIBOR.

As is often the case with hedge accounting, a change to the critical terms (including reference rate modifications) typically requires remeasurement of the contract, or in the case of a hedging relationship, a redesignation of the transaction. However, *ASU 2020-04* provides temporary, optional, and expeditious relief in that a qualifying modification (because of reference rate reform) should not be considered an event that requires contract remeasurement at the modification date or reassessment of a previous accounting determination. In essence, when a modification (because of reference rate reform) is made to a hedge’s critical terms, a reporting entity can continue hedge accounting rather than redesignate the hedging relationship. For fair value hedges, a reporting entity may change the hedged risk to another permitted benchmark interest rate without redesignating the relationship; that is if the hedge is expected to remain highly effective in offsetting changes in fair value attributed to the revised hedged risk. For cash flow hedges, a reporting entity may change to another permitted benchmark interest rate without redesignating the relationship if the forecasted hedge transaction remains probable of occurring.

The derivatives market continues to undergo various other transitions due to reference rate reform initiatives, specifically changing the reference rates used for marginging, discounting, or contract price alignment (this change is referred to as a “discounting transition”). While these changes are related to reference rate reform, they are not modifying an interest rate that is expected to be discontinued (e.g., LIBOR). The most prevalent example of a discounting transition occurred in October of 2020 with Central Clearing Parties (CCP). In October of 2020, the CME Group switched to using the Secured Overnight Financing Rate (SOFR) from the Effective Federal Funds Rate (EFFR) to discount, margin and price align most U.S. Dollar based derivative products. A change in the discount rate results in an immediate increase or decrease in a derivative’s fair value, which can affect required variation margin payments. In addition, using SOFR instead of EFFR impacts the amount of interest an entity will pay or receive in the related cumulative variation margin. Questions arose in that if a change in these terms would require hedge redesignation, or if these situations should be afforded the relief offered in *ASU 2020-04*.

In January 2021, FASB issued *ASU 2021-01, Reference Rate Reform* to clarify that all derivative instruments affected by changes to the interest rates used for discounting, marginging or contract price alignment (regardless of whether they reference LIBOR or another rate that is expected to be discontinued as a result of reference rate reform)
are in scope of Topic 848. In short summary, for all derivatives affected by the discounting transition, entities may apply the optional expedients and the continuation of contract exceptions allowed in ASU 2020-04.

ASU 2021-01 expands the scope of ASU 2020-04 by allowing an entity to apply the optional expedients, by stating that a change to the interest rate used for margining, discounting or contract price alignment for a derivative is not considered to be a change to the critical terms of the hedging relationship that requires dedesignation. The entity may apply the contract modification relief provided in ASU 2020-04 and continue to account for the derivative in the same manner that existed prior to the changes resulting from reference rate reform or the discounting transition.

Other Items:
The discounting transition previously discussed was primarily driven by CCPs. In October of 2020, CCPs converted open derivative end-of-day valuation calculations from EFFR to SOFR. The process entailed CCPs conducting a standard end-of-day valuation cycle based on EFFR. Then, CCPs conducted a special valuation cycle on those same positions, however utilizing SOFR as the new, ongoing discounting rate. Based on the differences between EFFR and SOFR, the CCP issued variation margin adjustments to offset the value differences arising from the change in discount rates. In addition to variation margin adjustments, CCPs issued mandatory EFFR/SOFR basis swaps, thus restoring the account holder’s original risk profile. ASU 2021-01 provides guidance for the final settlement of cashflows stating that fair value hedges may adjust the fair value hedge basis while cash flow hedges may adjust accumulated other comprehensive income. The accounting, reporting, and admittance of basis swaps was previously addressed by the Working Group in INT 20-09: Basis Swaps as a Result of the LIBOR Transition and is further discussed in the “Activities to Date” section of this agenda item.

Informal note, feedback received from interested parties indicates that most basis swaps were liquidated prior to year-end 2020.

Finally, the effective date of ASU 2021-01 mimics the effective date of ASU 2020-04 in that the optional, expedient guidance may be applied from the beginning of an interim period that includes or is after March 12, 2020 and terminates December 31, 2022.

Existing Authoritative Literature:

ASU 2021-01 effectively increases the scope of the optional, expedient accounting guidance for derivative instruments in ASU 2020-04. Accordingly, only applicable derivative authoritative literature will be shown below. While detailed in the original agenda item (Ref #2020-12), additional SSAPS impacted by ASU 2020-04 were SSAP No. 15—Debt and Holding Company Obligations and SSAP No. 22R—Leases.

The modifications in ASU 2020-04 address hedge accounting and the allowance for a reporting entity to change the reference rate and other critical terms related to reference rate reform without having to dedesignate the hedging relationship. While alternative benchmark interest rates were previously addressed in agenda item 2018-46 – Benchmark Interest Rate, the accounting for hedged transactions is noted below, with applicable areas bolded for emphasis.

Relevant/Applicable of Overview of existing SAP Accounting – SSAP No. 86—Derivatives

12. “Benchmark Interest Rate” is a widely recognized and quoted rate in an active financial market that is broadly indicative of the overall level of interest rates attributable to high-credit-quality obligors in that market. It is a rate that is widely used in a given financial market as an underlying basis for determining the interest rates of individual financial instruments and commonly referenced in interest-rate-related transactions. In theory, the benchmark interest rate should be a risk-free rate (that is, has no risk of default). In some markets, government borrowing rates may serve as a benchmark. In other markets, the benchmark interest rate may be an interbank offered rate. In the United States, the interest rates on direct Treasury
obligations of the U.S. government, the London Interbank Offered Rate (LIBOR) swap rate, the Fed Funds Effective Rate Overnight Index Swap Rate, the Securities Industry and Financial Markets Association (SIFMA) Municipal Swap Rate, and the Secured Overnight Financing Rate (SOFR) Overnight Index Swap Rate are considered to be benchmark interest rates.

Derivatives Used in Hedging Transactions

20. Derivative instruments used in hedging transactions that meet the criteria of a highly effective hedge shall be considered an effective hedge and are permitted to be valued and reported in a manner that is consistent with the hedged asset or liability (referred to as hedge accounting). For instance, assume an entity has a financial instrument on which it is currently receiving income at a variable rate but wishes to receive income at a fixed rate and thus enters into a swap agreement to exchange the cash flows. If the transaction qualifies as an effective hedge and a financial instrument on a statutory basis is valued and reported at amortized cost, then the swap would also be valued and reported at amortized cost. Derivative instruments used in hedging transactions that do not meet or no longer meet the criteria of an effective hedge, or that meet the required criteria but the entity has chosen not to apply hedge accounting, shall be accounted for at fair value and the changes in the fair value shall be recorded as unrealized gains or unrealized losses (referred to as fair value accounting).

21. Entities shall not bifurcate the effectiveness of derivatives. A derivative instrument is either classified as an effective hedge or an ineffective hedge. Entities must account for the derivative using fair value accounting if it is deemed to be ineffective or becomes ineffective. Entities may redesignate a derivative in a hedging relationship even though the derivative was used in a previous hedging relationship that proved to be ineffective. A change in the counterparty to a derivative instrument that has been designated as the hedging instrument in an existing hedging relationship would not, in and of itself, be considered a termination of the derivative instrument. An entity shall prospectively discontinue hedge accounting for an existing hedge if any one of the following occurs:

   a. Any criterion in paragraphs 24-36 is no longer met;
   b. The derivative expires or is sold, terminated, or exercised (the effect is recorded as realized gains or losses or, for effective hedges of firm commitments or forecasted transactions, in a manner that is consistent with the hedged transaction – see paragraph 22);
   c. The entity removes the designation of the hedge; or
   d. The derivative is deemed to be impaired in accordance with paragraph 17. A permanent decline in a counterparty’s credit quality/rating is one example of impairment required by paragraph 17, for derivatives used in hedging transactions.

22. For those derivatives which qualify for hedge accounting, the change in the carrying value or cash flow of the derivative shall be recorded consistently with how the changes in the carrying value or cash flow of the hedged asset, liability, firm commitment or forecasted transaction are recorded. Upon termination of a derivative that qualified for hedge accounting, the gain or loss shall adjust the basis of the hedged item and be recognized in income in a manner that is consistent with the hedged item (alternatively, if the item being hedged is subject to IMR, the gain or loss on the hedging derivative may be realized and shall be subject to IMR upon termination.) Entities who choose the alternative method shall apply it consistently thereafter.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):
The Working Group has taken several actions related to reference rate reform; each are summarized below.

1. Agenda item 2018-46 – Benchmark Interest Rate, incorporated revisions to SSAP No. 86, adding the Securities Industry and Financial Markets (SIFMA) Municipal Swap Rate and the Secured Overnight Financing Rate (SOFR) Overnight Index Swap (OIS) Rate as acceptable benchmark interest rates for hedge accounting. Prior to this change, only LIBOR and the Fed Funds Effective Swap Rate (also referred to as the Overnight Index Swap Rate) were considered acceptable benchmark interest rates.

2. Agenda item 2020-12 reviews ASU 2020-04, the foundation of which this agenda item and related ASU (2021-01) are based. Agenda item 2020-12 resulted in the Working Group adopting INT 20-01.

3. INT 20-01: ASU 2020-04 - Reference Rate Reform, adopted by the Working Group in April 2020, broadly adopted ASU 2020-04 for statutory accounting stating that for statutory accounting:
   - For all contracts within scope of ASU 2020-04, modifications due to reference rate reform are afforded an optional expedient to be accounted for as a continuation of the existing contract.
   - Debt and service agreement modifications, as a result of reference rate reform, should not typically rise to the level of requiring a reversal and rebooking of the liability, as SSAP No. 15—Debt and Holding Company Obligations states such liabilities should only be derecognized if extinguished.
   - Lease modifications, solely caused by reference rate reform and ones eligible for optional expedience, likely do not rise to the level of a modification requiring re-recognition as a new lease under SSAP No. 22R—Leases.
   - For derivative transactions within scope of ASU 2020-04, a change to the critical terms of the hedging relationship (due to reference rate reform), shall be afforded similar treatment in that the hedging relationship can continue the original hedge accounting rather than designdate the hedging relationship.

4. INT 20-09: Basis Swaps as a Result of the LIBOR Transition, adopted by the Working Group in July 2020, provided statutory accounting and reporting guidance for basis swaps issued by CCPs. This INT designated that basis swaps, issued by CCPs, in response to reference rate reform (i.e., the discounting transition), shall be classified as a derivative used for hedging. This categorization allowed for the basis swap derivatives to be admitted under SSAP No. 86. Additionally, the INT directed that basis swap derivatives shall not be reported as “effective” unless the instrument qualifies, with the required documentation, as highly effective under SSAP No. 86.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: N/A

Convergence with International Financial Reporting Standards (IFRS): IFRS has taken a similar approach when considering Reference Rate Reform’s impact on IFRS 9 (Financial Instruments), IAS 39 (Recognition and Measurement), and IFRS 7 (Financial Instruments – Disclosures).

NAIC Staff Recommendation:
NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose temporary (optional) expedient and exception interpretative guidance, with an expiration date of December 31, 2022. These optional expedients would expand the current exception guidance provided by INT 20-01: ASU 2020-04 - Reference Rate Reform. With this guidance, derivative instruments affected by changes to the interest rates used for discounting, margining or contract price alignment (regardless of whether they reference LIBOR or another rate that is expected to be discontinued
as a result of reference rate reform) would be in scope of INT 20-01. This exception would allow for continuation of the existing hedge relationship and thus not requiring hedge dedesignation.

The proposed modifications to INT 20-01 temporarily override SSAP No. 86 guidance for affected policies, therefore the policy statement in Appendix F requires 2/3rd (two-thirds) of the Working Group members to be present and voting and a supermajority of the Working Group members present to vote in support of the interpretation before it can be finalized.

**Staff Review Completed by:** Jim Pinegar, NAIC Staff – January 2021

**Status:**
On March 15, 2021, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed temporary (optional) expedient and exception interpretative guidance, with an expiration date of December 31, 2022. These optional expedients would expand the current exception guidance provided by *INT 20-01: ASU 2020-04 – Reference Rate Reform*. With this guidance, derivative instruments affected by changes to interest/reference rates because of reference rate reform (regardless of whether they reference LIBOR or another rate that is expected to be discontinued), in which are used for discounting, margining or contract price alignment would be in scope of the exception guidance afforded in INT 20-01. This exception would allow for continuation of the existing hedge relationship and thus not requiring hedge dedesignation.

On May 20, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions, which incorporated proposed interested party edits, to *INT 20-01: ASU 2020-04 – Reference Rate Reform*. The revisions expand the current exception guidance provided in the INT and provide additional temporary (optional) expedient and exception interpretative guidance, with an expiration date of December 31, 2022. With this guidance, derivative instruments affected by changes to the interest rates used for discounting, margining or contract price alignment (regardless of whether they reference LIBOR or another rate that is expected to be discontinued as a result of reference rate reform) will be in scope of INT 20-01. This exception will allow for continuation of the existing hedge relationship and thus not require hedge dedesignation. This INT is all-encompassing for “any hedging relationships” within the scope of the interpretation and captures all hedging transaction types, regardless of if the transaction occurred bilaterally or through a central clearing party.
Interpretation of the Statutory Accounting Principles (E) Working Group

INT 20-01: ASUs 2020-04 & 2021-01 - Reference Rate Reform

INT 20-01 Dates Discussed

March 26, 2020; April 15, 2020; March 15, 2021, May 20, 2021

INT 20-01 References

Current:
- SSAP No. 15—Debt and Holding Company Obligations
- SSAP No. 22R—Leases
- SSAP No. 86—Derivatives

This INT applies to all SSAPs with contracts within scope of ASU 2020-04, which allows for modifications due to reference rate reform and provides for the optional expedient to be accounted for as a continuation of the existing contract.

INT 20-01 Issue

1. This interpretation has been issued to provide statutory accounting and reporting guidance for the adoption with modification of ASU 2020-04, Reference Rate Reform (Topic 848): Facilitation of the Effects of Reference Rate Reform on Financial Reporting and ASU 2021-01, Reference Rate Reform (Topic 848) for applicable statutory accounting principles. The Financial Accounting Standards Board (FASB) issued both ASU 2020-04 and ASU 2021-01 in March 2020 to provide as optional, transitional and expedient guidance as a result of reference rate reform.

2. “Reference rate reform” typically refers to the transition away from referencing the London Interbank Offered Rate (LIBOR), and other interbank offered rates (IBORs), and moving toward alternative reference rates that are more observable or transaction based. In July 2017, the governing body responsible for regulating LIBOR announced it will no longer require banks to continue LIBOR submissions after 2021 – likely sunsetting both the use and publication of LIBOR. An important note is that while LIBOR is the primary interbank offering rate, other similar rates are potentially affected by reference rate reform.

3. With a significant number of financial contracts solely referencing IBORs, their discontinuance will require organizations to reevaluate and modify any contract that does not contain a substitute reference rate. A large volume of contracts and other arrangements, such as debt agreements, lease agreements, and derivative instruments, will likely need to be modified to replace all references of interbank offering rates that are expected to be discontinued. While operational, logistical, and legal challenges exist due to the sheer volume of contracts that will require modification, accounting challenges were presented as contract modifications typically require an evaluation to determine whether the modifications result in the establishment of a new contract or the continuation of an existing contract. As is often the case, a change to the critical terms (including reference rate modifications) typically requires remeasurement of the contract, or in the case of a hedging relationship, a redetermination of the transaction.

4. The overall guidance in ASU 2020-04 is that a qualifying modification (as a result of reference rate reform) should not be considered an event that requires contract remeasurement at the modification date or reassessment of a previous accounting determination. FASB concluded that as reference rate changes are a market-wide initiative, one that is required primarily due to the discontinuance of LIBOR, it is outside the control of an entity and is the sole reason compelling an entity to make modifications to contracts or hedging strategies. As such, FASB determined that the traditional financial reporting requirements of discontinuing such contracts and treating the
modified contract as an entirely new contract or hedging relationship would 1) not provide decision-useful information to financial statement users and 2) require a reporting entity to incur significant costs in the financial statement preparation and potentially reflect an adverse financial statement impact, one of which may not accurately reflect the intent or economics of a modification to a contract or hedging transaction.

5. Guidance in ASU 2020-04 allows a method to ensure that the financial reporting results would continue to reflect the intended continuation of contracts and hedging relationships during the period of the market-wide transition to alternative reference rates – thus, generally not requiring remeasurement or redesignation if certain criteria are met.

5.6. Guidance in ASU 2021-01 expanded the scope of ASU 2020-04 by permitting the optional, transitional, expedient guidance to also include derivative contracts that undergo a similar transition but do not specifically reference a rate that is expected to be discontinued. While these contract modifications do not reference LIBOR (or another reference rate expected to be discontinued), the changes are the direct result of reference rate reform and were deemed to be eligible for similar exception treatment. ASU 2021-01 allows for modifications in interest rates indexes used for margining, discounting or contract price alignment, as a result of reference rate reform initiatives (commonly referred to as a “discounting transition”) to be accounted for as a continuation of the existing contract and hedge accounting.

6.7. The optional, expedient and exceptions guidance provided by the amendments in ASU 2020-04 and ASU 2021-01 are applicable for all entities. However, they are only effective as of March 12, 2020 through December 31, 2022. This is because the amendments in ASU 2020-04 are intended to provide relief related to the accounting requirements in generally accepted accounting principles (GAAP) due to the effects of the market-wide transition away from IBORs. The relief provided by the amendments is temporary in its application in alignment with the expected market transition period. However, the FASB will monitor the market-wide IBOR transition to determine whether future developments warrant any changes, including changes to the end date of the application of the amendments in this ASU. If such an update occurs, the Working Group may also consider similar action. It is not expected that the Working Group will take action prior to or in the absence of a FASB amendment.

7.8. The accounting issues are:

   a. Issue 1: Should a reporting entity interpret the guidance in ASU 2020-04 as broadly accepted for statutory accounting?

   b. Issue 2: Should the optional, expedient and exception guidance in ASU 2020-04 apply to debt and other service agreements addressed in SSAP No. 15?

   c. Issue 3: Should the optional, expedient and exception guidance in ASU 2020-04 apply to lease transactions addressed in SSAP No. 22R?

   d. Issue 4: Should the optional, expedient and exception guidance in ASU 2020-04 apply to derivative transactions addressed in SSAP No. 86?

   d.e. Issue 5: Should the optional, expedient and exception guidance in ASU 2021-01 apply to derivative transactions addressed in SSAP No. 86?

INT 20-01 Discussion

8.9. For Issue 1, the Working Group came to the consensus that ASU 2020-04 shall be adopted, to include the same scope of applicable contracts or transactions for statutory accounting with the only modification related to a concept not utilized by statutory accounting, as noted below. The Working Group agreed the amendments provide appropriate temporary guidance that alleviate the following concerns due to reference rate reform:
a. Simplifies accounting analyses under current GAAP and statutory accounting principles (SAP) for contract modifications.

  i. All contracts within scope of ASU 2020-04, which allows for modifications due to reference rate reform and provides for the optional expedient to be accounted for as a continuation of the existing contract.

b. Allows hedging relationships to continue without redesignation upon a change in certain critical terms.

c. Allows a change in the designated benchmark interest rate to a different eligible benchmark interest rate in a fair value hedging relationship.

d. Suspends the assessment of certain qualifying conditions for fair value hedging relationships for which the shortcut method for assuming perfect hedge effectiveness is applied.

e. Simplifies or temporarily suspends the assessment of hedge effectiveness for cash flow hedging relationships.

f. The only SAP modification to this ASU is related to the option to sell debt currently classified held-to-maturity. This concept is not employed by statutory accounting and thus is not applicable.

For Issue 2, the Working Group came to the consensus that debt and service agreement modifications, as a result of reference rate reform, should not typically rise to the level of requiring a reversal and rebooking of the liability, as SSAP No. 15 states such liabilities should only be derecognized if extinguished. A reference rate modification should not generally require de-recognition and re-recognition under statutory accounting. Nonetheless, for clarity and consistency with ASU 2020-04, the Working Group came to the consensus that should an eligible contract be affected by reference rate reform, then the temporary guidance in ASU 2020-04 shall apply.

For Issue 3, the Working Group came to the consensus that lease modifications, solely caused by reference rate reform and ones eligible for optional expedience, likely do not rise to the level of a modification requiring re-recognition as a new lease under statutory accounting. SSAP No. 22R, paragraph 17 states only modifications in which grant the lessee additional rights shall be accounted for as a new lease. These changes are outside the scope allowed for optional expedience in ASU 2020-04. Nonetheless, for clarity and consistency with ASU 2020-04, the Working Group came to a consensus that if an eligible lease affected by reference rate reform, then the temporary guidance in ASU 2020-04 shall apply.

For Issue 4, the Working Group came to the consensus that ASU 2020-04 shall be applied to derivative transactions as the following considerations provided in the ASU are appropriate for statutory accounting:

a. For any hedging relationship, upon a change to the critical terms of the hedging relationship, allow a reporting entity to continue hedge accounting rather than redesignate the hedging relationship.

b. For any hedging relationship, upon a change to the terms of the designated hedging instrument, allow an entity to change its systematic and rational method used to recognize the excluded component into earnings and adjust the fair value of the excluded component through earnings.

c. For fair value hedges, allow a reporting entity to change the designated hedged benchmark interest rate and continue fair value hedge accounting.

d. For cash flow hedges, adjust the guidance for assessment of hedge effectiveness to allow an entity to continue to apply cash flow hedge accounting.
For Issue 5, the Working Group came to a consensus on May 20, 2021, that ASU 2021-01 shall be applied to derivative transactions for statutory accounting. Accordingly, derivative instruments that are modified to change the reference rate used for margining, discounting, or contract price alignment that is a result of reference rate reform (regardless of whether the reference rate that is expected to be discontinued) are eligible for the exception guidance afforded in ASU 2020-04 in that such a modification is not considered a change in the critical terms that would require redesignation of the hedging relationship. In addition, for all derivatives (those qualifying for hedge accounting, those that do not qualify for hedge accounting and replication (synthetic asset) transactions (RSAT)), a reporting entity may account for and report modifications (that are within the scope of INT 20-01) as a continuation of the existing contract even when the legal form of the modification is a termination of the original contract and its replacement with a new reference rate reform contract. This includes in-scope modifications of centrally cleared swap contracts whether they are automatically transitioned at a cessation date or voluntarily executed prior to cessation.

Additionally, for GAAP purposes, if an entity has not adopted the amendments in ASU 2017-12, Derivatives and Hedging, it is precluded from being able to utilize certain expedients for hedge accounting. For statutory accounting purposes, only the hedge documentation requirements were adopted from ASU 2017-12, while the remainder of the items are pending statutory accounting review. The Working Group concluded that all allowed expedient methods are permitted as elections for all reporting entities under statutory accounting. However, if a reporting entity is a U.S. GAAP filer, the reporting entity may only make elections under ASU 2017-12 if such elections were also made for their U.S. GAAP financials.

**INT 20-01 Status**

No further discussion is planned.
Ref #2021-05

Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Accounting for Cryptocurrencies

Check (applicable entity):

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Description of Issue:
NAIC staff have received several inquiries related to the statutory accounting treatment for cryptocurrencies, which are defined as a digital currency in which transactions are verified and records maintained by a decentralized system using cryptography, rather than by a centralized authority, such as the Federal Reserve System. These questions generally inquiry whether Bitcoin is permitted to be admitted, but a recent inquiry asked whether Bitcoin is captured in the cash definition within SSAP No. 2R—Cash, Cash Equivalents, Drafts, and Short-Term Investments.

The most valuable cryptocurrency as of February 2021 is Bitcoin, which has been in circulation since 2009. Cryptocurrencies are currently purchased and exchanged using a limited number of unregulated digital currency exchanges. As of February 2021, there are approximately 4,000 different cryptocurrencies available on 200 different cryptocurrency exchanges. Cryptocurrencies have seen significant price volatility and have experienced an extreme increase in value over the past year, with the value of total outstanding cryptocurrencies nearing $1 trillion as of February 2021. The total market value and increased popularity has led to increased interest in the market by traditional financial institutions. Additionally, the recently steep increase in value has attracted speculative investors.

For statutory accounting, cash is defined in SSAP No. 2R as a “medium of exchange that a bank or other similar financial institution will accept for deposit and allow an immediate credit to the depositor’s account.” Cryptocurrencies do not meet this definition because these assets are not able to be deposited or exchanged with most U.S. banks and financial institutions. There have been some recent changes in the market as PayPal now allows users to buy, sell and hold some cryptocurrencies. It is important to note that PayPal is not recognized as a bank. In addition to Bitcoin, some banks have shown interest in stablecoins, which trade like cryptocurrencies but are pegged to existing government-backed currencies, such as the U.S. dollar. NAIC staff are aware that this treatment is evolving and that in the future banks may accept cryptocurrencies in the same manner as true government-backed currencies, which could then meet the statutory accounting definition of cash. However, at this time, NAIC staff note that cryptocurrencies currently do not meet the definitions of cash equivalents, drafts, or short-term investments as they are defined in SSAP No. 2R.

With regards to the inquiry on whether cryptocurrencies are considered admitted assets, pursuant to SSAP No. 4—Assets and Nonadmitted Assets, paragraph 3, assets are not permitted to be admitted unless specifically identified as an admitted asset within the Accounting Practices and Procedures Manual. As such, as cryptocurrencies are not specifically identified as admitted, these are nonadmitted assets.

At this time, no Committees or groups at the NAIC, including the Securities Valuation Office (SVO), have taken any action or established a position on cryptocurrencies. Currently, auditors must rely on guidance provided by the American Institute of Certified Public Accountants through a nonauthoritative practice guide.
Existing Authoritative Literature:
Cash is defined in SSAP No. 2R—Cash, Cash Equivalents, Drafts, and Short-Term Investments as a “medium of exchange that a bank or other similar financial institution will accept for deposit and allow an immediate credit to the depositor’s account.” SSAP No. 4—Assets and Nonadmitted Assets provides guidance that assets which are not addressed in the Accounting Practices and Procedures Manual default to nonadmitted status. Nonadmitted assets are detailed in SSAP No. 20—Nonadmitted Assets.

SSAP No. 4
3. As stated in the Statement of Concepts, "The ability to meet policyholder obligations is predicated on the existence of readily marketable assets available when both current and future obligations are due. Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third-party interests should not be recognized on the balance sheet," and are, therefore, considered nonadmitted. For purposes of statutory accounting principles, a nonadmitted asset shall be defined as an asset meeting the criteria in paragraph 2, which is accorded limited or no value in statutory reporting, and is one which is:
   a. Specifically identified within the Accounting Practices and Procedures Manual as a nonadmitted asset; or

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None


Staff Recommendation:
NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose the interpretative guidance provided by INT 21-01T: Statutory Accounting Treatment for Cryptocurrencies. This guidance clarifies that cryptocurrencies do not meet the definition of cash in SSAP No. 2R—Cash, Cash Equivalents, Drafts, and Short-Term Investments and are nonadmitted assets for statutory accounting. NAIC staff will continue to monitor the evolution of cryptocurrencies and address this topic further, including addressing any statements made by FASB or the AICPA, for any significant changes in the usage and design of cryptocurrencies.

With this exposure, the Working Group requests input from Interested Parties and the insurance company trade groups that follow the Working Group to gather information from their members on current ownership of cryptocurrencies. The Working Group requests information on:

1. Extent to which companies currently hold cryptocurrencies,
2. How the acquisition in cryptocurrency is held (held directly by the insurer or indirectly through and SCA),
3. Which cryptocurrencies they are acquiring in (Bitcoin, Ethereum, Litecoin, etc.), and
4. General level of interest for future investment by both companies that currently do and do not own cryptocurrencies.

**Staff Review Completed by: Jake Stultz, February 2021**

**Status:**
On March 15, 2021, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed the interpretative guidance in INT 21-01T: Statutory Accounting Treatment for Cryptocurrencies to clarify that cryptocurrencies do not meet the definition of cash in SSAP No. 2R—Cash, Cash Equivalents, Drafts, and Short-Term Investments and are nonadmitted assets for statutory accounting. With the exposure, information from industry is requested per the above recommendation.

On May 20, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, INT 21-01: Statutory Accounting Treatment for Cryptocurrencies. The INT clarifies that directly held cryptocurrencies do not meet the definition of cash in SSAP No. 2R—Cash, Cash Equivalents, Drafts, and Short-Term Investments nor, when directly held, meet definition of an admitted asset per SSAP No. 4—Assets and Nonadmitted Assets. The adoption included minor edits to the exposure, which added the phrase “directly held.”
Interpretation of the Statutory Accounting Principles Working Group

INT 21-01: Accounting for Cryptocurrencies

INT 21-01 Dates Discussed

March 15, 2021, May 20, 2021

INT 21-01 References

SSAP No. 2R—Cash, Cash Equivalents, Drafts, and Short-Term Investments

INT 21-01 Issue

1. This agenda item is to address questions regarding statutory accounting treatment for cryptocurrencies, which are defined as a digital currency in which transactions are verified and records maintained by a decentralized system using cryptography, rather than by a centralized authority. Cryptocurrencies are purchased and exchanged using a limited number of unregulated digital currency exchanges and are not held or offered by major banks.

2. The most valuable cryptocurrency as of February 2021 is Bitcoin, which has been in circulation since 2009, and there are approximately 4,000 different cryptocurrencies available on 200 different cryptocurrency exchanges. Cryptocurrencies have seen significant price volatility and have experienced an extreme increase in value over the past year, with the value of the total outstanding cryptocurrencies nearing $1 trillion as of February 2021. The total market value and increased popularity has led to increased interest in the market by traditional financial institutions and insurance companies.

3. No NAIC Committees or groups have taken any action or established a position on cryptocurrencies. Currently, auditors must rely on guidance provided by the American Institute of Certified Public Accountants through a nonauthoritative practice guide.

4. This Interpretation intends to clarify that directly held cryptocurrencies are nonadmitted assets for statutory accounting.

INT 21-01 Discussion

5. Directly held cryptocurrencies have not been identified in the Accounting Practices and Procedures Manual (AP&P Manual) as an admitted asset, and do not meet the definition of any admitted asset that is defined in the AP&P Manual. Accordingly, by default they are a nonadmitted asset per SSAP No. 4—Assets and Nonadmitted Assets, paragraph 3, as they are not specifically identified in the Accounting Practices and Procedures Manual as an admitted asset.

6. Cash is defined in SSAP No. 2R—Cash, Cash Equivalents, Drafts, and Short-Term Investments as a “medium of exchange that a bank or other similar financial institution will accept for deposit and allow an immediate credit to the depositor’s account.” Cryptocurrencies are currently not accepted by major banks and do not operate like a traditional currency, and as such do not meet the definition of cash in SSAP No. 2R.
INT 21-01 Consensus

7. The Statutory Accounting Principles (E) Working Group reached a consensus that directly held cryptocurrencies do not meet the definition of an admitted asset and are therefore considered to be a nonadmitted asset for statutory accounting. The Working Group intends to rely on this interpretation for statutory accounting and will address cryptocurrencies further once FASB has provided definitive guidance.

INT 21-01 Status

8. No further discussion is planned.

9. The Statutory Accounting Principles (E) Working Group will continue to monitor the evolution of cryptocurrencies and subsequently review this interpretation as appropriate.
MEMORANDUM

TO: Philip Barlow (DC), Chair, Life Risk-Based Capital (E) Working Group
FROM: Dale Bruggeman (OH), Chair, Statutory Accounting Principles (E) Working Group
Carrie Mears (IA), Vice-Chair, Statutory Accounting Principles (E) Working Group
DATE: May 20, 2021
RE: SAPWG Response to the Life Real Estate Proposal

The Statutory Accounting Principles (E) Working Group appreciates the opportunity to provide comments to the Life Risk-Based Capital (E) Working Group on the American Council of Life Insurers (ACLI) proposal to modify the treatment of real estate in the life risk-based capital (RBC) formula. This proposal would potentially reduce the life RBC charges for real estate based on the fair value reported. The SAPWG understands the Life RBC (E) Working Group has adopted the structure for this change and is now reviewing whether the factors to be used will reduce charges. In summary, with the limited appraisal provisions of SSAP No. 40R—Real Estate and what appears to be inconsistent historical fair value data reported in Schedule A – Part 1: Real Estate Owned, the SAPWG identifies that relying on fair value amounts reported in Schedule A to influence real estate RBC could create a situation that is susceptible to RBC optimization. The following three points further highlight this conclusion for the Schedule A proposal:

1. **Fair Value Supplemental Disclosure** – The fair value reported for real estate captured on Schedule A is only a disclosure element and is not utilized in determining the reported balance sheet amount (book adjusted carrying value - BACV) or a company’s financial condition when exceeding the reported amount. This disclosed fair value is generally considered supplementary information and not subject to audit or verification procedures.

2. **Fair Value only for OTTI** – Other than supplemental information, the intent of fair value appraisals / assessment disclosure is for purposes of determining whether an other-than-temporary impairment (OTTI) assessment is required, not for the evaluation of unrealized gains. There are a number of reporting entities that have historically left the fair value field blank for some properties or reported a fair value amount that equals the reported BACV of the real estate. (These zero values / matching BACV reporting represent 29% of Schedule A properties. Detailed data can be provided to the Life RBC Working Group staff.) This reporting has been noted even when recent appraisals have been obtained. If the appraisal supported the balance sheet reported value, some entities simply reported BACV as the proxy for fair value, presumably because there was no incentive to use resources to calculate a different fair value. This proposal will require additional resources from companies to ensure comparability of RBC, potentially creating a disparate impact in RBC calculation between large and small reporting entities if such resources are not readily available.
3. **5 Year Appraisal** – The statutory accounting “every 5-year appraisal requirements for admittance” only impacts real estate that is income producing or held for sale. There is no ongoing appraisal requirement for property that is occupied by the reporting entity. Furthermore, there is no requirement for a current appraisal prior to revising the fair value reported for any of the real estate categories. From a review of the 2020 investment schedule detail, it was noted that some reporting entities made significant changes to the reported fair value, although the last appraisal (if any) occurred years prior.

In addition to the points raised for the Schedule A proposal, there are additional concerns for this proposal if it is applied to investments captured in scope of SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies and reported on Schedule BA – Other Long-Term Invested Asset as having underlying characteristics of real estate. These Schedule BA concerns are summarized as points 4-6 as follows:

4. **Subjectivity of Schedule BA classification and transparency of movement within** – Classification of SSAP No. 48 investments on Schedule BA as having “underlying characteristics of real estate” is subjective. The instructions indicate the investments should have “real estate development interest,” and direct that if the requisite details are not available for reporting, then the investment should be reported in the Schedule BA “Other” category. With a potential reduction of RBC based on fair value (particularly as the “Schedule BA Other” category has the highest RBC charge of all asset classes), this change may result with an increase of SSAP No. 48 investments being classified from “Other” to having underlying real estate interests. Under current RBC factors, the variation between these Schedule BA reporting lines (0.23 and 0.30 respectively) does not create a significant motivation for this reclassification. However, if this comparison were to significantly change – and perhaps result with the elimination of RBC based on fair value differentiation – there is a significant motivation for a company to reassess whether an investment could be considered to have characteristics of underlying real estate. Furthermore, movement between reporting lines on the same schedule does not trigger any regulator indicator for assessment. It is only when investments move from one schedule to another are they captured as disposals and reacquisitions and can be identified.

5. **U.S. GAAP valuation of real estate inside holding company** – SSAP No. 48 investments are required to be audited for admittance with the BACV reflecting the reporting entity’s share, calculated using the equity method, of the SSAP No. 48 investment. The equity method begins with cost and is adjusted to reflect gains and losses within the structure not distributed to the investors. Whether those gains / losses reflect fair value changes of the underlying real estate in the SSAP No. 48 structure depends on the measurement method used within the investment structure. Under U.S. GAAP, certain structures may be required to measure holdings at fair value. (If not required, fair value may be an election by the reporting entity.) This could result with significant variation on whether the proposal influences RBC:
a. SSAP No. 48 structures that account for the underlying real estate at historical cost would likely have a lower BACV and a potential higher fair value on Schedule BA. The lower BACV is already incurring a lower RBC impact, and under the proposal, the RBC impact could be further decreased based on the differential between BACV and fair value.

b. SSAP No. 48 structures that account for the underlying real estate at fair value would likely have a higher BACV and a lower differential to the fair value reported on Schedule BA. The higher BACV is already incurring a higher RBC impact and would be less likely to be reduced based on fair value under the proposal.

6. **No appraisal requirement for Schedule BA Real Estate** – There is no requirement for appraisals of the underlying real estate held within a SSAP No. 48 structure. As such, regardless of whether the underlying real estate is held at fair value in the SSAP No. 48 structure, or if the reporting entity is calculating fair value for the entire SSAP No. 48 structure for reporting on Schedule BA, there are no appraisal requirements to validate the fair value calculation of the underlying real estate property. Pursuant to **SSAP No. 100—Fair Value**, these fair value calculations can be entity-determined based on the entity’s own assumptions of what a market participant would assume in pricing the asset. Consistent with the comments for the proposal on Schedule A, the fair value column on Schedule BA is only a disclosure element and is not utilized in determining the reported balance sheet amount (BACV) or a company’s financial condition. Other than supplemental information, the intent of the fair value disclosure is for purposes of determining whether an OTTI assessment is required.

In response to these six points, it is noted that incorporating the ACLI proposal in the current year would likely result in inconsistent application in RBC as well as result with an environment that incentivizes companies to potentially inflate reported fair values to optimize their RBC results. Although the SAPWG notes concerns with the use of fair value to influence real estate RBC, if further consideration is supported, the following initial suggestions are offered:

1. Delay adjusting current factors until at least 2022 to ensure time for examiners to expand procedures to include an assessment of reported fair values on Schedule A and Schedule BA. This would also allow time for companies that have historically not determined fair value beyond the amount needed to support BACV to revise their procedures so that the proposed RBC change will uniformly impact companies. This may not be feasible if Life RBC Working Group decides real estate and bond factors should be updated to start with the same year-end.

2. Establish guidance to restrict fair values used for RBC to the “lesser of” current or prior year reported fair values, or possibly averaging reported fair values across multiple years. Such guidance would prevent reporting entities from increasing fair value in the current year to
optimize RBC results or in response to an expected RBC shortfall. This would also allow regulators time to review updated fair value amounts, particularly if there are significant increases from past reported amounts before the increased fair value is used to reduce RBC.

Summary
After review of the year-end 2020 reported Schedule A and Schedule BA information and the SSAP No. 40R appraisal requirements and SSAP No. 48 reporting requirements, the Statutory Accounting Principles (E) Working Group has concerns on the reliability and consistency of data with the ACLI proposal to allow reporting entities to reduce RBC through their reported fair value of real estate. Additional time and safeguards are needed to ensure consistent treatment across reporting entities, ensure regulators have procedures in place to assess reported fair value information and prevent situations in which reporting entities can utilize this guidance to optimize RBC results or prevent an RBC shortfall that hinders proper assessment of the entity’s financial condition.

If you have any questions on this referral response, please contact Dale Bruggeman, Chair of the Statutory Accounting Principles (E) Working Group, or Julie Gann, NAIC staff.

c: Jane Barr, Dave Fleming, Julie Gann, Robin Marcotte, Jim Pinegar, Jake Stultz, Fatima Sediqzad
In this memorandum and the subsequent responses to the questions from the Working Group in its communication of Jan. 22, 2021, the SVO would like to reflect its continued strong support for this asset class and the re-assessment of the current 5% cap on balloon payments in credit tenant loan (CTL) transactions. We thought it was important to highlight some of the unique characteristics of these investments and the potential risks posed by greater reliance on the residual value of the underlying property and increased reliance on rating agencies.

Credit Tenant Loan Overview

CTLs are a type of commercial real estate financing secured by one or more properties leased to a credit tenant. CTL structures are unique in that the credit risk is based solely upon the lessee's credit worthiness instead of the value of the real estate collateral. Pursuant to the lease terms of a CTL, the credit tenant is obligated to make rent payments regardless of casualty or condemnation and assumes responsibility for all operating, maintenance, and insurance expenses and real estate taxes with no lease "outs" (ways to avoid making lease or associated payments). Any obligations retained by the landlord, such as payment of maintenance, must be addressed though insurance or another acceptable mitigant. Additionally, CTLs are structured so that lease payments are available to timely pay the debt service, including the full amortization of the principal, along with all other costs related to the property. The investors benefit from a security interest in the real estate collateral but this protection only serves to benefit the noteholders if the lessee defaults on rent leading to a default on note payments.

Balloon Payments

The current Purposes and Procedures Manual of the Investment Analysis Office (the P&P) guidance permits balloon payments in CTL transactions of up to 5% of the original loan balance which do not correspond to a lease payment. This balloon amount can be greater so long as the risk is appropriately mitigated through residual value insurance or another mitigant. Since the final lease payment will not cover the balloon payment owed under the note, balloon payments are dependent on the proceeds from...
the landlord’s re-leasing of the property necessary for refinancing the debt or, failing that, its sale. Balloon payments therefore expose the noteholder to the residual value of the property and the risk that it might not be sufficient to cover the remaining balance of the note.

“Dark Value”

The value ascribed to real estate collateral is often called its “dark value.” Dark value is estimated from the possible future re-leasing of the commercial property and includes lump-sum charges for lost rent, re-tenanting costs, brokerage costs, brokerage fees, unreimbursed maintenance, and other holding-period or re-leasing expenses. The existing 5% limit of on balloon payments in the CTL guidelines minimizes the exposure to the real estate collateral’s dark value. However, with each percent increase in balloon payment size there is a lockstep increase in the residual exposure to the property’s dark value and the ability to re-lease the asset at a sufficient rate.

The SVO’s Opinion

The Working Group has asked the SVO whether it thinks it appropriate to revisit the 5% residual threshold in the CTL guidelines and, if so, to recommend an appropriate residual threshold. The SVO thinks the residual threshold should be revisited but we do not have a specific threshold to recommend. The SVO can assess the risk of, and assign NAIC Designations to, transactions with any level of residual exposure that the Working Group and Task Force approves, from 0% to 100%. The debt markets are awash in securities with repayment contingent on the re-leasing or liquidation of an asset and residual exposures at all levels, including greater than 100%. This shift in risk from the lessee's credit worthiness to the collateral asset's value can apply to any security backed by leased assets, whether they be railcars, aircraft, aircraft engines, vessels, shipping containers, etc., if repayment of the loan is dependent in part on the future re-leasing or sale of the asset. The appropriate residual threshold is really a question of what constitutes a bond for financial solvency, regulatory and statutory accounting purposes and, more specifically, what amount of residual exposure (i.e. direct exposure to an underlying asset at the end of an investment) should be permitted in insurance companies' debt investments. The SVO is not well positioned to answer with a specific threshold because its primary responsibility is credit assessment, which can performed on any level of residual risk, but would suggest the Working Group consider the financial effect to the investor of having to rely upon the future re-leasing of the property in order to refinance the debt or the sale of the asset for payment at maturity.

“Asset-Backed Securities” pursuant to Regulation AB

There have been recommendations for a 50% residual threshold based on the definition of “Asset-Backed Security” under the U.S. Securities and Exchange Commission’s (SEC) Regulation AB (17 CFR § 220.1101). Regulation AB dictates the disclosure and reporting requirements for publicly offered asset backed securities which, as defined in the regulation, includes non-auto lease backed securities with residual exposures up to, but not including, 50%, by dollar amount, of the securitized pool balance. The residual threshold drops to 20% if the securities are offered as part of a shelf registration. The regulation was intended to provide for better disclosure of asset level information and, by providing investors with timely and sufficient information, to reduce the likelihood of undue reliance on credit ratings. A security
with greater than 50% residual exposure could also be registered with the SEC but with different disclosure and reporting requirements. Likewise, a security with 49% residual exposure which meets the Regulation AB definition of “Asset-Backed Security” could be privately placed. Neither security would be subject to Regulation AB, but we would assert both are “asset-backed” securities. We make this point to demonstrate that the Regulation AB definition of Asset-Backed Security, while convenient, is not necessarily a compelling basis for determining a level of residual exposure compatible with NAIC’s regulatory objectives. According to the SEC’s 2004 proposing release for Regulation AB (SEC Release Nos. 33-8419; 34-49644) the SEC arrived at the 50% threshold “after reviewing residual value percentages for typical lease-backed securitizations.” The SEC’s disclosure regulations and regulatory objectives should not necessarily influence the NAIC’s regulatory financial solvency objective; one clear lesson from the Great Recession of 2007-2008 was that market convention and acceptance should not drive NAIC regulatory policy.

Rating Agencies

Markets will create any security an investor is willing to buy. Likewise, there is no limitation or restriction on what can be assigned a credit rating and one should never assume that because a security has a credit rating it is an appropriate investment for NAIC regulatory purposes. The SVO staff believes there is substantially less risk to investors when the residual asset exposure is limited. This is true for all securities that may have a residual asset exposure because there is far less transparency and consistency in assessing the risk of the residual asset, especially for small pools of non-commoditized assets like real estate. (We intentionally make the distinction between small pools of non-commoditized assets and large pools of commoditized assets, such as auto lease ABS, because it is possible to more accurately estimate cashflows for traditional asset backed securities, including the proceeds from the sale of the assets at the end of each lease, thereby more accurately mitigating residual asset risk.) The next few examples highlight the increase in variability and inconsistency in assessment of risk, even among rating agencies, for securities with large residual exposures.

The SVO staff has observed very different treatment by rating agencies of the valuation and refinancing or liquidation risk presented by exposure to the residual asset. Some rating agencies notch downward significantly from the rating of the lessee when there is substantial lease renewal and refinancing risk associated with the repayment of principal, while others notch up based on the property valuation. The assumptions and bases for property valuations, the biggest driver of risk when there is a large residual exposure, can vary significantly across the rating agencies. Some using capitalization rates, a key component of the valuation, in the 6.50-16.50% range depending upon the property type and location. Others do not provide stated capitalization rates in their methodology but apply rates in a lower narrower range of 6.00-7.50% in reports that we have seen leading to substantially higher valuations. These methodology difference have led to valuation difference of greater than 30-40% which significantly impact loan-to-values ratios.

One recent publicly rated (Nov. 2020) real estate lease backed transaction had a 76% residual exposure at maturity in 2035 for a facility leased by a U.S. government entity. The rating on the security was
notched downward five times to "A2" from the U.S. government's "AAA" rating and is now under ratings review for possible downgrade (Dec. 2020). Other rating agencies have taken the opposite approach and notched upward above the lessee's credit rating based on the collateral and the loan-to-value ratio, in some cases raising the transaction's credit rating two to five notches above the lessee's credit rating. For example, a non-conforming CTL transaction with a "BBB" rated large international company as tenant and a 37% residual exposure was rated "A+". In another transaction, the lessee was rated "BBB-" but the non-conforming CTL was rated "AA-" despite a 100% residual exposure. While these are only a few examples, they reflect the varied and highly inconsistent treatment of the risk of residual asset exposure and valuation across rating agency methodologies. It is the SVO staff’s opinion that these methodology inconsistencies should be addressed if these securities are to be considered eligible for Filing Exemption. The ratings on other lease-backed securities may have similarly varied and inconsistent treatment but the SVO has not yet reviewed those security types in detail. We note that in the adopting release for revisions to Regulation AB in 2014 (Release Nos. 33-9638; 34-72982), the SEC, in referring to the financial crisis of 2007-2008, wrote, “The failures of credit ratings to accurately measure and account for the risks associated with certain asset-backed securities have been well documented,” and, “The collapse of these ‘investment-grade’ rated securities was a major contributor to the financial crisis, and demonstrated the risks to investors of unduly relying on these securities’ credit ratings without engaging in independent due diligence.”

Specifically, responding to the Working Group's questions, the SVO staff's responses are below:

- **Whether it is appropriate to revisit the 5% residual asset risk threshold as a restriction for conforming CTLS.**

  The Task Force's adoption of the 5% residual asset risk threshold was generous under the CTL guidelines since it permits some exposure to the underlying real estate collateral in transactions assessed based on the credit worthiness of the lessee and allows them to be reported as a bond with comparable accounting and risk-based capital (RBC) treatment. Since the P&P guidance was adopted in the early 1990s, additional investment structures have been created to securitize lease payments for many types of assets well beyond the commercial real estate financing of CTLS and with residual asset exposure far in excess of 5%. In acknowledgment of the changes to the lease backed securities market since the CTL guidelines were adopted, the SVO recommends that the Working Group and Task Force re-consider the current 5% residual exposure threshold for CTLS and possibly for other lease-backed securities. As noted in several industry comments, CTLS have consistently performed well for insurers under the existing standards and the SVO believes that historical performance is directly related to the current structural framework, required mitigants and review process.

- **If applicable, a recommendation of an appropriate residual risk threshold.**
The SVO suggests limiting the residual asset risk exposure for CTLs and, possibly, for other lease-backed securities as well. As mentioned previously, as residual asset exposure increases, the security develops risk characteristics more like that of the underlying asset than that of an investment security making periodic payments of interest and principal. There are also separate reporting, statutory accounting, RBC, and investment limitations that would be applicable to the underlying assets were they to be held directly as an investment. Furthermore, the exposure is residual, meaning only determinable at or near maturity when the asset needs to be either released or sold to satisfy note payment obligations. The P&P defines CTLs as being, "mortgage loans that are made primarily in reliance on the credit standing of a major tenant." Therefore, at a minimum, a “primarily” standard would be appropriate, meaning no residual exposure should be 50% or greater. The SVO staff believes that even 50% is a very high exposure to the underlying collateral asset's re-leasing or salability risk, meaning that at maturity the noteholder’s risk of repayment of the remaining outstanding half of its principal is directly tied to the value of the underlying real estate and the ability to re-lease the asset at a sufficient rate. (If held directly, a mortgage loan on real estate is reported on Schedule B.) A lower residual threshold would lessen that risk. Industry has often pointed to the strong performance of CTLs through times of economic distress. However, until now all CTLs filed with the SVO have been conforming CTLs with minimal residual exposure. We do not know how a CTL with a larger residual exposure would perform should the balloon payment come due and the property need to be re-leased or sold in a year when commercial real estate values are suppressed. Ultimately, the Working Group and the Task Force will need to decide, from a regulatory risk and reporting perspective, how much exposure to any small pools (including single asset pools) of non-commoditized assets is appropriate to still be reported on the bond schedule with an NAIC Designation and receive commensurate RBC treatment. The SVO will be able to assign an NAIC Designation to whatever residual threshold, 0% to 100%, the Working Group and Task Force ultimately decide upon.

- **Whether other mechanisms or compensating controls (beyond a residual risk insurance policy) could be incorporated as a mitigating factor for CTLs that exceed the 5% residual risk threshold (or a threshold as recommended).**

Yes. Residual risk insurance is the most common mitigant to residual risk, but the SVO would accept other mitigants including, but not limited to, non-cancellable guarantees, cash escrows and reserves, excess rent set asides and recourse to the lessee. We would propose that a list of mitigants not be limiting but rather examples, so that we can assess and make a determination on any proposes mitigant.

- **A listing of the nonconforming CTLs that were filed with the SVO in accordance with the direction of Interpretation (INT) 20-10. Please include high level details including outstanding principal and NAIC designation assigned by the SVO.**
The SVO has received 61 CTLs from when the INT 20-10 was issued through Apr. 21, 2021. There were 16 conforming CTLs ($0.406 billion), 27 non-conforming CTLs ($0.789 billion) and 18 transactions still pending documentation and review ($0.414 billion). The typical outstanding documentation included: primary legal agreement, CTL evaluation form, mortgage, residual value insurance, lease agreement, condemnation insurance, appraisal, and assignment of lease and rents. The list of security IDs and descriptions for non-conforming CTLs has been included in a regulator-only addendum. After reviewing the data for existing CTLs filed in 2020, we thought it was important to highlight that there is no universal issue description for these investments, making them difficult to identify. For the 1,018 CTLs filed with the SVO in 2020, 130 were identified as a CTL, 113 were identified as lease related, 326 were trust certificates, 160 were pass-thru certificates, 61 had no security type description, and the remaining 228 were various types of notes or certificates. Without reviewing the actual legal agreements and their terms, it will be very difficult to identify these securities without an insurer providing them to the SVO and the SVO identifying them in NAIC systems for all regulators.

In addition, the Working Group is also requesting information, to the extent possible, using best efforts, on (1) how many CTLs originally exceeded the residual risk threshold but were later deemed “conforming” due to mitigating factors, and (2) the nature of those factors (e.g. a residual risk insurance policy).

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To put these numbers into perspective, the SVO staff reviews over 1,000 CTL transactions each year. During the three-year period from 2018 to 2020, the yearly filing average was 1,203 CTL filings comprising: 86 initial filings, 1,112 annual update filings, and 2 material change filings. The SVO has developed extensive experience reviewing CTL transactions.

We hope that the Task Force and Working Group find this report useful as they deliberate this important issue.
TO:    Kevin Fry, Chair, Valuation of Securities (E) Task Force
FROM: Dale Bruggeman, Chair of the Statutory Accounting Principles (E) Working Group
       Carrie Mears, Vice-Chair of the Statutory Accounting Principles (E) Working Group
RE:    Proposed VOSTF Attachment B – Filing Exemption for CTLs
DATE:  May 21, 2021

After a detailed review of the proposed revisions within Attachment B of the Valuation of Securities (E) Task Force meeting materials for Monday, May 24, it appears that the proposed revisions go beyond providing a filing exemption to allow non-SVO assigned designations. Rather, the edits also appear to modify the structural requirements for credit tenant loans (CTLs), and would thus permit direct mortgage loans, in scope of SSAP No. 37 and reported on Schedule B—Mortgage Loans, to be reclassified from Schedule B to Schedule D-1—Long-Term Bonds with up to 50% residual risk and a CRP rating, without any SVO structural assessments.

From prior review of the history of the CTL provisions, the original intent was to permit mortgage loans, captured on Schedule B, to be reclassified to Schedule D-1 based on the credit standing of a major tenant, but only if there was very limited residual risk (5%). Over time, the structure of these investments has shifted, but not the name used, and it is believed that most designs now meet the definition of a security and not a mortgage loan. Further, since the scope of SSAP No. 37—Mortgage Loans specifically excludes securities, these revised investment designs would not be captured in scope of SSAP No. 37 and not reported on Schedule B. Rather, under the existing guidance in the Accounting Practices and Procedures Manual, securities that reflect a creditor relationship, whereby there is a fixed schedule for one or more future payments, are captured in scope of SSAP No. 26R—Bonds or SSAP No. 43R—Loan-Backed and Structured Securities and reported on Schedule D-1.

Although the process to assess whether securities with underlying real estate risk shall be subject to filing exempt provisions or be submitted to the NAIC SVO for a credit assessment is a decision of the Task Force, as noted above, the current proposed revisions do not appear to be limited to that aspect. To prevent inadvertent application of the proposed revisions to direct mortgage loans, and to clarify that securities (SSAP No. 26R/SSAP No. 43R) shall be reported in accordance with existing AP&P Manual guidance, it is suggested that the Task Force reconsider the proposed exposure of Attachment B. Instead, it is recommended that the Task Force expose proposed edits to the Purposes and Procedures Manual to clarify that in all instances in which a CTL is defined, it is noted to be a mortgage loan “in scope of SSAP No. 37.” It is noted that this limited edit would clarify that the application of the structural assessment of CTLs is limited to direct mortgage loans and relates to the potential reclassification from Schedule B to Schedule D for those investments. Furthermore, it would clarify that securities are not subject to the CTL structural assessments and should continue to be reported in accordance with the scope provisions of the guidance within the AP&P Manual.
Examples of the proposed recommendations are shown below:

P&P Manual, Page 101 – FE Securities:

**Credit Tenant Loan (CTL)** – A CTL is a mortgage loan, in scope of SSAP No. 37, made primarily in reliance on the credit standing of a major tenant, structured with an assignment of the rental payments to the lender with real property pledged as collateral in the form of a first lien. This Manual identifies four categories of CTLs as eligible for reporting on Schedule D conditioned on an SVO determination that the transaction meets the criteria specified by the VOS/TF for Schedule D treatment. A transaction that purports to be a Credit Tenant Loan, including one that is assigned a credit rating by an NAIC CRP, is not eligible for Schedule D reporting unless the SVO confirms that the transaction is eligible for Schedule D reporting and assigns the transaction an NAIC Designation.

P&P Manual, Page 29 – Credit Tenant Loans:

**CTL Categories**

100. Mortgage loans, in scope of SSAP No. 37, that are made primarily in reliance on the credit standing of a major tenant, structured with an assignment of the rental payments to the lender with real property pledged as collateral in the form of a first lien, are referred to as a Credit Tenant Loan. Four categories of CTLs are recognized as eligible for reporting on Schedule D: Bond Lease Based CTLs; Credit Lease Based CTLs; Acceptable CTL Variants (ACVs); and Multiple Property Transactions (MPTs).

If the limited edits, as shown above, are incorporated, than further revisions to the P&P Manual, particularly to the structural assessment for CTLs and the existing 5% residual risk threshold, are not expected to be needed at this time. It is also believed that this will resolve the current uncertainty and inconsistency with regards to the reporting of securities that have underlying elements of mortgage loan or real estate risk. Although these revisions will clarify the current ability to report securities that represent a creditor relationship under the existing bond definition, it is noted that a current project is underway to establish principles to clarify what should be considered a bond for reporting on Schedule D-1. Once that project is finalized, security structures that do not qualify under those bond principles will be reclassified to a more appropriate schedule.

Thank you for considering this revised proposal. Please contact Dale Bruggeman, or Carrie Mears, SAPWG Chair and Vice Chair, with any questions on this memorandum.
The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force conducted an e-vote that concluded April 20, 2021. The following Working Group members participated: Dale Bruggeman, Chair (OH); Kevin Clark, Vice Chair (IA); Richard Ford (AL); Kim Hudson (CA); William Arfanis (CT); Stewart Guerin (LA); Judy Weaver (MI); Doug Bartlett (NH); Bob Kasinow (NY); David Smith (VA); and Amy Malm (WI).

1. **Exposed Agenda Item 2021-03**

The Working Group conducted an e-vote to consider exposure of agenda item 2021-03: SSAP No. 103R – Disclosures. This agenda item was drafted in conjunction with the Working Group’s continued deliberation of agenda item 2019-21: SSAP No. 43R – Equity Instruments, a substantive project to consider which investments fall within scope of *Statement of Statutory Accounting Principles (SSAP) No. 43R—Loan-Backed and Structured Securities*. Agenda item 2021-03 proposes minor disclosure enhancements to SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities and a data capture template to identify situations in which a reporting entity has entered into a securitization, asset-backed financing, or similar transfer transaction where a significant economic interest in the transferred asset is retained by the reporting entity, its related parties, or another member within the holding company group. This agenda item had an initial exposure on March 15 and has been updated to reflect preliminary comments received from interested parties.

Mr. Smith made a motion, seconded by Mr. Hudson, to expose agenda item 2021-03. The motion passed unanimously.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
The Blanks (E) Working Group of the Accounting Practices and Procedures (E) Task Force met July 22, 2021. The following Working Group members participated: Jake Garn, Chair (UT); Kim Hudson, Vice Chair (CA); William Arfanis (CT); N. Kevin Brown (DC); Carolyn Morgan (FL); Daniel Mathis (IA); Roy Eft (IN); Dan Schaefer (MI); Lindsay Crawford (NE); Patricia Gosselin (NH); Mariam Awad and Nakia Reid (NJ); Diane Carter (OK); Melissa Greiner and Kimberly Rankin (PA); Trey Hancock (TN); Shawn Frederick (TX); Steve Drutz (WA); Randy Milquet (WI); and Jamie Taylor (WV). Also participating: Phil Vigliaturo (MN).

1. **Adopted its May 26 Minutes**

Mr. Garn said the Blanks (E) Working Group met May 26 and took the following action: 1) adopted eight blanks proposals: a) 2021-01BWG, add reference to health care receivables line in the Asset page; b) 2021-02BWG, add questions to the General Interrogatories, Part 1 regarding depository institution holding companies as it pertains to the group capital calculation (GCC); c) 2021-03BWG, add category lines to the Separate Accounts General Interrogatories for additional granularity; d) 2021-04BWG, add a General Interrogatory to identify insurers that use third parties to pay agent commissions in which the amounts advanced by the third parties are not settled in full within 90 days; e) 2021-05BWG, modify Note 17B(4) to reflect changes made by the Statutory Accounting Principles (E) Working Group reference number SAPWG 2021-03 regarding transferred assets; f) 2021-06BWG, add crosschecks to the long-term care (LTC) reporting forms to gain consistency; g) 2021-07BWG, add additional line categories to capture collateral type data for all residential mortgage-backed securities (RMBS), commercial mortgage-backed securities (CMBS), and loan-backed and structured securities (LBSS) securities regardless of reporting category; and h) 2021-08BWG, add a new supplement Mortgage Guaranty insurance Exhibit to capture more information from mortgage guaranty insurers; 2) adopted its editorial listing; and 3) exposed five proposals for public comment.

Mr. Eft made a motion, seconded by Ms. Reid, to adopt the Working Group’s May 26 minutes (Attachment Two-A). The motion passed unanimously.

2. **Adopted Proposals Previously Exposed**

   a. **Agenda Item 2021-10BWG – Effective Jan.1, 2022**

Mr. Hudson stated that this proposal removes language in the quarterly General Interrogatories Part 1, line 4.1 that requires the filing of a quarterly merger/history form. Proposal 2017-21BWG added language to the General Interrogatories to require filing a merger/history form for annual and quarterly statements. The annual form works as intended. It is used for Insurance Regulatory Information System (IRIS) calculations, as well as validations. He stated that the quarterly form does not function with the database system as currently designed. Therefore, the requirement to file quarterly should be removed. The annual form will still be required. There were no interested party comments received for this proposal.

Mr. Hudson made a motion, seconded by Mr. Drutz, to adopt the proposal (Attachment Two-B). The motion passed unanimously.

3. **Deferred Proposals Previously Exposed**

   a. **Agenda Item 2021-11BWG**

Binry Birnbaum (Center for Economic Justice—CEJ) stated that this proposal adds the data capture elements of direct written exposures and direct earned exposures for the personal lines of business of homeowners and private passenger auto (PPA) to the annual and quarterly statements for the Property and Casualty blank. He stated that this proposal was discussed during a meeting of the Casualty Actuarial and Statistical (C) Task Force. The Task Force asked for a revision to line 4 of the annual statement instructions for homeowners to exclude renters, condominiums and co-ops.

Tip Tipton (Thrivent Financial) stated that interested parties recommend that this proposal be rejected and returned to the Casualty Actuarial and Statistical (C) Task Force because this is statistical data and inconsistent with the responsibilities of the
Mr. Garn stated that this proposal modifies lines on the Analysis of Operations by Lines of Business - Accident and Health for request for more time to review and provide additional comments. He stated that there are some modifications to the proposal that were suggested, as well as a Life/Fraternal to capture health-specific data consistent with that of the health blank. He stated that the Casualty Actuarial and Statistical (C) Task Force’s vote of nine to 17 for rejection of the proposal suggests that some state insurance regulators do not see the need for this data within the annual statement. Mr. Tipton stated that interested parties support the Task Force request to determine the reason the statistical report takes two years to accumulate the information and release.

Rachel Underwood (Cincinnati Insurance Companies) stated that it was suggested that this proposal was aimed at getting average premium per exposure for the Casualty Actuarial and Statistical (C) Task Force reports quicker. She stated that, however, the proposal asks for company-level detail and new statistical data that is not found in those reports today. The current reports contain narrative content regarding things such as data sources, limitations, and exclusion of data factors that affect the cost of insurance. She stated that it is unreasonable to think that all the pertinent and relevant data from these two reports should or could be incorporated into the annual statement. Ms. Underwood stated that companies do not have the written exposure counts readily available. The fastest growing personal automobile insurer does not provide exposure counts on a monthly basis, which she states is proprietary information. She stated that there are also issues related to the COVID-19 pandemic where companies gave relief payments. Some states had moratoriums on lapses due to nonpayment of premium.

Derek Freihaut (Pinnacle Actuarial Resources) stated that there should be a clear definition of “exposure.” Comparisons may not be accurate when looking at average premiums related to the various mixes of exposures over time and comparing against different companies. Another concern he expressed is that this is statistical data, which can be difficult to pull over to the financial data and have a true comparison. He suggests that there be additional work performed to develop clear specifications on the data request and better definitions to minimize distortions. If the proposal did move forward, he suggests it be considered for a 2023 annual implementation.

Mr. Vigliaturo, chair of the Casualty Actuarial and Statistical (C) Task Force, stated that the problem is that this information is based on rate service organizations. With that, there are significant delays in obtaining the information and compiling it for the reports. There are at least four organizations to which companies report this data. With the way things are done currently, it is unrealistic to accelerate the production of these reports.

Mr. Birnbaum stated that the information is typically delayed when comparing premiums and losses in that the losses develop over a period of time. He stated that the information does not come from only statistical agents but from several states as well. He stated that there are delays for the time needed to compile the data. Mr. Birnbaum stated that the request for this data is not for rate making but for financial and market analysis purposes. The annual statement is the best mechanism for collecting this type of data. The Casualty Actuarial and Statistical (C) Task Force does not have the same mechanism to collect this data. He stated that he does not agree with the claims that the data would be misleading as it is just the data elements. It would be whatever analysis the user performs that could potentially be misleading.

Jonathan Rodgers (National Association of Mutual Insurance Companies—NAMIC) stated that there is a question as to whether there is a regulatory need for this information and how it will be used for solvency monitoring. He indicated that this proposal should be rejected as state insurance regulators are currently able to obtain this information from statistical agents and within Schedule P of the annual statement filing. He agreed, however, with the re-exposure and referral to the financial analysis groups if this proposal does move forward.

Mr. Hudson made a motion, seconded by Mr. Mathis, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Hudson made a motion, seconded by Mr. Drutz, to re-expose the modified proposal for a 90-day public comment period ending Oct. 22, send a copy of the proposal to the Casualty Actuarial and Statistical (C) Task Force for review, and send a referral to the Financial Analysis (E) Working Group and Financial Analysis Solvency Tools (E) Working Group for comment. The motion passed unanimously.

b. Agenda Item 2021-12BWG

Mr. Garn stated that this proposal modifies lines on the Analysis of Operations by Lines of Business - Accident and Health for Life/Fraternal to capture health-specific data consistent with that of the health blank Analysis of Operations by Lines of Business, as well as adding crosschecks for the new lines. The change allows for more consistent information to be collected with that of the Health blank. He stated that there are some modifications to the proposal that were suggested, as well as a request for more time to review and provide additional comments.
Mr. Hudson made a motion, seconded by Mr. Drutz, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Drutz made a motion, seconded by Mr. Hudson, to defer the modified proposal for a 90-day comment period ending Oct. 22. The motion passed unanimously.

c. Agenda Item 2021-13BWG

Ms. Gosselin stated that this proposal adds a new supplement to capture premium and loss data for annual statement lines 17.1, 17.2 and 17.3 of the Exhibit of Premiums and Losses (State Page) – Other Liability to add more granular lines of business. The purpose is to provide state insurance regulators with greater detail of business reported in the aggregate “other liability” category. She stated that the Casualty Actuarial and Statistical (C) Task Force reviewed this proposal and indicated that it is in favor of the proposal with or without modification. The Casualty Actuarial and Statistical (C) Task Force suggested one modification to change the incurred but not reported (IBNR) to “case reserves” because the IBNR is likely not available at this level of detail. There were four interested party comments related to the proposal, as well as a request by interested parties to have more time to review the proposal and provide additional comments.

Ms. Gosselin made a motion, seconded by Mr. Hudson, to adopt the modifications to the proposal, including the Casualty Actuarial and Statistical (C) Task Force request to change IBNR to “case reserves.” The motion passed unanimously. Ms. Gosselin made a motion, seconded by Mr. Milquet, to defer the modified proposal for a 90-day comment period ending Oct. 22. The motion passed unanimously.

d. Agenda Item 2021-14BWG

Mr. Frederick stated that this proposal expands the number of lines of business reported on Schedule H to match the lines of business reported on the Health Statement. The purpose of the proposal is to bring uniformity in the accident and health (A&H) lines of business used on Schedule H with other schedules and exhibits in the annual statement. Interested parties provided comments asking for additional time to consider the impacts to the Life/Fraternal blank and Property/Casualty blank. He stated that with the effective date of annual 2022, there is time to defer for further consideration if the state insurance regulators want to allow. Mr. Frederick stated that there are minor modifications to the proposal.

Mr. Frederick made a motion, seconded by Mr. Hudson, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Frederick made a motion, seconded by Mr. Eft, to defer the modified proposal for a 90-day comment period ending Oct. 22. The motion passed unanimously.

4. Adopted the Editorial Listing

Mr. Garn stated that there has been a request to make some additional editorial changes related to the Mortgage Guaranty Supplement. Andy Daleo (NAIC) stated that there are three clarifying modifications needed to the Mortgage Guaranty Supplement that the Working Group adopted during its May 26 meeting, proposal 2021-08BWG. He stated that the changes are clarifying in nature for the users. The proposed editorial changes consist of: 1) removing the word “Total” from column 23, which reads “Total net adjusting and other expenses unpaid.” The true “Total” column is column 24 of Part 1A and Part 1B of the exhibit; 2) change the column 32 heading in Part 1A and Part 1B from “Net Loss and LAE Coverage” to “Net Loss and LAE as a % of Original Risk in Force” to clarify the intended reporting; and 3) remove column 33 “Net Reserves” in Part 1A and Part 1B as it requests duplicative information of that shown in column 24 “Total net losses and LAE unpaid.”

Mr. Hudson made a motion, seconded by Ms. Taylor, to adopt the editorial listing, including the additional changes to the Mortgage Guaranty Supplement requested (Attachment Two-C). The motion passed unanimously.

5. Adopted Health Actuarial Statement of Opinion Guidance for the 2021 Reporting Year

Mr. Eft made a motion, seconded by Mr. Hudson, to adopt the Health Actuarial Statement of Opinion guidance for year-end 2021 reporting and approve the posting to the Blanks (E) Working Group website (Attachment Two-D). The motion passed unanimously.

Having no further business, the Blanks (E) Working Group adjourned.
The Blanks (E) Working Group of the Accounting Practices and Procedures (E) Task Force met May 26, 2021. The following Working Group members participated: Jake Garn, Chair (UT); Kim Hudson, Vice Chair (CA); William Arfanis (CT); N. Kevin Brown (DC); Tom Hudson (DE); Virginia Christy (FL); Kevin Clark (IA); Roy Eft (IN); Dan Schaefer (MI); Debbie Doggett (MO); Lindsay Crawford (NE); Patricia Gosselin (NH); Mariam Awad (NJ); Dale Bruggeman and Tracy Snow (OH); Diane Carter (OK); Greg Lathrop (OR); Melissa Greiner and Kimberly Rankin (PA); Trey Hancock (TN); Steve Drutz (WA); Randy Milquet (WI); and Jamie Taylor (WV). Also participating were: Phil Vigliaturo (MN); and Jaakob Sundberg (UT).

1. Adopted its March 16 Minutes

The Working Group met March 16 and took the following action: 1) adopted seven proposals: a) 2020-32BWG, adding a health care receivables supplement to the life/fraternal blank; b) 2020-33BWG, gaining consistency in the annual statement line references; c) 2020-34BWG, adding definitions for consistency with the Property Uniform Product Matrix; d) 2020-35BWG, expanding the line characters in the investment schedules; e) 2020-36BWG, modifying general investment instructions and Schedule DB instructions for publicly traded stock warrant treatment; f) 2020-37BWG, adding a Schedule Y, Part 3 for reporting ownership with greater than 10% capturing the ultimate controlling parties of those owners and other entities that the ultimate controlling party controls; and g) 2020-38BWG, modifying the Accident and Health Policy Experience, including the addition of reinsurance columns, direct premiums written, and net incurred claims; 2) exposed five new proposals with a comment deadline of April 27; 3) adopted its Dec. 16, 2020, minutes; and 4) adopted its editorial listing.

Mr. Hudson made a motion, seconded by Mr. Lathrop, to adopt the Working Group’s March 16 minutes (see NAIC Proceedings – Spring 2021, Accounting Practices and Procedures (E) Task Force, Attachment Two). The motion passed unanimously.

2. Adopted Proposals Previously Exposed

a. Agenda Item 2021-01BWG – Effective Dec. 31, 2021

Mr. Drutz stated that this proposal adds reference to health care receivables to Line 24 – Health Care and Other Amounts Receivable on the Asset Page, changes the description of Line 0699999 to read Other Health Care Receivables on Exhibit 3, and modifies column headers for Exhibit 3A. There were some changes suggested by interested parties that were made to the proposal as modifications. Interested parties also suggested moving the Health Care Receivables instructions paragraph on page 3 of the portable document format (PDF) to the beginning of the “Include” section to be more in alignment with the description of Line 24 – Health Care and Other Amounts Receivable. Mr. Drutz stated that NAIC staff did not make that change, as the line also references “other amounts receivable.”

Mr. Drutz made a motion, seconded by Mr. Hudson, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Drutz made a motion, seconded by Mr. Eft, to adopt the modified proposal (Attachment Two-A1). The motion passed unanimously.

b. Agenda Item 2021-02BWG – Effective Dec. 31, 2021

Mr. Garn stated that this proposal adds questions to the General Interrogatories, Part 1 regarding depository institution holding companies as it pertains to the group capital calculation (GCC). Additionally, the proposal modifies the terminology in the first two questions for consistency with the new questions, considering that many insurers that are part of a depository institution holding company are savings and loan holding companies, which is picked up with the broader terminology compared to the more specific term of bank holding company. There were some minor changes suggested by interested parties, which were fixed in the modifications.

Mr. Hudson made a motion, seconded by Mr. Drutz, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Hudson made a motion, seconded by Mr. Eft, to adopt the modified proposal (Attachment Two-A2). The motion passed unanimously.

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c. **Agenda Item 2021-03BWG – Effective Dec. 31, 2021**

Mr. Bruggeman stated that this agenda item is in response to Statutory Accounting Principles (E) Working Group agenda items #2020-37 and #2020-38, adopted by the Working Group on May 20, regarding pension risk transfer transactions (PRTs) and registered index-linked annuity products (RILAs). These pose some potential risks to the general account. The revisions increase the reporting granularity in the Separate Accounts General Interrogatories, specifically for Interrogatory Questions 1.01, 1.01A, 2.5 and 4.2. Mr. Bruggeman stated that this blanks proposal adds separate and distinct reporting product identifiers for RILAs and PRTs. The instructions to the general interrogatories have been slightly modified to require a disaggregated product identifier for each product represented. Mr. Bruggeman stated that aggregation in reporting can still occur if the products are under the same product filing or policy form; however, to the extent that they are not, it would require disaggregated reporting.

Mr. Bruggeman stated that there are a couple of additional notes: 1) the distinct product identifier requirements have been a long-standing instruction; however, most reporting entities have been grouping or aggregating reporting. This instruction change simply requires further detailed reporting; 2) the blanks proposal also includes instructions so that a company may eliminate proprietary or confidential information, but still require a unique reporting product identifier. This change will be effective for annual 2021 reporting. Mr. Bruggeman stated that no comments were received on this item.

Mr. Bruggeman made a motion, seconded by Ms. Gosselin, to adopt the proposal (Attachment Two-A3). The motion passed unanimously.

d. **Agenda Item 2021-04BWG – Effective Dec. 31, 2021**

Mr. Bruggeman stated that this blanks proposal is related to Statutory Accounting Principles (E) Working Group agenda item #2019-24, which was adopted by the Working Group in March 2021, regarding levelized commission guidance in *Statement of Statutory Accounting Principles (SSAP) No. 71—Policy Acquisition Costs and Commissions.* This proposal was in response to state insurance regulators wanting a more readily available method to identify situations where an insurer utilized a third party to pay commission obligations. The general interrogatory has been written in such a way to not require disclosure if the amounts are settled in full within 90 days, to scope out situations where an insurer uses a third party for typical accounts payable processing. This change will be effective for annual 2021 reporting. Mr. Bruggeman stated that interested parties had minor editorial changes, specifically regarding reference numbers for PDF printing. The proposed edits have been made by NAIC staff.

Mr. Bruggeman made a motion, seconded by Mr. Eft, to adopt the proposal with the friendly amendments (Attachment Two-A4). The motion passed unanimously.

e. **Agenda Item 2021-05BWG – Effective Dec. 31, 2021**

Mr. Bruggeman stated that this blanks proposal is related to Statutory Accounting Principles (E) Working Group agenda item #2021-03, which was derived from the ongoing SSAP No. 43R—Loan-Backed and Structured Securities project. This blanks proposal is primarily to data capture certain existing PDF disclosures required in SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, specifically when a reporting entity has entered into a securitization, asset-backed financing or other similar transfer where a significant economic interest in the transferred asset is retained by the reporting entity.

Mr. Bruggeman stated that the agenda item and its corresponding blanks proposal underwent considerable revisions through collaborative efforts with state insurance regulators, NAIC staff, and interested parties. As a result of these efforts, the Statutory Accounting Principles (E) Working Group exposed an updated agenda item on April 20, which can be seen on the Working Group’s web page. This change will be effective for annual 2021 and quarterly 2022 reporting. Mr. Bruggeman stated that there are two minor edits identified during the comment period, which have been made by blanks support staff.

Mr. Bruggeman made a motion, seconded by Ms. Doggett, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Bruggeman made a motion, seconded by Ms. Doggett, to adopt the modified proposal (Attachment Two-A5). The motion passed unanimously.
f. **Agenda Item 2021-06BWG – Effective Dec. 31, 2021**

Mr. Hudson stated that this proposal adds validations to check the consistency between the long-term care (LTC) Form 5 and Form 1 for Columns 2, 3, 4, 6 and 7 of Form 5. There were no interested party comments.

Mr. Hudson made a motion, seconded by Mr. Lathrop, to adopt the proposal (Attachment Two-A6). The motion passed unanimously.

g. **Agenda Item 2021-07BWG – Effective Dec. 31, 2021**

Mr. Bruggeman stated that this blanks agenda item adds additional line categories to the instruction for Column 26 – Collateral Type on Schedule D, Part 1 to capture collateral type data for all residential mortgage-backed securities (RMBS), commercial mortgage-backed securities (CMBS), and loan-backed and structured securities (LBSS) regardless of reporting category. This change will be effective for annual 2021 reporting. Mr. Bruggeman stated that there were no comments received on this item.

Mr. Bruggeman made a motion, seconded by Ms. Greiner, to adopt the proposal (Attachment Two-A7). The motion passed unanimously.

h. **Agenda Item 2021-08BWG – Effective Dec. 31, 2021**

Kevin Conley (NC), chair of the Mortgage Guaranty Insurance (E) Working Group, stated that this proposal adds a new supplement as the Mortgage Guaranty Insurance Exhibit. This supplement is intended to capture more detailed information from mortgage guaranty insurers, of which there are six in the U.S. The proposed supplement will be primarily used by the domestic regulators of mortgage guaranty insurers. Currently, there is limited data captured on mortgage guaranty insurance within the financial statement. The proposed supplement will provide the means for the state insurance regulators to assess the capital level of the insurer and their overall financial solvency. Mr. Conley stated that this proposal was exposed by the Working Group, and several comments were received by interested parties during the comment period. Those changes have been made and highlighted in the proposal as modifications. There are some minor corrections to be added as a friendly amendment: 1) correct the column reference on the page 6 instructions for Part 1A column 26; 2) the instruction for column 26 should read “Should equal Part 2F, Column 10” not column 9; 3) for the blank, Part 1B, column 25 – Number of delinquencies (direct) should be XXX’d for all lines, as pool business is not reported in Part 2F and would not report in these lines for 1B of this exhibit; 4) for the Part 1 Summary, Parts 1A and 1B, add clarifying instructions indicating that “Number of Claims Closed with Payment (Direct)” should be reported “per claim” and not “per claimant”; and 5) add a question in the Supplemental Exhibits and Schedules Interrogatories for this supplement to appear as the last item under the optional April filings.

Mr. Hudson made a motion, seconded by Mr. Milquet, to adopt the modifications to the proposal, including the friendly amendments. The motion passed unanimously. Mr. Hudson made a motion, seconded by Mr. Milquet, to adopt the modified proposal (Attachment Two-A8). The motion passed unanimously.

i. **Agenda Item 2021-09BWG**

Mr. Garn stated that this proposal adds instructions to Annual Health Statement Blank, Actuarial Opinion, modifying sections 4 (Identification section), section 5 (Scope section), and section 7 (Opinion section). However, some of the aspects of this proposal are still under discussion, so it has been suggested that this proposal be withdrawn and resubmitted once discussions are complete. Mr. Sundberg, co-vice chair of the Health Actuarial (B) Task Force, stated that the Task Force would like to defer the issue until the next annual 2022 filing. He stated that there are clarifications needed to match up the definitions for actuarial assets in the Actuarial Opinion with those of the actuarial standards of practice (ASOPs) definitions. He stated that the Task Force will codify the new language in a proposal for annual 2022. Mr. Hudson stated that since the effective date will be annual 2022, it makes more sense to withdraw this proposal and submit a new proposal when the issue is finalized.

3. **Exposed New Items**

a. **Agenda Item 2021-10BWG**

Mr. Hudson stated that this proposal removes language in quarterly General Interrogatories Part 1, line 4.1 that requires filing of a quarterly merger/history form. The annual form will still be required. Amendment proposal 2017-21BWG added language to the General Interrogatories to require the filing of a merger/history form for annual and quarterly statements. The annual...
form works as intended. It is used for Insurance Regulatory Information System (IRIS) calculations, as well as validations. The quarterly form does not function with the electronic database system as currently designed. Therefore, this proposal is requesting that the requirement to file quarterly be removed.

Hearing no objection from the Working Group, the proposal was exposed for a six-week public comment period ending June 25.

b. Agenda Item 2021-11BWG

Birny Birnbaum (Center for Economic Justice—CEJ) stated that this proposal adds the data capture elements of direct written exposures and direct earned exposures for select personal lines of business, including private flood, homeowners, and private passenger auto (PPA) to the annual and quarterly statements for the Property and Casualty blank. He stated that the state pages of the annual statement and Part 1 and Part 2 of the quarterly statement show earned and written premium by line of business. These data elements allow the state analysts to review changes in premium by line of business from one period to the next and for longer periods of time. By adding written and earned exposures, financial and market analysts will be able to calculate and analyze changes in the number of exposures and the changes in average premium per exposure. Mr. Birnbaum stated that this is useful, not just to better understand changes in premium volume (e.g., is the change a result of increased exposure or higher rates) but also to examine changes in average premium over time. Average premium per policy and exposure is an important metric for state insurance regulators.

Mr. Birnbaum stated that the NAIC publishes two annual reports using these values; i.e., one for PPA and one for residential property insurance. The problem is that these reports are published three years after the beginning of the experience year and two years after the end of the experience year. While these reports contain other valuable data elements than average premium, the premium numbers are not useful because they are so old. The proposal being presented will allow state insurance regulators and interested parties the time to calculate the average premium value for personal lines by state within a few months of the end of the experience year and calculate on a country wide basis using the quarterly data just a few months after the experience quarter.

Mr. Birnbaum stated that the proposal adds a new annual statement supplement to the property/casualty (P/C) annual statement to capture “Direct Exposures Written” and “Direct Exposures Earned.” It adds one column to P/C quarterly statement Part 1 for “Direct Exposures Earned.” It adds one column to P/C quarterly statement Part 2 for “Direct Exposures Written.”

Ralph Blanchard (Travelers) stated that there are concerns with this proposal, and the Casualty Actuarial and Statistical (C) Task Force should provide some feedback on this issue. He stated that private flood is more than just residences; it is also commercial business. He stated that the proposal, as it is currently drafted, needs some changes. The calculation that is described is not an easy task to complete. There are multi-car policies, cars routinely added and removed from policies, as well as mid-term cancellations. The calculation would be a stretch to get a program and utilize it by first quarter 2022. Mr. Blanchard stated that it would be difficult to calculate homeowners accurately, as it includes renters, condos, starter homes and mansions. To add up all of these, makes it questionable as to what information would be reported. Mr. Blanchard suggested that with the calculation and the system programming that would be needed, it would be deferred for implementation until annual 2023 with limitation.

Mr. Birnbaum stated that private flood may be included in commercial, but the identification of the property for the private flood is fairly straightforward. There is still a property to be insured. Mr. Birnbaum stated that the calculation should not be that difficult, as companies do something similar for rating on a routine basis. He stated that he would be happy to work with interested parties to address any issues or concerns.

Tip Tipton (Thrivent Financial) stated that he supports exposure and a concurrent referral to the Casualty Actuarial and Statistical (C) Task Force.

Mr. Vigliaturo, chair of the Casualty Actuarial and Statistical (C) Task Force, stated that the information obtained in this supplement would be of value to the Task Force. It would replace or be an improvement of the information currently published in the dwelling, fire and auto database. The Task Force will receive the referral and provide comment.

Hearing no objection from the Working Group, the proposal was exposed for a six-week public comment period ending June 25.
c. **Agenda Item 2021-12BWG**

Mr. Drutz stated that this proposal adds and deletes lines on the Analysis of Operations by Lines of Business – Accident and Health for Life/Fraternal to capture health specific data captured in the Health Analysis of Operations by Lines of Business but not in the Life/Fraternal Analysis of Operations page. It also adds new crosschecks for the new lines, as well as crosschecks added to the Analysis of Operations by Lines of Business – Summary to map the lines on the accident and health page to the summary.

Hearing no objection from the Working Group, the proposal was exposed for a six-week public comment period ending June 25.

d. **Agenda Item 2021-13BWG**

Ms. Gosselin stated that this proposal adds a new supplement to capture premium and loss data in the Annual Statement Exhibit of Premiums and Losses (State Page) – Other Liability by more granular lines of business. The purpose of this proposal is to provide state insurance regulators with greater detail of the premium and losses of the diverse lines of business reported on Annual Statement Line 17 of the Exhibit of Premiums and Losses (State Page).

Mr. Blanchard stated that this proposal should be referred to the Casualty Actuarial and Statistical (C) Task Force to review the issue of incurred but not reported (IBNR) reserves. IBNR reserves are calculated by actuaries and aggregated. Mr. Blanchard stated that if one other liability line is broken out into 29 separate pieces, the IBNR reserves number loses reliability and meaning. The other issue is that the breakout may not currently be available in companies’ systems. Mr. Vigliaturo, chair of the Task Force, stated that Mr. Blanchard had alerted him to the possibility of a referral of this proposal. He stated that while there is an interest in receiving the additional data referenced in proposal 2021-11BWG, with this proposal, the Task Force does not have any reports that it produces using other liability data. He stated that he does not believe the Task Force would be opposed to this proposed change, but it also has no immediate interest in this data. He stated that at the initial review, he did not see the need for the Task Force to be involved, but he would not object to the Task Force receiving the referral to review the proposal and provide comment.

Hearing no objection from the Working Group, the proposal was exposed for a six-week public comment period ending June 25.

e. **Agenda Item 2021-14BWG**

Mr. Garn stated that this proposal expands the number of lines of business reported on Schedule H to match the lines of business reported on the Health Statement. It modifies the instructions to be uniform between life/fraternal and property. The purpose of the proposal is to bring uniformity in the accident and health lines of business used on Schedule H with other schedules and exhibits in the annual statement.

Hearing no objection from the Working Group, the proposal was exposed for a six-week public comment period ending June 25.

4. **Adopted the Editorial Listing**

Mr. Hudson made a motion, seconded by Mr. Drutz, to adopt the editorial listing (Attachment Two-A9). The motion passed unanimously.

Having no further business, the Blanks (E) Working Group adjourned.
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

DATE: 12/18/2020

FOR NAIC USE ONLY

Agenda Item # 2021-01BWG MOD
Year 2021

Changes to Existing Reporting [ X ]
New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

No Impact [ X ]
Modifies Required Disclosure [ ]

DISPOSITION

[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ X ] Adopted Date 05/26/2021
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify) ____________

BLANK(S) TO WHICH PROPOSAL APPLIES

[ X ] ANNUAL STATEMENT
[ ] QUARTERLY STATEMENT
[ X ] INSTRUCTIONS
[ X ] BLANK

[ X ] Life, Accident & Health/Fratal
[ X ] Property/Casualty
[ X ] Health

[ ] Separate Accounts
[ ] Protected Cell
[ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2021

IDENTIFICATION OF ITEM(S) TO CHANGE

Add reference to health care receivables to Line 24 – Health Care and Other Amounts Receivable on the Asset Page, change description of Line 0699999 to read Other Health Care Receivables on Exhibit 3 and modify column headers for Exhibit 3A.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of the proposal is to add clarifying language to Exhibit 3, Exhibit 3A and Assets page for health care receivables.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

Updates to the Health Care Receivable Guidance would be needed to the headers of Exhibit 3A if the proposal is adopted.

** This section must be completed on all forms. Revised 7/18/2018
ANNUAL STATEMENT INSTRUCTIONS – HEALTH AND LIFE/FRATERNAL (HEALTH CARE RECEIVABLES SUPPLEMENT)

EXHIBIT 3 – HEALTH CARE RECEIVABLES

Individually list the greater of any account balances greater than $10,000 or those that are 10% of gross health care receivables. Use Lines 0100001 through 0699996, as needed. Report gross amounts for insured plans although these amounts may be offset against corresponding liabilities on the balance sheet. Report the aggregate of amounts not individually listed on Lines 0199998 through 0699998. The subtotal and grand total amounts should be reported on the following lines:

<table>
<thead>
<tr>
<th>Category</th>
<th>Line Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmaceutical Rebate Receivables</td>
<td>0199999</td>
</tr>
<tr>
<td>Claim Overpayment Receivables</td>
<td>0299999</td>
</tr>
<tr>
<td>Loans and Advances to Providers</td>
<td>0399999</td>
</tr>
<tr>
<td>Capitation Arrangement Receivables</td>
<td>0499999</td>
</tr>
<tr>
<td>Risk sharing Receivables</td>
<td>0599999</td>
</tr>
<tr>
<td>Other Health Care Receivables</td>
<td>0699999</td>
</tr>
<tr>
<td>Gross Health Care Receivables</td>
<td>0799999</td>
</tr>
</tbody>
</table>

Column 7  –  Admitted

Total line should equal the inset amount on Line 24 of the Asset Page.
ANNUAL & QUARTERLY STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

ASSETS

Detail Eliminated to Conserve Space

Line 24 – Health Care and Other Amounts Receivable

Include:  
Bills Receivable – Report any unsecured amounts due from outside sources or receivables secured by assets that do not qualify as investments.

Amounts due resulting from advances to agents or brokers – Refer to SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers for accounting guidance.

Health Care Receivables – Include pharmaceutical rebate receivables, claim overpayment receivables, loans and advances to providers, capitation arrangement receivables, and risk sharing receivables and other health care receivables from affiliated and non-affiliated entities. Refer to SSAP No. 84—Health Care and Government Insured Plan Receivables for accounting guidance.

Other amounts receivable that originate from the government under government insured plans, including undisputed amounts over 90 days due that qualify as accident and health contracts are admitted assets. Refer to SSAP No. 84—Health Care and Government Insured Plans Receivables and SSAP No. 50—Classifications of Insurance or Managed Care Contracts for accounting guidance.

Exclude:  
Pharmaceutical rebates relating to uninsured plans that represent an administrative fee and that are retained by the reporting entity and earned in excess of the amounts to be remitted to the uninsured plan. These amounts should be reported on Line 17.

Premiums receivable for government insured plans reported on Lines 15.1, 15.2 or 15.3.
### EXHIBIT 3A – ANALYSIS OF HEALTH CARE RECEIVABLES COLLECTED AND ACCRUED

<table>
<thead>
<tr>
<th>Health Care Receivables Collected or Offset During the Year</th>
<th>Health Care Receivables Accrued as of December 31 of Current Year</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pharmaceutical rebate receivables ....................................</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Claim overpayment receivables ........................................</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3. Loans and advances to providers ......................................</td>
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<tr>
<td>4. Capitation arrangement receivables ..................................</td>
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<tr>
<td>5. Risk sharing receivables ................................................</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Other health care receivables ...........................................</td>
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<tr>
<td>7. Totals (Lines 1 through 6)</td>
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</tr>
</tbody>
</table>

Note that the accrued amounts in Columns 3, 4 and 6 are the total health care receivables, not just the admitted portion.
**AIC BLANKS (E) WORKING GROUP**

**Blanks Agenda Item Submission Form**

| CONTACT PERSON: | ____________________________ |
| TELEPHONE: | ____________________________ |
| EMAIL ADDRESS: | ____________________________ |
| ON BEHALF OF: | ____________________________ |
| NAME: | Dan Daveline |
| TITLE: | Staff Support Group Capital Calculation (E) Working Group |
| AFFILIATION: | Staff Support Group Capital Calculation (E) Working Group |
| ADDRESS: | ____________________________ |

| DATE: | 01/28/2020 |

**FOR NAIC USE ONLY**

- **Agenda Item #**: 2021-02BWG MOD
- **Year**: 2021
- **Changes to Existing Reporting**: [X]
- **New Reporting Requirement**: [ ]

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**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**

- **No Impact**: [ ]
- **Modifies Required Disclosure**: [ ]

**DISPOSITION**

- [ ] Rejected For Public Comment
- [ ] Referred To Another NAIC Group
- [ ] Received For Public Comment
- [X] Adopted Date: 05/26/2021
- [ ] Rejected Date
- [ ] Deferred Date
- [ ] Other (Specify)

---

**BLANK(S) TO WHICH PROPOSAL APPLIES**

- [X] ANNUAL STATEMENT
- [X] QUARTERLY STATEMENT
- [X] Life, Accident & Health/Fraternal
- [X] Property/Casualty
- [X] Health

- [ ] INSTRUCTIONS
- [ ] CROSSCHECKS
- [ ] Separate Accounts
- [ ] Protected Cell
- [X] Title
- [ ] Other _______________________

- [X] Health (Life Supplement)

**Anticipated Effective Date**: Annual 2021

---

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Add questions to the General Interrogatories, Part 1 regarding depository institution holding companies as it pertains to the group capital calculation. Additionally, modify the terminology in the first two questions for consistency with the new questions, which has been modified to consider that many insurers that are part of a depository institution holding company are savings and loan holding companies, which is picked up with the broader terminology compared to the more specific term of bank holding company.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

To assist state regulators in identifying depository institution holding companies significantly engaged in insurance activities that would be subject to the Federal Reserve’s Building Block Approach to group capital, thereby prompting the communication necessary to exempt the holding company from the group capital calculation.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: ____________________________

Other Comments:

---

**This section must be completed on all forms.**

Revised 7/18/2018
ANNUAL STATEMENT BLANK – LIFE\FRATERNAL, HEALTH, PROPERTY AND TITLE

GENERAL INTERROGATORIES

8.1 Is the company a subsidiary of a depository institution holding company (DIHC), bank holding company, or a DIHC itself regulated by the Federal Reserve Board? 
[ ] Yes [ ] No

8.2 If response to 8.1 is yes, please identify the name of the DIHC or bank holding company.
____________________________________________________________________________________

8.3 Is the company affiliated with one or more banks, thrifts or securities firms? 
[ ] Yes [ ] No

8.4 If response to 8.3 is yes, please provide the names and locations (city and state of the main office) of any affiliates regulated by a federal regulator.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affiliate Name</td>
<td>Location (City, State)</td>
<td>FRB</td>
<td>OCC</td>
<td>FDIC</td>
<td>SEC</td>
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<tr>
<td>…………………………………</td>
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</table>

8.5 Is the reporting entity a depository institution holding company with significant insurance operations as defined by the Board of Governors of Federal Reserve System or a subsidiary of the reporting entity such company? 
[ ] Yes [ ] No

8.6 If response to 8.5 is no, is the reporting entity a company or subsidiary of a company that has otherwise been made subject to the Federal Reserve Board’s capital rule?
[ ] Yes [ ] No [ ] N/A

9. What is the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit?
____________________________________________________________________________________
____________________________________________________________________________________

Detail Eliminated to Conserve Space
## NAIC BLANKS (E) WORKING GROUP

### Blanks Agenda Item Submission Form

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<td>ON BEHALF OF:</td>
<td></td>
</tr>
<tr>
<td>NAME:</td>
<td>Dale Bruggeman</td>
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<tr>
<td>TITLE:</td>
<td>Chair SAPWG</td>
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<tr>
<td>AFFILIATION:</td>
<td>Ohio Department of Insurance</td>
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<td>ADDRESS:</td>
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**FOR NAIC USE ONLY**

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<td>Changes to Existing Reporting</td>
<td>[ X ]</td>
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<tr>
<td>New Reporting Requirement</td>
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**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**

<table>
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<th>No Impact</th>
<th>[ X ]</th>
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<td>Modifies Required Disclosure</td>
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**DISPOSITION**

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<tr>
<td>Referred To Another NAIC Group</td>
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**BLANK(S) TO WHICH PROPOSAL APPLIES**

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<thead>
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<td>[ X ]</td>
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<tr>
<td>INSTRUCTIONS</td>
<td>[ ]</td>
</tr>
<tr>
<td>CROSSCHECKS</td>
<td>[ ]</td>
</tr>
<tr>
<td>Life, Accident &amp; Health/Fraternal</td>
<td>[ X ]</td>
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<td>Property/Casualty</td>
<td>[ ]</td>
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<td>Health</td>
<td>[ ]</td>
</tr>
<tr>
<td>Separate Accounts</td>
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<tr>
<td>Protected Cell</td>
<td>[ ]</td>
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<tr>
<td>Health (Life Supplement)</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Other (Specify):  

**Anticipated Effective Date:** Annual 2021

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Modify the tables for Interrogatory Questions 1.01, 1.01A, 2.5 and 4.2 in the Separate Accounts General Interrogatories by adding category lines to reflect additional granularity in the reporting on those tables.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of the proposal is to modify select tables on the Separate Accounts General Interrogatories to reflect the increased granularity in the product identifiers per by the Statutory Accounting Principles (E) Working Group agenda item (Ref #2020-37 & Ref #2020-38).

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date:  

Other Comments:

**This section must be completed on all forms.**

Revised 7/18/2018

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### Product Mix

1.01 Identify the product types in the separate account, quantify the assets associated with those products, indicate if there are any guarantees associated with those products, quantify seed money and quantify other fees and expenses due to the general account. For the products (and related assets) that are not registered with the SEC, identify whether the products are considered private placement variable annuity products or private placement life insurance.

**Note:** A distinct disaggregated product identifier shall be used for each product and shall be used consistently throughout the interrogatory. Disaggregation of reporting shall be such that each product filing or policy form is separately identified. For example, if a company has 5 defined separate group annuities, each annuity shall be separately reported. Companies may eliminate proprietary information however such elimination will require the use of unique reporting identifiers.

Additional Required Surplus Amounts is defined as additional or permanent surplus that is required to be retained in the separate account in accordance with state law or regulation. These amounts should not include reinvested separate account investment proceeds that have not been allocated to separate account contract holders.

<table>
<thead>
<tr>
<th>Product Identifier</th>
<th>Separate Account Assets</th>
<th>Guarantees Associated with the Product</th>
<th>Fees and Expenses Due to the General Account</th>
<th>Additional Required Surplus Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Registered with SEC</td>
<td>Not Registered with SEC</td>
<td>Seed Money</td>
<td></td>
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<tr>
<td>1.01A Pension Risk Transfer Group Annuities</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Total Pension Risk Transfer Group Annuities</td>
<td>$</td>
<td>$</td>
<td>$</td>
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<tr>
<td>1.01B All Other Group Annuities</td>
<td>$</td>
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<tr>
<td>Total All Other Group Annuities</td>
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<tr>
<td>1.01C Registered Index Linked Annuities Individual Annuities</td>
<td>$</td>
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<tr>
<td>Total Registered Index Linked Annuities Individual Annuities</td>
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<td>1.01E Life Insurance</td>
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<td>Total Life Insurance</td>
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<td>1.01F Totals</td>
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<td>$</td>
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</table>

**Note:** Additional Required Surplus Amounts is defined as additional or permanent surplus that is required to be retained in the separate account in accordance with state law or regulation. These amounts should not include reinvested separate account investment proceeds that have not been allocated to separate account contract holders.

1.01A For the products (and related assets) that are not registered with the SEC, identify whether the products are considered private placement variable annuity products or private placement life insurance.
### 1.01A Pension Risk Transfer Group Annuities

<p>| | | |</p>
<table>
<thead>
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**Total Pension Risk Transfer Group Annuities**

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### 1.01B All Other Group Annuities

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**Total All Other Group Annuities**

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### 1.01C Registered Index Linked Annuities Individual Annuities

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</table>

**Total Registered Index Linked Annuities Individual Annuities**

<p>| | | |</p>
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</tbody>
</table>

### 1.01D All Other Individual Annuities

<p>| | | |</p>
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<tbody>
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</table>

**Total All Other Individual Annuities**

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<tbody>
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</table>

### 1.01E Life Insurance

<p>| | | |</p>
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</thead>
<tbody>
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</table>

**Total Life Insurance**

<p>| | | |</p>
<table>
<thead>
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<tbody>
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</table>

### 1.01F Totals

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

#### 2.4 To compensate the general account for the risk taken, for any separate account products with general account guarantees, does the separate account remit risk charges to the general account related to separate account guarantees? Yes [ ] No [ ]

#### 2.5 If yes, identify the separate account products with risk charges that are remitted to the general account and whether the risk charge for that product is reviewed and opined upon:

<table>
<thead>
<tr>
<th>Product Identifier with Risk Charges</th>
<th>Risk Charge Reviewed and Opined Upon</th>
<th>Name and Title of Individual Who Provided Opinion on Risk Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5A Pension Risk Transfer Group Annuities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5B All Other Group Annuities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5C Registered Index Linked Annuities Individual Annuities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5D All Other Individual Annuities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5E Life Insurance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.1 Does the reporting entity have separate account assets in which less than 100% of investment proceeds (net of contract fees and assessments) are attributed to a contract holder? (This should identify any situations where there is a ceiling on investment performance results.)

Yes [   ]  No [   ]

4.2 If yes, provide detail on the net investment proceeds that were attributed to the contract holder, transferred to the general account and reinvested within the separate account:

<table>
<thead>
<tr>
<th>Product Identifier</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2A Pension Risk Transfer Group Annuities</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>4.2B All Other Group Annuities</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>4.2C Registered Index Linked Annuities</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>4.2D All Other Individual Annuities</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>4.2E Life Insurance</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Total</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

Detail Eliminated to Conserve Space
### NAIC BLANKS (E) WORKING GROUP

**Blanks Agenda Item Submission Form**

<table>
<thead>
<tr>
<th>DATE:</th>
<th>02/25/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTACT PERSON:</td>
<td></td>
</tr>
<tr>
<td>TELEPHONE:</td>
<td></td>
</tr>
<tr>
<td>EMAIL ADDRESS:</td>
<td></td>
</tr>
<tr>
<td>ON BEHALF OF:</td>
<td></td>
</tr>
<tr>
<td>NAME:</td>
<td>Dale Bruggeman</td>
</tr>
<tr>
<td>TITLE:</td>
<td>Chair SAPWG</td>
</tr>
<tr>
<td>AFFILIATION:</td>
<td>Ohio Department of Insurance</td>
</tr>
<tr>
<td>ADDRESS:</td>
<td>50W. Town St., 3rd Fl., Ste. 300 Columbus, OH 43215</td>
</tr>
</tbody>
</table>

---

**FOR NAIC USE ONLY**

<table>
<thead>
<tr>
<th>Agenda Item #</th>
<th>2021-04BWG MOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>2021</td>
</tr>
<tr>
<td>Changes to Existing Reporting</td>
<td>[ X ]</td>
</tr>
<tr>
<td>New Reporting Requirement</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**

<table>
<thead>
<tr>
<th>No Impact</th>
<th>[ X ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modifies Required Disclosure</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

**DISPOSITION**

| Rejected For Public Comment | [ ] |
| Referred To Another NAIC Group | [ ] |
| Received For Public Comment | [ ] |
| Adopted Date | 05/26/2021 |
| Rejected Date | [ ] |
| Deferred Date | [ ] |
| Other (Specify) | [ ] |

---

**BLANK(S) TO WHICH PROPOSAL APPLIES**

| [ X ] ANNUAL STATEMENT | [ X ] INSTRUCTIONS | [ ] CROSSCHECKS |
| [ ] QUARTERLY STATEMENT | [ X ] BLANK | [ ] |

- [ X ] Life, Accident & Health/Fraternal
- [ X ] Property/Casualty
- [ X ] Health
- [ X ] Health (Life Supplement)
- [ ] Separate Accounts
- [ ] Protected Cell
- [ X ] Title
- [ ] Other ________________

Anticipated Effective Date: **Annual 2021**

---

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Add interrogatory questions 24.1 and 24.2 to the General Interrogatories, Part 1 and renumber those below them. Renumber the questions and question references in the General Interrogatories, Part 1 to match the renumbering on the blank page.

---

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

During the Statutory Accounting Principles (E) Working Group’s ongoing discussion of agenda item #2019-24: Levelized and Persistency Commissions, regulators expressed the desire for a GI to identify certain scenarios in which an insurer utilizes third parties to pay commission expenses.

---

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: ________________________________

Other Comments:

---

**This section must be completed on all forms.**

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ANNUAL STATEMENT BLANK – LIFE\FRATERNAL, HEALTH, PROPERTY AND TITLE

GENERAL INTERROGATORIES

Detail Eliminated to Conserve Space

FINANCIAL

Detail Eliminated to Conserve Space

23.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? Yes [ ] No [ ]
23.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: $ ____________________

24.1 Does the insurer utilize third parties to pay agent commissions in which the amounts advanced by the third parties are not settled in full within 90 days? Yes [ ] No [ ]
24.2 If the response to 24.1 is yes, identify the third-party that pays the agents and whether they are a related party.

<table>
<thead>
<tr>
<th>Name of Third-Party</th>
<th>Is the Third-Party Agent a Related Party (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INVESTMENT

2425.01 Were all the stocks, bonds and other securities owned December 31 of current year, over which the reporting entity has exclusive control, in the actual possession of the reporting entity on said date? (other than securities lending programs addressed in 2425.03) Yes [ ] No [ ]
2425.02 If no, give full and complete information, relating thereto:......................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................
2425.03 For securities lending programs, provide a description of the program including value for collateral and amount of loaned securities, and whether collateral is carried on or off-balance sheet. (an alternative is to reference Note 17 where this information is also provided)

2425.04 For the reporting entity’s securities lending program, report amount of collateral for conforming programs as outlined in the Risk-Based Capital Instructions. $ ____________________
2425.05 For the reporting entity’s securities lending program, report amount of collateral for other programs. $ ____________________
2425.06 Does your securities lending program require 102% (domestic securities) and 105% (foreign securities) from the counterparty at the outset of the contract? Yes [ ] No [ ] N/A [ ]
2425.07 Does the reporting entity non-admit when the collateral received from the counterparty falls below 100%? Yes [ ] No [ ] N/A [ ]
2425.08 Does the reporting entity or the reporting entity’s securities lending agent utilize the Master Securities Lending Agreement (MSLA) to conduct securities lending? Yes [ ] No [ ] N/A [ ]
GENERAL INTERROGATORIES

2425.09 For the reporting entity’s securities lending program, state the amount of the following as of December 31 of the current year:

2425.091 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2

$ ______________________

2425.092 Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2

$ ______________________

2425.093 Total payable for securities lending reported on the liability page

$ ______________________

2426.1 Were any of the stocks, bonds or other assets of the reporting entity owned at December 31 of the current year not exclusively under the control of the reporting entity or has the reporting entity sold or transferred any assets subject to a put option contract that is currently in force? (Exclude securities subject to Interrogatory 2422.09). Yes [ ] No [ ]

2426.2 If yes, state the amount thereof at December 31 of the current year:

2426.21 Subject to repurchase agreements

$ ______________________

2426.22 Subject to reverse repurchase agreements

$ ______________________

2426.23 Subject to dollar repurchase agreements

$ ______________________

2426.24 Subject to dollar reverse repurchase agreements

$ ______________________

2426.25 Placed under option agreements

$ ______________________

2426.26 Letter stock or securities restricted as to sale – excluding FHLB Capital Stock

$ ______________________

2426.27 FHLB Capital Stock

$ ______________________

2426.28 On deposit with states

$ ______________________

2426.29 On deposit with other regulatory bodies

$ ______________________

2426.30 Pledged as collateral – excluding collateral pledged to an FHLB

$ ______________________

2426.31 Pledged as collateral to FHLB – including assets backing funding agreements

$ ______________________

2426.32 Other

$ ______________________

2526.3 For category (2426.26) provide the following:

<table>
<thead>
<tr>
<th>1</th>
<th>Nature of Restriction</th>
<th>2</th>
<th>Description</th>
<th>3</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2427.1 Does the reporting entity have any hedging transactions reported on Schedule DB?

Yes [ ] No [ ]

2427.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state?

Yes [ ] No [ ] N/A [ ]

If no, attach a description with this statement.

LINES 2427.3 through 2427.5: FOR LIFE/FRATERNAL REPORTING ENTITIES ONLY:

2427.3 Does the reporting entity utilize derivatives to hedge variable annuity guarantees subject to fluctuations as a result of interest rate changes?

Yes [ ] No [ ]

If the response to 2427.3 is YES, does the reporting entity utilize:

2427.4 Special accounting provision of SSAP No. 108

Yes [ ] No [ ]

2427.5 Permitted accounting practice

Yes [ ] No [ ]

2427.6 Other accounting guidance

Yes [ ] No [ ]

2427.5 By responding YES to 2427.4 regarding utilizing the special accounting provisions of SSAP No. 108, the reporting entity attests to the following:

- The reporting entity has obtained explicit approval from the domiciliary state.
- Hedging strategy subject to the special accounting provisions is consistent with the requirements of VM-21.
- Actuarial certification has been obtained which indicates that the hedging strategy is incorporated within the establishment of VM-21 reserves and provides the impact of the hedging strategy within the Actuarial Guideline Conditional Tail Expectation Amount.
- Financial Officer Certification has been obtained which indicates that the hedging strategy meets the definition of a Clearly Defined Hedging Strategy within VM-21 and that the Clearly Defined Hedging Strategy is the hedging strategy being used by the company in its actual day-to-day risk mitigation efforts.

2428.1 Were any preferred stocks or bonds owned as of December 31 of the current year mandatorily convertible into equity, or, at the option of the issuer, convertible into equity?

Yes [ ] No [ ]

2428.2 If yes, state the amount thereof at December 31 of the current year.

$ ______________________

2429. Excluding items in Schedule E– Part 3 – Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity’s offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III – General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook?

Yes [ ] No [ ]

2429.01 For agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

<table>
<thead>
<tr>
<th>1</th>
<th>Name of Custodian(s)</th>
<th>2</th>
<th>Custodian’s Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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GENERAL INTERROGATORIES

2829.02 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Name(s)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Location(s)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Complete Explanation(s)</td>
<td></td>
</tr>
</tbody>
</table>

2829.03 Have there been any changes, including name changes, in the custodian(s) identified in 2829.01 during the current year? Yes [ ] No [ ]

2829.04 If yes, give full and complete information relating thereto:

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Old Custodian</td>
<td>2</td>
<td>New Custodian</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Date of Change</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Reason</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2829.05 Investment management – Identify all investment advisors, investment managers, broker/dealers, including individuals that have the authority to make investment decisions on behalf of the reporting entity. For assets that are managed internally by employees of the reporting entity, note as such. [“…that have access to the investment accounts”; “…handle securities”]

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Name of Firm or Individual</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Affiliation</td>
</tr>
</tbody>
</table>

2829.0597 For those firms/individuals listed in the table for Question 2829.05, do any firms/individuals unaffiliated with the reporting entity (i.e., designated with a “U”) manage more than 10% of the reporting entity’s invested assets? Yes [ ] No [ ]

2829.0598 For firms/individuals unaffiliated with the reporting entity (i.e., designated with a “U”) listed in the table for Question 2829.05, does the total assets under management aggregate to more than 50% of the reporting entity’s invested assets? Yes [ ] No [ ]

2829.06 For those firms or individuals listed in the table for 2829.05 with an affiliation code of “A” (affiliated) or “U” (unaffiliated), provide the information for the table below.

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Central Registration Depository Number</td>
<td>2</td>
<td>Name of Firm or Individual</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Registered With</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Investment Management Agreement (IMA) Filed</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2930.1 Does the reporting entity have any diversified mutual funds reported in Schedule D – Part 2 (diversified according to the Securities and Exchange Commission (SEC) in the Investment Company Act of 1940 [Section 5 (b) (1)])? Yes [ ] No [ ]

2930.2 If yes, complete the following schedule:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CUSIP #</td>
</tr>
<tr>
<td>2</td>
<td>Name of Mutual Fund</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Book/Adjusted Carrying Value</td>
</tr>
</tbody>
</table>

2930.2999 TOTAL

2930.3 For each mutual fund listed in the table above, complete the following schedule:

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Name of Mutual Fund (from above table)</td>
<td>2</td>
<td>Name of Significant Holding of the Mutual Fund</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Amount of Mutual Fund’s Book/Adjusted Carrying Value Attributable to the Holding</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Date of Valuation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### GENERAL INTERROGATORIES

#### 3031.1
Provide the following information for all short-term and long-term bonds and all preferred stocks. Do not substitute amortized value or statement value for fair value.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statement (Admitted Value)</td>
<td>Fair Value</td>
<td>Excess of Statement over Fair Value (–), or Fair Value over Statement (+)</td>
<td></td>
</tr>
<tr>
<td>Bonds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred Stocks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 3031.4
Describe the sources or methods utilized in determining the fair values:

- ............................................................................................................................
- ............................................................................................................................
- ............................................................................................................................

#### 3132.1
Was the rate used to calculate fair value determined by a broker or custodian for any of the securities in Schedule D?

- Yes [ ] No [ ]

#### 3132.2
If the answer to 3132.1 is yes, does the reporting entity have a copy of the broker’s or custodian’s pricing policy (hard copy or electronic copy) for all brokers or custodians used as a pricing source?

- Yes [ ] No [ ]

#### 3132.3
If the answer to 3132.2 is no, describe the reporting entity’s process for determining a reliable pricing source for purposes of disclosure of fair value for Schedule D:

- ............................................................................................................................
- ............................................................................................................................
- ............................................................................................................................

#### 3233.1
Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed?

- Yes [ ] No [ ]

#### 3233.2
If no, list exceptions:

- ............................................................................................................................
- ............................................................................................................................

#### 3334
By self-designating 5GI securities, the reporting entity is certifying the following elements of each self-designated 5GI security:

- a. Documentation necessary to permit a full credit analysis of the security does not exist or an NAIC CRP credit rating for an FE or PL security is not available.
- b. Issuer or obligor is current on all contracted interest and principal payments.
- c. The insurer has an actual expectation of ultimate payment of all contracted interest and principal.

Has the reporting entity self-designated 5GI securities?

- Yes [ ] No [ ]

#### 3435
By self-designating PLGI securities, the reporting entity is certifying the following elements of each self-designated PLGI security:

- a. The security was purchased prior to January 1, 2018.
- b. The reporting entity is holding capital commensurate with the NAIC Designation reported for the security.
- c. The NAIC Designation was derived from the credit rating assigned by an NAIC CRP in its legal capacity as an NRSRO which is shown on a current private letter rating held by the insurer and available for examination by state insurance regulators.
- d. The reporting entity is not permitted to share this credit rating of the PL security with the SVO.

Has the reporting entity self-designated PLGI securities?

- Yes [ ] No [ ]

#### 3436
By assigning FE to a Schedule BA non-registered private fund, the reporting entity is certifying the following elements of each self-designated FE fund:

- a. The shares were purchased prior to January 1, 2019.
- b. The reporting entity is holding capital commensurate with the NAIC Designation reported for the security.
- c. The security had a public credit rating(s) with annual surveillance assigned by an NAIC CRP in its legal capacity as an NRSRO prior to January 1, 2019.
- d. The fund only or predominantly holds bonds in its portfolio.
- e. The current reported NAIC Designation was derived from the public credit rating(s) with annual surveillance assigned by an NAIC CRP in its legal capacity as an NRSRO.
- f. The public credit rating(s) with annual surveillance assigned by an NAIC CRP has not lapsed.

Has the reporting entity assigned FE to Schedule BA non-registered private funds that complied with the above criteria?

- Yes [ ] No [ ]

#### 3437
By rolling/renewing short-term or cash equivalent investments with continued reporting on Schedule DA, Part 1 or Schedule E, Part 2 (identified through a code (%) in those investment schedules), the reporting entity is certifying to the following:

- a. The investment is a liquid asset that can be terminated by the reporting entity on the current maturity date.
- b. If the investment is with a nonrelated party or nonaffiliate, then it reflects an arms-length transaction with renewal completed at the discretion of all involved parties.
- c. If the investment is with a related party or affiliate, then the reporting entity has completed robust re-underwriting of the transaction for which documentation is available for regulator review.
- d. Short-term and cash equivalent investments that have been renewed/rolled from the prior period that do not meet the criteria in 3437 and 3437.c are reported as long-term investments.

Has the reporting entity rolled/renewed short-term or cash equivalent investments in accordance with these criteria?

- Yes [ ] No [ ] N/A [ ]
### GENERAL INTERROGATORIES

#### OTHER

<table>
<thead>
<tr>
<th>1</th>
<th>Name</th>
<th>2</th>
<th>Amount Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **Amount of payments to trade associations, service organizations and statistical or rating bureaus, if any?**

   $ ____________________

2. **List the name of the organization and the amount paid if any such payment represented 25% or more of the total payments to trade associations, service organizations, and statistical or rating bureaus during the period covered by this statement.**

<table>
<thead>
<tr>
<th>1</th>
<th>Name</th>
<th>2</th>
<th>Amount Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

---

1. **Amount of payments for legal expenses, if any?**

   $ ____________________

2. **List the name of the firm and the amount paid if any such payment represented 25% or more of the total payments for legal expenses during the period covered by this statement.**

<table>
<thead>
<tr>
<th>1</th>
<th>Name</th>
<th>2</th>
<th>Amount Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

1. **Amount of payments for expenditures in connection with matters before legislative bodies, officers, or departments of government, if any?**

   $ ____________________

2. **List the name of the firm and the amount paid if any such payment represented 25% or more of the total payment expenditures in connection with matters before legislative bodies, officers, or departments of government during the period covered by this statement.**

<table>
<thead>
<tr>
<th>1</th>
<th>Name</th>
<th>2</th>
<th>Amount Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ANNUAL STATEMENT INSTRUCTIONS – LIFE\FRATERNAL, HEALTH, PROPERTY AND TITLE

GENERAL INTERROGATORIES

PART 1 – COMMON INTERROGATORIES

Detail Eliminated to Conserve Space

FINANCIAL

Detail Eliminated to Conserve Space

INVESTMENT

2425. For the purposes of this interrogatory, “exclusive control” means that the company has the exclusive right to dispose of the investment at will, without the necessity of making a substitution thereof. For purposes of this interrogatory, securities in transit and awaiting collection, held by a custodian pursuant to a custody arrangement or securities issued subject to a book entry system are considered to be in actual possession of the company.

If bonds, stocks and other securities owned December 31 of the current year, over which the company has exclusive control are: (1) securities purchased for delayed settlement, or (2) loaned to others, the company should respond “NO” to 2425.01 and “YES” to 2526.1.

2425.03 Describe the company’s securities lending program, including value for collateral and amount of loaned securities, and whether the collateral is held on- or off-balance sheet. Note 17 of Notes to Financial Statement provides a full description of the program.

2425.04 Report amount of collateral for conforming programs as outlined in the Risk-Based Capital Instructions.

2425.05 Report amount of collateral for other programs.

2425.091 The fair value amount reported should equal the grand total of Schedule DL, Part 1, Column 5 plus Schedule DL, Part 2, Column 5.

The fair value amount reported amount should also equal the fair value amount reported in Note 5E(5)a1(m).

2425.092 The book adjusted/carrying value amount reported should equal the grand total of Schedule DL, Part 1, Column 6 plus Schedule DL, Part 2, Column 6.

2425.093 The payable for securities lending amount reported should equal current year column for payable for securities lending line on the liability page.

2526. Disclose the statement value of investments that are not under the exclusive control of the reporting entity within the categories listed in 2526.2.
2828. The purpose for this General Interrogatory is to capture the statement value for securities reported in Schedule D, Part 1, Bonds or Schedule D, Part 2, Section 1, Preferred Stock that are mandatorily convertible into equity, or at the option of the issuer, are convertible into equity. This disclosure will facilitate the application of the equity factors to the statement value of such securities for purposes of RBC.

2829. The question, regarding whether items are held in accordance with the Financial Condition Examiners Handbook, must be answered.

2829.01 If the answer to 2829 is “YES,” then list all of the agreements in 2829.01. If the answer is “NO,” but one or more of the agreements do comply with the Financial Condition Examiners Handbook, then list the agreements that do comply in 2829.01.

2829.02 If the answer to 2829 is “NO,” then list all agreements that do not comply with the Financial Condition Examiners Handbook. Provide a complete explanation of why each custodial agreement does not include the characteristics outlined in the Financial Condition Examiners Handbook (Section 1 (III) (F), Outsourcing of Critical Functions, Custodial or Safekeeping Agreements), available at the NAIC website:

www.naic.org/documents/committees_e_examover_fehtg_custodial_or_safekeeping_agreements.doc

2829.03 This question, regarding changes in custodian, must be answered.

2829.04 If the answer to 2829.03 is “YES,” list the change(s).

2829.05 Identify all investment advisors, investment managers and broker/dealers, including individuals who have the authority to make investment decisions on behalf of the reporting entity. For assets that are managed internally by employees of the reporting entity, note as such.

Name of Firm or Individual:

Should be name of firm or individual that is party to the Investment Management Agreement

Affiliation:

Note if firm or individual is affiliated, unaffiliated or an employee by using the following codes:

A Investment management is handled by firms/individuals affiliated with the reporting entity.

U Investment management is handled by firms/individuals unaffiliated with the reporting entity.

I Investment management is handled internally by individuals that are employees of the reporting entity.

2829.0597 If the total assets under management of any the firms/individuals unaffiliated with the reporting entity (i.e., designated with a “U”) listed in the table for Question 2829.05 are greater than 10% of the reporting entity’s invested assets (Line 12 of the Asset page), answer “YES” to Question 2829.0597.

2829.0598 If the total assets under management of all the firms/individuals unaffiliated with the reporting entity (i.e., designated with a “U”) listed in the table for Question 2829.05 are greater than 50% of the reporting entity’s invested assets (Line 12 of the Asset page), answer “YES” to Question 2829.0598. When determining the aggregate total of assets under management, include all firms/individuals unaffiliated with the reporting entity not just those who manage more than 10% of the reporting entity’s assets.
For assets managed by an affiliated or unaffiliated firm or individual, provide for each firm or individual the Central Registration Depository Number, Legal Entity Identifier (LEI), who they are registered with and if an Investment Management Agreement has been filed for each firm or individual.

**Name of Firm or Individual:**

Should be name of firm or individual provided for 2829.05

**Central Registration Depository Number**

The Central Registration Depository (CRD) number is a number issued by the Financial Industry Regulatory Authority (FINRA) to brokers, dealers or individuals when licensed, and can be verified against their database [www.finra.org](http://www.finra.org). These brokers, dealers or individuals would be those contracted to manage some of the reporting entity’s investments or funds and invest them for the reporting entity. The brokers, dealers or individuals can be affiliated or unaffiliated with the reporting entity. The reporting entity must list all brokers, dealers or individuals who have the authority to make investments on behalf of the reporting entity.

**Legal Entity Identifier (LEI)**

Provide the 20-character Legal Entity Identifier (LEI) for issuer as assigned by a designated Local Operating Unit. If no LEI number has been assigned, leave blank.

**Registered With:**

If a Registered Investment Advisor, specify if registered with Securities Exchange Commission or state securities authority. Note if not a Registered Investment Advisor.

**Investment Management Agreement (IMA) Filed:**

Indicate if a current Investment Management Agreement (IMA) has been filed with the state of domicile or the insurance department in another state(s). Use one of the codes below to indicate if the IMA has been filed and with whom it was filed.

- **DS** If the current IMA has been filed with the state of domicile regardless if it was also filed with another state.
- **OS** If the current IMA has been filed with a state(s) other than the state of domicile but not the state of domicile
- **NO** If the current IMA has not been filed with any state

This interrogatory is applicable to Property/Casualty and Health entities only.

The diversified mutual funds (diversified according to the U.S. Securities and Exchange Commission (SEC) in the Investment Company Act of 1940 [Section 5(b)(1)]) that are excluded from the Asset Concentration Factor section of the risk-based capital filing are to be disclosed in this interrogatory.

“Significant Holding” means the top five largest holdings of the mutual fund. For each diversified mutual fund disclosed in Interrogatory 2930.2, the top largest holdings of the mutual fund must be disclosed in this interrogatory.

The “Amount of Mutual Fund’s Book/Adjusted Carrying Value Attributable to the Holding” should be based upon the fund’s latest available valuation as of year-end (e.g., fiscal year-end or latest periodic valuation available prior to year-end).
The “Date of Valuation” should be the date of the valuation amount provided in the Amount of Mutual Fund’s Book/Adjusted Carrying Value Attributable to the Holding column.

3031. Include bonds reported as cash equivalents in Schedule E, Part 2.

3233. This interrogatory applies to any investment required to be filed with the SVO (or that would have been required if not exempted in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*), whether in the general account or separate accounts.

The existence of Z securities does not mean that a reporting entity is not complying with the procedures. As long as the entity has filed its Z securities with the SVO within 120 days of purchase, compliance with the procedures has been met. If an entity wishes to provide the counts of Z securities, include those counts in the explanation lines. An explanation is only expected if the answer to the compliance question is NO.

**OTHER**

3338. The purpose of this General Interrogatory is to capture information about payments to any trade association, service organization, and statistical or rating bureau. A “service organization” is defined as every person, partnership, association or corporation that formulates rules, establishes standards, or assists in the making of rates or standards for the information or benefit of insurers or rating organizations.

3839. The purpose of this General Interrogatory is to capture information about legal expenses paid during the year. These expenses include all fees or retainers for legal services or expenses, including those in connection with matters before administrative or legislative bodies. It excludes salaries and expenses of company personnel, legal expenses in connection with investigation, litigation and settlement of policy claims, and legal fees associated with real estate transactions, including mortgage loans on real estate. Do not include amounts reported in General Interrogatories No. 32-38 and No. 3940.

3940. The purpose of this General Interrogatory is to capture information about expenditures in connection with matters before legislative bodies, officers or departments of government paid during the year. These expenses are related to general legislative lobbying and direct lobbying of pending and proposed statutes or regulations before legislative bodies and/or officers or departments of government. Do not include amounts reported in General Interrogatories No. 32-38 and No. 3839.
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

<table>
<thead>
<tr>
<th>FOR NAIC USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE: 02/25/2021</td>
</tr>
<tr>
<td>CONTACT PERSON:</td>
</tr>
<tr>
<td>TELEPHONE:</td>
</tr>
<tr>
<td>EMAIL ADDRESS:</td>
</tr>
<tr>
<td>ON BEHALF OF:</td>
</tr>
<tr>
<td>NAME: Dale Bruggeman</td>
</tr>
<tr>
<td>TITLE: Chair SAPWG</td>
</tr>
<tr>
<td>AFFILIATION: Ohio Department of Insurance</td>
</tr>
<tr>
<td>ADDRESS: 50W. Town St., 3rd Fl., Ste. 300 Columbus, OH 43215</td>
</tr>
<tr>
<td>Year: 2021</td>
</tr>
<tr>
<td>Changes to Existing Reporting: [X]</td>
</tr>
<tr>
<td>New Reporting Requirement: [ ]</td>
</tr>
<tr>
<td>REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT</td>
</tr>
<tr>
<td>No Impact: [X]</td>
</tr>
<tr>
<td>Modifies Required Disclosure: [ ]</td>
</tr>
<tr>
<td>DISPOSITION</td>
</tr>
<tr>
<td>[ ] Rejected For Public Comment</td>
</tr>
<tr>
<td>[ ] Referred To Another NAIC Group</td>
</tr>
<tr>
<td>[ ] Received For Public Comment</td>
</tr>
<tr>
<td>[X] Adopted Date: 05/26/2021</td>
</tr>
<tr>
<td>[ ] Rejected Date:</td>
</tr>
<tr>
<td>[ ] Deferred Date:</td>
</tr>
<tr>
<td>[ ] Other (Specify):</td>
</tr>
<tr>
<td>BLANK(S) TO WHICH PROPOSAL APPLIES</td>
</tr>
<tr>
<td>[X] ANNUAL STATEMENT</td>
</tr>
<tr>
<td>[ ] QUARTERLY STATEMENT</td>
</tr>
<tr>
<td>[X] INSTRUCTIONS</td>
</tr>
<tr>
<td>[X] CROSSCHECKS</td>
</tr>
<tr>
<td>[ ] Life, Accident &amp; Health/ Fraternal</td>
</tr>
<tr>
<td>[X] Property/Casualty</td>
</tr>
<tr>
<td>[X] Health</td>
</tr>
<tr>
<td>[ ] Separate Accounts</td>
</tr>
<tr>
<td>[ ] Protected Cell</td>
</tr>
<tr>
<td>[ ] Health (Life Supplement)</td>
</tr>
<tr>
<td>Anticipated Effective Date: Annual 2021</td>
</tr>
<tr>
<td>IDENTIFICATION OF ITEM(S) TO CHANGE</td>
</tr>
<tr>
<td>Modify the instructions for Note 17B(4)b1(a) and add a table to the illustrations to data capture some aspects of the disclosure.</td>
</tr>
<tr>
<td>REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**</td>
</tr>
<tr>
<td>The purpose of the proposal is to modify the disclosure in Note 17 – Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities to reflect disclosure changes per by the Statutory Accounting Principles (E) Working Group agenda item (Ref #2021-03).</td>
</tr>
<tr>
<td>NAIC STAFF COMMENTS</td>
</tr>
<tr>
<td>Comment on Effective Reporting Date:</td>
</tr>
<tr>
<td>Other Comments:</td>
</tr>
</tbody>
</table>

** This section must be completed on all forms. Revised 7/18/2018

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17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

Instruction:

B. Transfer and Servicing of Financial Assets

For securitizations, asset-backed financing arrangements and similar transfers accounted for as sales when the transferor has continuing involvement (as defined in the glossary of the Accounting Practices and Procedures Manual) with the transferred financial assets:

b. For each statement of financial position presented, regardless of when the transfer occurred:

1. Qualitative and quantitative information about the transferor’s continuing involvement with transferred financial assets that provides financial statement users with sufficient information to assess the reasons for the continuing involvement and the risks related to the transferred financial assets to which the transferor continues to be exposed after the transfer and the extent that the transferor’s risk profile has changed as a result of the transfer (including, but not limited to, credit risk, interest rate risk and other risks), including:

   a. The total original principal amount outstanding (BACV), the amount that has been derecognized and the outstanding amount that continues to be recognized in the statement of financial position. The amount recognized (allocated fair value) by the reporting entity for the acquired participation in the transferred assets. The reporting schedules of both the transferred and reacquired assets. The percentage of beneficial interests from the reporting entity’s transferred assets acquired by affiliated entities. The percentage of original principal held in the company group and the percentage of derecognized principal held by related parties.

The purpose of the table illustrated below is to provide for data capture of certain disclosures required in SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, paragraph 28g. As detailed in paragraph 28.g.ii, disclosure is required for each statement of financial position presented, regardless of when the transfer occurred. Determination of continuing involvement shall be applied in accordance with the definition reflected in SSAP No. 103R, Appendix A.
Columns requesting information that results in a null result (i.e., if column 5 results in a zero balance as 100% of the asset was transferred), shall indicate zero (0). In the event a column is not applicable, (i.e., if affiliated entities did not acquire an interest in the transferred asset), the column shall be referenced as zero (0).

In circumstances where an entity has multiple assets associated with a sale (i.e., several limited partnerships are sold as a single transaction), the assets should be aggregated and reported as a single transaction.

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Identification of Transaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification of each material transaction. Identification should be consistent across reporting periods so that the circumstances for each item are adequately associated with the applicable transaction.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 2</th>
<th>BACV Prior to Transfer</th>
</tr>
</thead>
<tbody>
<tr>
<td>The aggregate book value, at the time of transfer, of all assets associated with the transaction.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 3</th>
<th>Original Reporting Schedule of the Transferred Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>The investment schedule(s) in which the transferred assets were reported, immediately prior to the transfer. If the transferred assets were reported on multiple schedules, all reporting schedules shall be identified. (For example, input BA-1 for Schedule BA-Part 1)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 4</th>
<th>Amount Derecognized from Sale Transaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>The aggregate book value derecognized from the investment schedules as a result of the transfer. If the assets were transferred in their entirety, Column 4 will equal Column 2.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 5</th>
<th>Amount That Continues to be Recognized in the Statement of Financial Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>The amount that continues to be recognized in the statement of financial position. This should equal Column 2 less Column 4.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 6</th>
<th>BACV of Acquired Interests in Transferred Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>The original BACV reported for acquired beneficial interests (or any other interest) in the previously transferred asset. (BACV for these transactions is often the allocated fair value associated with the transaction.)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 7</th>
<th>Reporting Schedule of Acquired Interests</th>
</tr>
</thead>
<tbody>
<tr>
<td>The reporting schedule of the acquired beneficial interest reported in Column 6. (For example, input D-1 for Schedule D, Part 1)</td>
<td></td>
</tr>
</tbody>
</table>
(b) The terms of any arrangements that could require the transferor to provide financial support (for example, liquidity arrangements and obligations to purchase assets) to the transferee or its beneficial interest holders, including a description of any events or circumstances that could expose the transferor to loss and the amount of the maximum exposure to loss.

## Illustration:

### A. Transfers of Receivables Reported as Sales

1. During 20___ the company sold $_______ of agent balances without recourse to the ABC Company.

2. The company realized a loss of $_______ as a result of the sale.

### B. Transfer and Servicing of Financial Assets

<table>
<thead>
<tr>
<th>Identification of Transaction</th>
<th>BACV at Time of Transfer</th>
<th>Original Reporting Schedule of the Transferred Assets</th>
<th>Amount Derecognized from Sale Transaction</th>
<th>Amount that continues to be recognized in the statement of financial position (Col. 2 minus 4)</th>
<th>BACV of acquired interests in transferred assets</th>
<th>Reporting Schedule of Acquired Interests</th>
<th>Percentage of interests of a reporting entity’s transferred assets acquired by affiliated entities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Identification of Transaction</th>
<th>Original Principal</th>
<th>Total Principal handovers to the company group (Column 3 + Column 4)</th>
<th>Amount Derecognized</th>
<th>Total derecognized handovers to related parties</th>
<th>Reconciliation of amount and movement in the statement of financial position</th>
<th>Net cashflows</th>
<th>E/loss of proceeds</th>
<th>Gain/loss on sale of transferred assets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

### C. Wash Sales

1. In the course of the company’s asset management, securities are sold and reacquired within 30 days of the sale date to enhance the company’s yield on its investment portfolio.
The details by NAIC designation 3 or below, or unrated of securities sold during the year ended December 31, 20___ and reacquired within 30 days of the sale date are:

<table>
<thead>
<tr>
<th>Description</th>
<th>NAIC Designation</th>
<th>Number of Transactions</th>
<th>Book Value of Securities Sold</th>
<th>Cost of Securities Repurchased</th>
<th>Gain (Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>$</td>
</tr>
</tbody>
</table>

Note: Examples of values for the Description Column are Bonds, Preferred Stocks, Common Stocks, etc.

The NAIC Designation Column should indicate 3 through 6 for those transactions for securities that would have been reported with an NAIC Designation if still owned at the end of the reporting period (e.g., bonds and preferred stocks).

For those transactions for securities that would not have been reported with an NAIC Designation if still owned at the end of the reporting period (e.g., real estate mortgage loans and common stocks), leave the column blank.

Detail Eliminated to Conserve Space
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

| CONTACT PERSON: | ___________________________ |
| TELEPHONE: | ___________________________ |
| EMAIL ADDRESS: | ___________________________ |
| ON BEHALF OF: | ___________________________ |
| NAME: | Kim Hudson |
| TITLE: | ___________________________ |
| AFFILIATION: | California Department of Insurance |
| ADDRESS: | 300 South Spring St. |
| | Los Angeles, CA 90013 |

DATE: 03/25/2021

FOR NAIC USE ONLY

Agenda Item # 2021-06BWG
Year 2021

Changes to Existing Reporting [ X ]
New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

No Impact [ X ]
Modifies Required Disclosure [ ]

DISPOSITION

[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ X ] Adopted Date 05/26/2021
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify)

BLANK(S) TO WHICH PROPOSAL APPLIES

[ X ] ANNUAL STATEMENT [ X ] INSTRUCTIONS [ X ] CROSSCHECKS
[ ] QUARTERLY STATEMENT [ ] BLANK [ ] Separate Accounts [ ] Title
[ X ] Life, Accident & Health/Fraternal [ X ] Protected Cell [ ] Other _______________________
[ X ] Property/Casualty [ X ] Health (Life Supplement)
[ X ] Health

Anticipated Effective Date: Annual 2021

IDENTIFICATION OF ITEM(S) TO CHANGE

Add crosschecks between LTC Form 5 and Form 1 for Columns 2, 3, 4, 6 and 7 of Form 5.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to add crosschecks for Columns 2, 3, 4, 6 and 7 of Form 5 to Columns 8, 1, 2, 5 and 3 respectively.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:__________________________

Other Comments:

** This section must be completed on all forms.

Revised 7/18/2018

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ANNUAL STATEMENT INSTRUCTIONS – LIFE\FRATERNAL, HEALTH AND PROPERTY

INSTRUCTIONS FOR FORM 5

**Standalone and Hybrid Products – Direct State Reporting ($000 Omitted)**

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Number of New Lives Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total number of new lives issued LTC or hybrid policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 2</th>
<th>Number of Lives In-force Year End</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.</td>
</tr>
</tbody>
</table>

Grand Total Page, Line 1 should equal Form 1, Column 8, Line 1 plus Line 6.

<table>
<thead>
<tr>
<th>Column 3</th>
<th>Earned Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.</td>
</tr>
</tbody>
</table>

If necessary, the premium may be derived as the gross premium of the policy with the inclusion of LTC coverage less the gross premium of that policy without LTC coverage.

Grand Total Page, Line 1 should equal Form 1, Column 1, Line 1 plus Line 6.

<table>
<thead>
<tr>
<th>Column 4</th>
<th>Incurred LTC Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Developed claim amounts for LTC claims incurred during the calendar year including accelerated claims, but not including payments due to extension of benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.</td>
</tr>
</tbody>
</table>

Grand Total Page, Line 1 should equal Form 1, Column 2, Line 1 plus Line 6.

<table>
<thead>
<tr>
<th>Column 5</th>
<th>Incurred Extended Benefits Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Developed claim amounts for LTC claims incurred during the calendar year due to extension of benefits after exhaustion of accelerated benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.</td>
</tr>
</tbody>
</table>
Column 6 – Number of Claims Remaining Open

Open claims are all claims that have been opened at any date but have not been closed as of the end of the year.

Grand Total Page, Line 1 should equal Form 1, Column 5, Line 1 plus Line 6.

Column 7 – Number of Claims Opened

The number of claims that have at least one LTC benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Grand Total Page, Line 1 should equal Form 1, Column 3, Line 1 plus Line 6.

---

Detail Eliminated to Conserve Space

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NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

| CONTACT PERSON: | Dale Bruggeman |
| TELEPHONE: |
| EMAIL ADDRESS: |
| ON BEHALF OF: | Ohio Department of Insurance |
| ADDRESS: | 50W. Town St., 3rd Fl., Ste. 300 |
| DISPOSITION | Adopted Date 05/26/2021 |

FOR NAIC USE ONLY

| Agenda Item # | 2021-07BWG |
| Year | 2021 |
| Changes to Existing Reporting | X |
| New Reporting Requirement | |

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

- No Impact [X]
- Modifies Required Disclosure [ ]

BLANK(S) TO WHICH PROPOSAL APPLIES

- [X] ANNUAL STATEMENT
- [X] INSTRUCTIONS
- [X] CROSSCHECKS
- [ ] QUARTERLY STATEMENT
- [ ] BLANK
- [X] Life, Accident & Health/Fraternal
- [X] Property/Casualty
- [X] Health
- [X] Title
- [ ] Separate Accounts
- [ ] Protected Cell
- [ ] Health (Life Supplement)
- [ ] Other

ANTICIPATED EFFECTIVE DATE: Annual 2021

IDENTIFICATION OF ITEM(S) TO CHANGE

Add additional line categories to the instruction for Column 26 – Collateral Type to capture collateral type data for all RMBS, CMBS and LBSS securities regardless of reporting category.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to expand the line categories listed in the instructions for Column 26 – Collateral Type on Schedule D, Part 1 so the column captures collateral type data for all RMBS, CMBS and LBSS securities regardless of reporting category.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

** This section must be completed on all forms. Revised 7/18/2018

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### ANNUAL STATEMENT INSTRUCTIONS – LIFE\FRATERNAL, HEALTH, PROPERTY AND TITLE

### SCHEDULE D – PART 1

#### LONG-TERM BONDS OWNED DECEMBER 31 OF CURRENT YEAR

**Detail Eliminated to Conserve Space**

<table>
<thead>
<tr>
<th>Column 26 – Collateral Type</th>
<th>U.S. Governments</th>
<th>All Other Governments</th>
<th>U.S. States, Territories and Possessions (Direct and Guaranteed)</th>
<th>U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed)</th>
<th>U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions</th>
<th>Industrial and Miscellaneous (Unaffiliated)</th>
<th>Hybrid Securities</th>
<th>Parent, Subsidiaries and Affiliates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Residential Mortgage-Backed Securities</td>
<td>Commercial Mortgage-Backed Securities</td>
<td>Other Loan-Backed and Structured Securities</td>
<td>Residential Mortgage-Backed Securities</td>
<td>Commercial Mortgage-Backed Securities</td>
<td>Other Loan-Backed and Structured Securities</td>
<td>Residential Mortgage-Backed Securities</td>
<td>Commercial Mortgage-Backed Securities</td>
</tr>
<tr>
<td>U.S. Governments</td>
<td>0299999</td>
<td>0399999</td>
<td>0499999</td>
<td>1299999</td>
<td>1399999</td>
<td>1499999</td>
<td>2699999</td>
<td>2799999</td>
</tr>
<tr>
<td>All Other Governments</td>
<td>0799999</td>
<td>0899999</td>
<td>0999999</td>
<td>1999999</td>
<td>2099999</td>
<td>2199999</td>
<td>3399999</td>
<td>3499999</td>
</tr>
<tr>
<td>U.S. States, Territories and Possessions (Direct and Guaranteed)</td>
<td>1299999</td>
<td>1399999</td>
<td>1499999</td>
<td>1999999</td>
<td>2099999</td>
<td>2199999</td>
<td>3399999</td>
<td>3499999</td>
</tr>
<tr>
<td>U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed)</td>
<td>2699999</td>
<td>2799999</td>
<td>2899999</td>
<td>3399999</td>
<td>3499999</td>
<td>3599999</td>
<td>4399999</td>
<td>4499999</td>
</tr>
<tr>
<td>U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions</td>
<td>2699999</td>
<td>2799999</td>
<td>2899999</td>
<td>3399999</td>
<td>3499999</td>
<td>3599999</td>
<td>4399999</td>
<td>4499999</td>
</tr>
<tr>
<td>Industrial and Miscellaneous (Unaffiliated)</td>
<td>3399999</td>
<td>3499999</td>
<td>3599999</td>
<td>4399999</td>
<td>4499999</td>
<td>4599999</td>
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<td>5199999</td>
</tr>
<tr>
<td>Hybrid Securities</td>
<td>4399999</td>
<td>4499999</td>
<td>4599999</td>
<td>5099999</td>
<td>5199999</td>
<td>5299999</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Enter one of the following codes to indicate collateral type. Pick exactly one collateral type for each reported security. For securities that fit in more than one type, pick the predominant one. Judgment may need to be used when making selections involving prime, Alt-A and subprime, as there are no uniform definitions for these collateral types. In the description field, use abbreviations like ABS, CDO or CLO to disclose the type of the loan-backed/structured security.

Note: Various investments below require SVO review and approval, please refer to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) for further description.

1  Residential Mortgage Loans/RMBS
   Include all types of residential first lien mortgage loans as collateral (e.g., prime, subprime, Alt-A).

2  Commercial Mortgage Loans/CMBS
   Include all types of commercial mortgage loans as collateral (e.g., conduits, single name, etc.).

3  Home Equity
   Include all home equity loans and/or home equity lines of credit as collateral. These are not first liens and are deemed loans to individuals. Bonds that are collateralized by home equity loans/lines of credit are considered asset-backed securities (ABS) rather than RMBS.

4  Individual Obligations – Credit Card, Auto, Student Loans and Recreational Vehicles
   Include bonds collateralized by individual obligations. Do not include individual obligations that have a real-estate aspect.

5  Corporate/Industrial Obligations – Tax Receivables, Utility Receivables, Trade Receivables, Small Business Loans, Commercial Paper
   Include bonds collateralized by corporate or industrial obligations (sometimes referred to as commercial obligations).

6  Lease Transactions – Aircraft Leases, Equipment Leases and Equipment Trust Certificates
   Include bonds collateralized by leases. Equipment leases are loans on heavy equipment. Equipment trust certificates are certificates that entitle the holder to the lease payments on the underlying assets.

7  CLO/CBO/CDO
   Include bank loans, which securitize CLOs; investment grade and high-yield corporate bonds, which securitize CBOs; and corporate bonds and structured securities, which securitize CDOs.

8  Manufactured Housing and Mobile Home Loans
   Include manufactured housing loans and mobile home loans as collateral. These are not typical residential mortgage loans, and when they securitize bonds, they are considered ABS.
9  Credit Tenant Loans

Real estate loans secured by the obligation of a single (usually investment grade) company to pay debt service by means of rental payments under a lease, where real estate is pledged as collateral also referred to as credit tenant lease, sale-leaseback or CTL.

10  Ground Lease Financing

Real estate loans secured by the obligation to pay debt service by means of rental payments of subleased property; where a long-term ground lease was issued in which the lessee intends significant land development and the subleasing of such property to other long-term tenants.

11  Other

Include other collateral types that do not fit into categories 1 through 10.
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

<table>
<thead>
<tr>
<th>CONTACT PERSON:</th>
<th>Andy Daleo</th>
</tr>
</thead>
<tbody>
<tr>
<td>TELEPHONE:</td>
<td>(816) 783-8141</td>
</tr>
<tr>
<td>EMAIL ADDRESS:</td>
<td><a href="mailto:adaleo@naic.org">adaleo@naic.org</a></td>
</tr>
<tr>
<td>ON BEHALF OF:</td>
<td>Mortgage Guaranty Ins. Working Group</td>
</tr>
<tr>
<td>NAME:</td>
<td>Kevin Conley</td>
</tr>
<tr>
<td>TITLE:</td>
<td>Chair</td>
</tr>
<tr>
<td>AFFILIATION:</td>
<td>NC Department of Insurance</td>
</tr>
<tr>
<td>ADDRESS:</td>
<td>325 N Salisbury Street, Raleigh, NC 27603</td>
</tr>
</tbody>
</table>

**FOR NAIC USE ONLY**

<table>
<thead>
<tr>
<th>Agenda Item #</th>
<th>2021-08BWG MOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>2021</td>
</tr>
<tr>
<td>Changes to Existing Reporting</td>
<td>[ X ]</td>
</tr>
<tr>
<td>New Reporting Requirement</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**

| No Impact | [ X ] |
| Modifies Required Disclosure | [ ] |

**DISPOSITION**

- [ ] Rejected For Public Comment
- [ ] Referred To Another NAIC Group
- [ ] Received For Public Comment
- [ X ] Adopted Date 05/26/2021
- [ ] Rejected Date
- [ ] Deferred Date
- [ ] Other (Specify)

**BLANK(S) TO WHICH PROPOSAL APPLIES**

- [ X ] ANNUAL STATEMENT
- [ ] QUARTERLY STATEMENT
- [ X ] INSTRUCTIONS
- [ ] CROSSCHECKS
- [ ] Life, Accident & Health/Fraternal
- [ X ] Property/Casualty
- [ ] Health
- [ ] Separate Accounts
- [ ] Protected Cell
- [ ] Health (Life Supplement)
- [ ] Title
- [ ] Other _______________________

Anticipated Effective Date: Annual 2021

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Add a new supplement Mortgage Guaranty insurance Exhibit to capture more information from mortgage guaranty insurers.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The proposed Mortgage Guaranty Insurance Supplement will be primarily used by the domestic regulators of mortgage guaranty insurers. Currently, there is limited data captured on mortgage guaranty insurance within the financial statement. The proposed supplement will provide the means for the regulators to assess the capital level of the insurer and their overall financial solvency.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: ______________________________________

Other Comments:

** This section must be completed on all forms. Revised 7/18/2018

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ANNUAL STATEMENT INSTRUCTIONS - PROPERTY

MORTGAGE GUARANTY INSURANCE EXHIBIT

This exhibit is required to be completed annually by all insurers, excluding reinsurers, with any mortgage guaranty exposure and filed no later than April 1. The exhibit is provided for the benefit of regulators of mortgage guaranty insurers to use as an assessment tool aiding in the evaluation of an insurer’s capital adequacy and financial solvency.

All reporting entities reporting mortgage guarantees on Line 6 of the Annual Statement Underwriting and Investment Exhibit of Premiums and Losses, Part 1 and/or Part 2 must prepare this Exhibit.

The following definitions should be used in completing the Mortgage Guaranty Insurance Exhibit:

a. “Primary Flow and Bulk Business” means loans are insured on an individual loan-by-loan transaction basis. Premium rates typically vary depending on the perceived risk of a potential claim on the loan type based on consideration of the loan to value ratio, borrower credit score, payment plan, mortgage term and property type. The mortgage instrument may require the borrower to pay for the mortgage insurance, which is referred to as “borrower paid”. Alternatively, the lender may be required to pay the premium, who in turn recovers the premium through an increase in the note rate, which is referred to as “lender paid.” Bulk Business means coverage is provided on each mortgage loan included in a defined portfolio of loans insured under a single or bulk transaction. Bulk coverage typically insures the closed loans in an insured portfolio to a specified level of coverage. Loans insured on a bulk basis are typically part of a negotiated transaction, resulting in a composite rate applied to all such loans in the portfolio.

b. “Pool Business” means a collection of mortgages with similar rates and terms which are often securitized by dividing the pool into bonds backed by the payments of principal and interest into the pool by borrowers. Pool insurance typically covers the loss on a defaulted mortgage loan included in the pool, which is in excess of the loan’s primary coverage, as well as the total loss on a defaulted mortgage which does not require primary coverage. Pool insurance may have a stated aggregate loss limit for a pool of loans or a deductible under which no loss is paid by the insurer until the deductible is exceeded.

c. “State Regulatory Mortgage Insurer Capital Standard” (SRMICS) means the economically countercyclical risk-based margin of safety developed to recognize risk and control elements unique to the mortgage guaranty insurance industry, the calculation of which is described in the Mortgage Guaranty Insurance Standards Manual.

SCHEDULE MG

Schedule MG This Exhibit includes only the data for the insurer identified on the cover of the exhibit. Do not include consolidated data for affiliated companies. If the insurer participates in a pooling agreement, it should report only its share of the business, not the total of all participants.

In those instances where an insurer files an amended annual statement as a result of a restatement of prior year written premium, losses or loss adjustment expenses, Schedule MG this Exhibit must be restated and included in the amended exhibit. In those instances where one insurer is merged into another mortgage guaranty insurer, Schedule MG the Exhibit must be prepared so it includes the entire combined history of both companies.

When changes to pooling agreements impact prior policy years, historical data values in Schedule MG Parts 1 and 2 should be restated based on the new pooling percentage. This should be done to present meaningful development patterns in Schedule MG the Exhibit. When pooling changes only impact future policy years, no restatement of historical values should be made. Even though no restatement is required, changes are to be included within the Notes to Financial Statements, per SSAP No. 3—Accounting Changes and Corrections of Errors.
Earned premiums, losses paid, and losses incurred should be assigned to the year in which the policy was written that triggered coverage under the contract.

Retroactive reinsurance should not be reflected in Schedule MG this Exhibit. The transferor in such an agreement must record, without recognition of the retroactive reinsurance, its loss and loss adjustment expense reserves on a gross basis on its balance sheet and in all schedules and exhibits. The transferee in such an agreement must exclude the retroactive reinsurance from its loss and loss expense reserves and from its schedules and exhibits.

The reserves for unpaid losses and loss adjustment expenses should take into account the explicit or implicit impacts of the various factors affecting claim frequency or ultimate claim cost.

Schedule MG, Part 1 is organized so that written premiums and other income for a year are matched with corresponding losses and Defense &and Cost Containment expenses (D&CC) and Adjusting &and Other expenses for policies issued during that year. Experience is shown for direct business, reinsurance assumed, reinsurance ceded and net of reinsurance.

Policy year loss and loss adjustment expense payments and reserves should be assigned to the year in which the policy was written under which coverage is triggered.

Part 2 displays 20-year loss development triangles on a policy year basis. In Part 2, losses are combined with D&CC. Loss and D&CC development is shown for total incurred, payments, case basis reserves, bulk reserves and incurred but not reported (IBNR) reserves (policy year basis only). Part 2 displays 20-year claim count development triangles on a policy year basis.

Report all dollar amounts in the Schedule MMortgage Guaranty Insurance Exhibit in thousands of dollars ($000 omitted), either by rounding or truncating. All claim counts are to be shown in whole numbers.

The number of claims reported is to be cumulative by policy year. The number of claims reported for each policy year is equal to the number of open claims at the end of the current year plus cumulative claims closed with or without payment for the current and prior calendar years.

For reporting entities reporting on a pooling basis, the pooling percentage should be applied to claim counts as well as dollar amounts.

If the company changes its method of counting claims, the new method should be disclosed in the Notes to Financial Statements.
SCHEDULE MG- PART 1 – SUMMARY

Part 1 – Summary provides a 10-year summary of loss and defense & cost containment experience for the company. Part 1 – Summary should be equal to the sum of Part 1A and Part 1B. Columnar headings provide instructions necessary for completion.

The columnar headings provide instructions necessary for completion.

For reporting entities reporting on a pooling basis, the pooling percentage should be applied to claim count as well as dollar amounts.

Cumulative salvage and subrogation received and losses and expenses paid should be reported for each specific year. For “prior,” report only salvage and subrogation received and losses and expenses paid in current year.

In Schedule MG, Part 1, salvage and subrogation received should be reported net of reinsurance, if any. Loss payments are to be reported net of salvage and subrogation received in Schedule MG.

Premiums earned and losses paid, unpaid, and incurred should reconcile with the Statement of Income page. The workpapers that show a reconciliation explaining reinsurance and salvage and subrogation adjustments should be available for examination on request.

“Assumed” means reinsurance assumed, including from affiliated pooling agreements, but excluding any non-proportional reinsurance assumed reported as a separate line and reported accordingly.

“Direct” means as directly written, but not if part of an affiliated pooling agreement.

“Ceded” means reinsurance ceded on business so reported as direct or assumed.

Line 1, “Prior,” Columns 8 through 16 should only reflect amounts paid or received in the current calendar year.

Report cumulative amounts paid or received for specific years.

“Defense & Cost Containment” expenses include defense, and litigation and cost containment expenses, whether internal or external. “Defense” means defense by the reporting entity in a contentious situation, whether a first party or a third-party claim. The fees charged for reporting entity employees should include overhead, just as an outside firm’s charges would include. The expenses exclude expenses incurred in the determination of coverage. These expenses include the following items:

1. Surveillance expenses;
2. Fixed amounts for cost containment expenses;
3. Litigation management expenses;
4. Loss adjustment expenses for participation in voluntary and involuntary market pools if reported by policy year;
5. Fees or salaries for appraisers, private investigators, hearing representatives, inspectors and fraud investigators, if working in defense of a claim, and fees or salaries for rehabilitation nurses, if such cost is not included in losses;
6. Attorney fees incurred owing to a duty to defend, even when other coverage does not exist; and
7. The cost of engaging experts.
“Adjusting & Other” expenses are those expenses other than those above and which have been assigned to the “Loss Adjustment Expense” group in the Underwriting and Investment Exhibit, Part 3, Expenses. These expenses include the following items:

1. Fees of adjusters and settling agents (but not if engaged in a contentious defense);
2. Loss adjustment expenses for participation in voluntary and involuntary market pools if reported by calendar year;
3. Attorney fees incurred in the determination of coverage, including litigation between the reporting entity and the policyholder; and
4. Fees or salaries for appraisers, private investigators, hearing representatives, re-inspectors and fraud investigators, if working in the capacity of an adjuster.

The foregoing list is not intended to be all-inclusive. We are relying on the reporting entities to use reasonable judgment in particular situations.

Reporting entities should assign the “Defense & Cost Containment” expenses to the policy year in which the associated losses were assigned. Reporting entities may assign the “Adjusting & Other” expenses in any justifiable way among the policy years. The preferred way is to apportion these expenses in proportion to the number of claims reported, closed, or outstanding each year.

Please Note: This instruction is intended solely to give guidance on reporting loss adjustment expenses in Schedule MG, the Mortgage Guaranty Insurance Exhibit, in the annual statement. It is not intended to provide guidance on the types of expenses to include in loss adjustment expenses. These definitions of defense cost containment expense and adjusting other expense are not intended to affect insurance or reinsurance agreements or other contractual agreements.

Pooling

Many insurers have a pooling arrangement with affiliated companies, approved by the domiciliary commissioner, in which the business written is reallocated among the affiliated companies according to a specified percentage. Some affiliated companies may be part of the pool and some may not, and some lines may be included, and some may not. The premiums and losses are to be reported in Schedule P after such pooling arrangements, not before.

Pooled business ceded is that which, if retained instead of ceded, would be pooled among the affiliated companies who are party to the pooling agreement. Any such business that is ceded by the pool participants to non-pooled companies prior to the pooling distribution among the participating companies is considered pooled business ceded. Non-pooled business includes all direct, assumed, and ceded business not subject to pooling, as well as any pooled business that is ceded after the pooling distribution has been made.

Direct and Assumed columns include the participation in any pool. In addition, all direct business not pooled plus assumed business from other than the pool is to be included. Ceded columns include the company’s participation in the pool such as any ceding by the company to companies independent of the pool.

Claim counts should be reported in accordance with the pooling arrangement and should reflect the company’s proportionate share of the total number of claims. If the company’s losses are 40% of the pool, then 40% of the claim count should be reported.

The pooling percentage is to reflect the company’s participation in the pool as of year-end. When changes to pooling agreements impact prior policy years, historical data values in Schedule MG, Parts 1 and 2 should be restated based on the new pooling percentage. This should be done to present meaningful development patterns in Schedule MG, this exhibit. When pooling changes only impact future policy years, no restatement of historical values should be made.
Column 7 ——— Premiums Earned and Other Income Net
Should equal Columns 3 + 4 + 5 – 6.

Column 16 ——— Total Net Loss and Expense Paid
Should equal Columns 8 + 9 – 10 + 11 + 12 – 13 + 15.

Column 25 ——— Total Net Loss and LAE Unpaid

Column 27 ——— Losses and Defense & Cost Containment Expenses Incurred Direct
Should equal Columns 8 + 11 + 18 + 21.

Column 28 ——— Losses and Defense & Cost Containment Expenses Incurred Assumed
Should equal Columns 9 + 12 + 19 + 22.

Column 29 ——— Losses and Defense & Cost Containment Expenses Incurred Ceded
Should equal Columns 10 + 13 + 20 + 23.

Column 30 ——— Losses and Defense & Cost Containment Expenses Incurred Net
Should equal Columns 27 + 28 – 29.

Column 31 ——— Loss and LAE Ratio Direct Basis
Should equal (Columns 15 + 24 + 27)/Column 3.

Column 32 ——— Loss and LAE Ratio Net Basis
Should equal (Columns 15 + 24 + 30)/(Columns 7 – 5).

Column 33 ——— Net Loss & LAE Coverage
Should equal (Columns 15 + 24 + 30)/Column 1.

Column 34 ——— Net Reserves
Should equal Columns 25 – 33.

**PART 1A – PRIMARY FLOW AND BULK BUSINESS**

Part 1A provides a summary of primary flow and bulk business premium, payments, claims, and reserves by policy year. Columnar headings provide instructions necessary for completion.

Column 2625 — Number of Direct Delinquencies
Should equal Part 2F, Column 910.

**PART 1B – POOL BUSINESS**

Part 1B provides a summary of pool business premium, payments, claims, and reserves by policy year. Columnar headings provide instructions necessary for completion.
## SCHEDULE MG – Part 1 – SUMMARY, PARTS 1A and PART 1B

### NOTE:
Starting with 2021 reporting, Line 1 and Lines 7 through 12 are required. Lines 2 through 6 will be phased over the years 2022 through 2026.

Reporting entities should complete Schedule MG report dollar amounts in thousands only but must report all claim counts in whole numbers.

Part 1 is organized so that written premiums for a year are matched with corresponding losses and Defense and Cost Containment expenses (DCC) and Adjusting and Other expenses for policies issued during that year. Experience is shown for direct business, reinsurance assumed, reinsurance ceded and net of reinsurance.

Policy year loss and loss adjustment expense payments and reserves should be assigned to the year in which the policy was written under which coverage is triggered.

### NOTE:
For “prior,” report amounts paid or received in current year only. Report cumulative amounts paid or received for specific years. Report loss payments net of salvage and subrogation received.

The number of claims closed with payment is to be cumulative by policy year.

| Column 16 | Number of Claims Closed with Payment (Direct) | Number of claims closed with payment should be reported “per claim” and not “per claimant.” |
| Column 26 | Number of Direct Delinquencies | Should equal Part 2E, Column 10. |
| Column 2726 | Losses and Defense & Cost Containment Expenses Incurred Direct | Should equal Columns 87 + 140 + 187 + 204. |
| Column 2827 | Losses and Defense & Cost Containment Expenses Incurred Assumed | Should equal Columns 98 + 121 + 198 + 221. |
| Column 3130 | Loss and LAE Ratio Direct Basis | Should equal (Columns 154 + 243 + 276)/Column 3. |
Column 3231 – Loss and LAE Ratio Net Basis
Should equal (Columns 154 + 243 + 3029)/(Columns 76 – 5).

Column 3332 – Net Loss and& LAE Coverage
Should equal (Columns 154 + 243 + 3029)/Column 1.

Column 3433 – Net Reserves
Should equal Columns 254 – 332.

SCHEDULE MG- PART 1A – PRIMARY FLOW AND BULK BUSINESS
Part 1A provides a summary of primary flow and bulk business premium, payments, claims, and reserves by policy year. Columnar headings provide instructions necessary for completion.

SCHEDULE MG- PART 1B – POOL BUSINESS
Part 1B provides a summary of pool business premium, payments, claims, and reserves by policy year. Columnar headings provide instructions necessary for completion.

PART 2
Part 2 provides a historical summary of loss and defense and cost containment expenses development by policy year. Exclude pool business.
Part 2 displays 20-year loss development triangles on a policy year basis. In Parts 2A and 2B, losses are combined with D&CC. Loss and D&CC development is shown for total incurred; payments, case basis reserves, bulk reserves and incurred but not reported (IBNR) reserves (policy year basis only). Part 2F displays 20-year policy count development triangles on a policy year basis.

The definition of “prior years” should be the same as that used by the company in Part 1.

SCHEDULE MG- PART 2
PART 2A – POLICY YEAR DIRECT INCURRED LOSS AND DEFENSE & COST CONTAINMENT EXPENSE
Part 2A provides a historical summary of loss and defense & cost containment expenses development by policy year. Columnar headings provide instructions necessary for completion. Exclude pool business.

The definition of “prior years” should be the same as that used by the company in Part 1.

SCHEDULE MG- PART 2A
PART 2B – POLICY YEAR DIRECT PAID LOSS AND DEFENSE & COST CONTAINMENT EXPENSE
Part 2BA shows cumulative direct loss and defense & cost containment expense payments by year the policy was written as of December 31 of each year shown in Columns 1 to 10. Exclude pool business.

SCHEDULE MG- PART 2B
PART 2C – POLICY YEAR DIRECT CURRENT RISK IN FORCE
Part 2CB provides a policy year summary of direct risk in force. Exclude pool business.
SCHEDULE MG- PART 2C
PART 2D – POLICY YEAR DIRECT EARNED PREMIUM

For Schedule MG, Part 2DC, the premiums to be reported are exposure or coverage year earned premiums, recalculated each subsequent year to reflect audits, retrospective adjustments based on loss experience, accounting lags, etc. Mechanically, the earned premium file would be restated and the earned premium calculation repeated each year. Premium adjustments for policy periods that cover more than one calendar year should be proportionately distributed between the calendar years covered by the policy period. The objective is to develop earned premiums by policy year of coverage consistent with the loss and Defense & Cost Containment expense by policy year. Only policy years 1993 and subsequent must be reported. Exclude pool business.

SCHEDULE MG- PART 2D
PART 2E – POLICY YEAR DIRECT CALCULATED STATE REGULATORY MORTGAGE INSURER CAPITAL STANDARD (SRMICS)


SCHEDULE MG- PART 2E
PART 2F – POLICY YEAR DIRECT DELINQUENCIES

Part 2FE provides a policy year summary of direct delinquencies. Exclude pool business.
### ANNUAL STATEMENT BLANK - PROPERTY

### SUPPLEMENTAL EXHIBITS AND SCHEDULES

**INTERROGATORIES**

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a “NONE” report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason, enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

**MARCH FILING**

1. Will an actuarial opinion be filed by March 1?

   ………………………………

**APRIL FILING**

28. Will the Credit Insurance Experience Exhibit be filed with the state of domicile and the NAIC by April 1?

   ………………………………

29. Will the Long-term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?

   ………………………………

30. Will the Accident and Health Policy Experience Exhibit be filed by April 1?

   ………………………………

31. Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?

   ………………………………

32. Will the regulator-only (non-public) Supplemental Health Care Exhibit’s Allocation Report be filed with the state of domicile and the NAIC by April 1?

   ………………………………

33. Will the Cybersecurity and Identity Theft Insurance Coverage Supplement be filed with the state of domicile and the NAIC by April 1?

   ………………………………

34. Will the Life, Health & Annuity Guaranty Association Assessable Premium Exhibit – Parts 1 and 2 be filed with the state of domicile and the NAIC by April 1?

   ………………………………

35. Will the Private Flood Insurance Supplement be filed with the state of domicile and the NAIC by April 1?

   ………………………………

36. Will the Mortgage Guaranty Insurance Exhibit be filed with the state of domicile and the NAIC by April 1?

   ………………………………

**AUGUST FILING**

37. Will Management’s Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?

   ………………………………

**Explanation:**

Bar Code:
ANNUAL STATEMENT BLANK - PROPERTY

MORTGAGE GUARANTY INSURANCE EXHIBIT

FOR THE YEAR ENDED DECEMBER 31, 20XX

(To Be Filed by April 1)

Of: ......................................................................................

NAIC Group Code .................. NAIC Company Code ....................... Employer’s ID Number ..........................................

© 2021 National Association of Insurance Commissioners
# SCHEDULE MG: PART 1 – SUMMARY

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<th>Original Direct Premium</th>
<th>Current Direct Premium</th>
<th>Assumed Premium</th>
<th>Ceded Premium</th>
<th>Loss Payments</th>
<th>Defense &amp; Cost Containment Expenses Payments</th>
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# Schedule 2

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<th>Total Net Loss Reserve</th>
<th>Number of Claims Closed with Premium</th>
<th>Losses &amp; Defense &amp; Cost Containment Expenses</th>
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<th>Net Loss &amp; LAE Coverage</th>
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### SCHEDULE MG - PART 1B – POOL BUSINESS

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### Loss and Defense and Cost Containment Expenses

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### SCHEDULE MG- PART 2AB – POLICY YEAR DIRECT PAID LOSSES AND DEFENSE & AND COST CONTAINMENT EXPENSES

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## SCHEDULE MG-PART 2DE – POLICY YEAR DIRECT CALCULATED STATE REGULATED MORTGAGE INSURANCE CAPITAL STANDARD (SRMICS)

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<td>6. 2007</td>
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<td>7. 2008</td>
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<td>8. 2009</td>
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<td>9. 2010</td>
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<td>11. 2012</td>
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<td>12. 2013</td>
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<td>13. 2014</td>
<td>XXX</td>
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<td>14. 2015</td>
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<td>16. 2017</td>
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<td>17. 2018</td>
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<td>18. 2019</td>
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</tr>
<tr>
<td>19. 2020</td>
<td>XXX</td>
</tr>
<tr>
<td>20. 2021</td>
<td>XXX</td>
</tr>
</tbody>
</table>

State Regulatory Mortgage Insurance Capital Standard
**Effective** | **Table Name** | **Description** | **Statement Type** | **Filing Type**
--- | --- | --- | --- | ---
2021 | Accident and Health Policy Experience Exhibit | **CHANGE TO BLANK**
Removed United States Policy Forms from header as alien amounts were to be included on line D1 and will need to be included for validations to tie.
Deleted line 19 in the Individual section and renumbered as it was a duplication of line 20. | H, L/F, P/C | Annual
2021 | Accident and Health Policy Experience Exhibit | **CHANGE TO INSTRUCTION**
Add clarifying instruction on transitioning to by state reporting of the exhibit in 2022. | H, L/F, P/C | Annual

---

**ACCIDENT AND HEALTH POLICY EXPERIENCE EXHIBIT**

This exhibit is required to be filed no later than April 1.

A schedule must be prepared and submitted to the state of domicile for each jurisdiction in which the company has Written Premium (Direct), Earned Premium (Direct, Assumed and Ceded) or Incurred Claims (Direct, Assumed and Ceded). In addition, a schedule must be prepared and submitted that contains the grand total (GT) for the company.

---

**For 2021 Reporting Only**

For 2021, the reporting entity can choose to complete a separate page for each jurisdiction (plus an OT for other than US) and the Grand Total (GT) page or the reporting entity can submit a page for their state of domicile and the Grand Total (GT) page.

---
<table>
<thead>
<tr>
<th>Effective</th>
<th>Table Name</th>
<th>Description</th>
<th>Statement Type</th>
<th>Filing Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>2021</td>
<td>Schedule F, Part 3</td>
<td><strong>CHANGE TO INSTRUCTION</strong>&lt;br&gt;Make the following changes to Column 34 to be consistent with changes made in the Property RBC Instructions.&lt;br&gt;&lt;br&gt;Column 34 – Reinsurer Designation Equivalent&lt;br&gt;&lt;br&gt;Following is a listing of the valid codes.</td>
<td>P/C</td>
<td>Annual</td>
</tr>
</tbody>
</table>

The equivalent designation category assigned will correspond to a current financial strength rating received from any one of the approved rating agencies as outlined in the table below. Ratings shall be based on interactive communication between the rating agency and the assuming reinsurer and shall not be based solely on publicly available information. If the reinsurer does not have at least one financial strength rating, it should be assigned the “Vulnerable 6 or Unrated Reinsurers” equivalent rating. Amounts recoverable from unrated voluntary pools should be assigned the “reinsurer equivalent code of Secure 3” equivalent rating.<br><br>An authorized association, including incorporated and individual unincorporated underwriters or a member thereof (e.g. individual authorized syndicates of Lloyds’ of London that are backed by the Central Fund), may utilize the lowest financial strength group rating received from an approved rating agency.

<table>
<thead>
<tr>
<th>Reinsurer Designation Equivalent Category</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Secure 1</td>
<td>Secure 2</td>
<td>Secure 3</td>
<td>Secure 4</td>
<td>Secure 5</td>
<td>Vulnerable 6 or Unrated Reinsurers</td>
</tr>
<tr>
<td>Moody's</td>
<td>Aaa</td>
<td>Aa1, Aa2, Aa3</td>
<td>A1, A2</td>
<td>A3</td>
<td>Baal, Ba2, Ba3</td>
<td>Ba1, Ba2, Ba3, B1, B2, B3, Caa, C, C</td>
</tr>
<tr>
<td>Effective</td>
<td>Table Name</td>
<td>Description</td>
<td>Statement Type</td>
<td>Filing Type</td>
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<td>-------------------------------------</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
| 2021      | Supplemental Investment Risks Interrogatories | **CHANGE TO INSTRUCTION**  
Modify the instructions as shown below to clarify preferred stock reporting for Line 3.  
Line 3 – Report by NAIC designation, the amounts and percentages of the reporting entity’s total admitted assets held in bonds and preferred stocks (perpetual preferred and redeemable preferred).  
Report the total amount for each subcategory. The amounts reported in the bond subcategories should be consistent with the amounts reported in Schedule D, Part 1A, Section 1, Column 7, Lines 11.1 – 11.6. Schedule D, Part 1A, Section 1 is reported gross and will not tie to this line if any amounts are reported and nonadmitted for bonds and preferred stocks on the asset page.  
The amounts reported in the preferred stock subcategories should be consistent with the amounts reported in Asset Page, Column 3, Lines 2.1. | H, L/F, P/C, T | Annual |
| 2022      | Schedule DL, Part 1                  | **CHANGE TO INSTRUCTION**  
Remove the “$” code for certificates of deposit to be consistent with the change for Schedule D, Part 1 adopted with 2020-35BWG. This change should have been included in original proposal.  
Column 3 – Code  
Enter “*” in this column for all SVO Identified Funds designated for systematic value.  
Enter “@” in this column for all Principal STRIP Bonds or other zero coupon bonds.  
Enter “$” in this column for Certificates of Deposit under the FDIC limit.  
Enter “&” in this column for To Be Announced (TBA) securities.  
If assets are not under the exclusive control of the company as shown in the General Interrogatories, they are to be identified by placing one of the codes (identified in the Investment Schedules General Instructions) in this column. | H, L/F, P/C, T | Quarterly |
<table>
<thead>
<tr>
<th>Effective</th>
<th>Table Name</th>
<th>Description</th>
<th>Statement Type</th>
<th>Filing Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>2022</td>
<td>Schedule DL, Part 2</td>
<td>CHANGE TO INSTRUCTION</td>
<td>H, L/F, P/C, T</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Remove the “$” code for certificates of deposit to be consistent with the change for Schedule D, Part 1 adopted with 2020-35BWG. This change should have been included in original proposal.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Column 3 — Code</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enter “*” in this column for all SVO Identified Funds designated for systematic value.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enter “@” in this column for all Principal STRIP Bonds or other zero coupon bonds.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enter “$” in this column for Certificates of Deposit under the FDIC limit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enter “&amp;” in this column for To Be Announced (TBA) securities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>If assets are not under the exclusive control of the company as shown in the General Interrogatories, they are to be identified by placing one of the codes (identified in the Investment Schedules General Instructions) in this column.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>If the security is an SVO Identified Fund designated for systematic value, Principal STRIP bond or other zero coupon bond, certificates of deposit under the FDIC limit or a To Be Announced (TBA) security and is not under the exclusive control of the company, the “*”, “@”, “$” or “&amp;” should appear first, immediately followed by the appropriate code (identified in the Investment Schedules General Instructions).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective</td>
<td>Table Name</td>
<td>Description</td>
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<td>-----------</td>
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<td></td>
</tr>
</tbody>
</table>
| 2022      | Schedule DL, Part 1 | **CHANGE TO INSTRUCTION**  
Remove the “$” code for certificates of deposit to be consistent with the change for Schedule D, Part 1 adopted with 2020-35BWG. This change should have been included in original proposal. |

**Column 3 – Code**
- Enter “*” in this column for all SVO Identified Funds designated for systematic value.
- Enter “@” in this column for all Principal STRIP Bonds or other zero-coupon bonds.
- Enter “$” in this column for Certificates of Deposit under the FDIC limit.
- Enter “&” in this column for TBA (To Be Announced) securities.
- Enter “^” in this column for all assets that are bifurcated between the insulated separate account filing and the non-insulated separate account filing.

If assets are not under the exclusive control of the company as shown in the General Interrogatories, they are to be identified by placing one of the codes (identified in the Investment Schedules General Instructions) in this column.

If the security is an SVO Identified Fund designated for systematic value, Principal STRIP bond or other zero coupon bond, certificates of deposit under the FDIC limit or a TBA (To Be Announced) security and is not under the exclusive control of the company, the “*”, “@”, “$” or “&” should appear first, immediately followed by the appropriate code (identified in the Investment Schedules General Instructions).

**Separate Account Filing Only:**
If the asset is a bifurcated asset between the insulated separate account filing and the non-insulated separate account filing, the “^” should appear first and may be used simultaneously with the “*”, “@”, “$” or “&” with the “^” preceding the other characters (“*”, “@”, “$” or “&”) depending on the asset being reported, immediately followed by the appropriate code (identified in the Investment Schedules General Instructions).
<table>
<thead>
<tr>
<th>Effective</th>
<th>Table Name</th>
<th>Description</th>
<th>Statement Type</th>
<th>Filing Type</th>
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</thead>
<tbody>
<tr>
<td>2022</td>
<td>Schedule DL, Part 2</td>
<td><strong>CHANGE TO INSTRUCTION</strong>&lt;br&gt;Remove the “$” code for certificates of deposit to be consistent with the change for Schedule D, Part 1 adopted with 2020-35BWG. This change should have been included in original proposal.&lt;br&gt;&lt;br&gt;Column 3 – Code&lt;br&gt;Enter “<em>” in this column for all SVO Identified Funds designated for systematic value.&lt;br&gt;Enter “@” in this column for all Principal STRIP Bonds or other zero-coupon bonds.&lt;br&gt;Enter “$” in this column for Certificates of Deposit under the FDIC limit.&lt;br&gt;Enter “&amp;” in this column for TBA (To Be Announced) securities.&lt;br&gt;Enter “^” in this column for all assets that are bifurcated between the insulated separate account filing and the non-insulated separate account filing.&lt;br&gt;Separate Account Filing Only:&lt;br&gt;If the asset is a bifurcated asset between the insulated separate account filing and the non-insulated separate account filing, the “^” should appear first and may be used simultaneously with the “</em>”, “@”, “$” or “&amp;” with the “^” preceding the other characters (“*”, “@”, “$” or “&amp;”) depending on the asset being reported, immediately followed by the appropriate code (identified in the Investment Schedules General Instructions).&lt;br&gt;</td>
<td>H, L/F, P/C, T</td>
<td>Annual</td>
</tr>
<tr>
<td>Effective</td>
<td>Table Name</td>
<td>Description</td>
<td></td>
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<tr>
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<td></td>
</tr>
<tr>
<td>2021</td>
<td>General Instructions</td>
<td><strong>CHANGE TO INSTRUCTION</strong>&lt;br&gt;Modify the instruction on minimum font size to read as shown.&lt;br&gt;b. No font smaller than 86-point type for the annual statement or 6-point type for the Long-Term Care Experience Reporting Forms 1 through 5 and all investment schedules may be used. Ornate fonts may not be used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>General Instructions</td>
<td><strong>CHANGE TO INSTRUCTION</strong>&lt;br&gt;Modify the instruction on minimum font size to read as shown.&lt;br&gt;b. No font smaller than 86-point type for the annual statement or 6-point type for the Long-Term Care Experience Reporting Forms 1 through 5 and all investment schedules may be used. Ornate fonts may not be used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>General Instructions</td>
<td><strong>CHANGE TO INSTRUCTION</strong>&lt;br&gt;Modify the instruction on minimum font size to read as shown.&lt;br&gt;b. No font smaller than 86-point type for the annual statement or 6-point type for the Long-Term Care Experience Reporting Forms 1 through 5, Exhibit of Premiums and Losses (Statutory Page 14) and all investment schedules may be used. Ornate fonts may not be used.</td>
<td></td>
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<tr>
<td>2021</td>
<td>General Instructions</td>
<td><strong>CHANGE TO INSTRUCTION</strong>&lt;br&gt;Modify the instruction on minimum font size to read as shown.&lt;br&gt;b. No font smaller than 86-point type for the annual statement or 6-point type for all investment schedules may be used. Ornate fonts may not be used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>Schedule A, Part 1</td>
<td><strong>CHANGE TO INSTRUCTION</strong>&lt;br&gt;Modify the instructions as shown below&lt;br&gt;Column 8 – Amount of Encumbrances&lt;br&gt;Properties may be mortgaged and the outstanding principal balance, excluding accrued interest, of all liens at December 31 of the current year should be reported in this column.&lt;br&gt;Amount reported for encumbrances should not be less than zero.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Supplemental Health Care Exhibit - Part 2

**CHANGE TO INSTRUCTION**

Remove crosscheck because Accident and Health Policy Experience Exhibit, Part 4 has been eliminated.

For Part 2, the GT (Grand Total) page:

- Column 13, Line 1.16 (Net Premiums Earned) should equal the Accident and Health Policy Experience Exhibit, Part 4, Column 1, Line D24 (Grand Total Individual, Group, and Other Business) minus Line D25 (Other Total Non-U.S. Policy Forms Direct Business).
- Column 13, Line 1.11 (Total Direct Premiums Earned) minus Line 1.15 (Other Adjustments Due to MLR Calculation – Premiums) should equal the Accident and Health Policy Experience Exhibit, Part 4, Column 21, Line D2 (Grand Total Individual, Group, and Other Business) minus Line D1 (U.S. Total Non-U.S. Policy Forms Direct Business).
- Column 13, Line 2.20 (Net Incurred Claims) minus Line 2.11 (Incurred Medical Incentive Pools and Bonuses) should equal the Accident and Health Policy Experience Exhibit, Part 4, Columns 92 plus 103, Line D26 (Grand Total Individual, Group, and Other Business) minus Line D12 (Other Total Non-U.S. Policy Forms Direct Business).
- Column 13, Line 2.15 (Total Incurred Claims) minus Line 2.8 (Paid Rate Credits) minus Line 2.9 (Reserve for Rate Credits Current Year) plus Line 2.10 (Reserve for Rate Credits Prior Year) minus Line 2.11 (Incurred Medical Incentive Pools and Bonuses) plus Line 2.19 (Other Adjustments Due to MLR Calculation – Claims) should equal the Accident and Health Policy Experience Exhibit, Part 4, Columns 62 plus 103, Line D2 (Grand Total Individual, Group, and Other Business) minus Line D1 (U.S. Total Non-U.S. Policy Forms Direct Business).

**NOTE:** If the reporting entity has a Premium Deficiency Reserve, they will fail the crosschecks above due to the Accident and Health Policy Experience Exhibit excluding Premium Deficiency Reserve. The reporting entity should provide that explanation for the crosscheck failure.
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<th>Statement Type</th>
<th>Filing Type</th>
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<tr>
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<td>Schedule BA, Part 1 FN</td>
<td><strong>CHANGE TO BLANK</strong></td>
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</tr>
<tr>
<td></td>
<td>Schedule D, Part 1 FN</td>
<td>Insert line numbers at beginning of footnote rows to distinguish between line numbers and designation categories.</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Schedule D, Part 2, Sn 1 FN</td>
<td>Book/Adjusted Carrying Value by NAIC Designation Category Footnote:</td>
<td></td>
<td>H, L/F,</td>
</tr>
<tr>
<td></td>
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<td>1A $ ---------------------------- 1B $ ------------------------- 1C $ ---------------------- 1D $ --------------------- 1 E $ --------------------- 1F $ ----------------</td>
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<td>P/C, T, SA</td>
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<td>Schedule DA, Part 1 FN</td>
<td>2. Book/Adjusted Carrying Value by NAIC Designation Category Footnote:</td>
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<td>Schedule E, Part 2 FN</td>
<td>3. Book/Adjusted Carrying Value by NAIC Designation Category Footnote:</td>
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<td>Insert line numbers at beginning of footnote rows to distinguish between line numbers and designation categories.</td>
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<td>Annual</td>
</tr>
<tr>
<td>2021</td>
<td>Schedule Y, Part 3</td>
<td><strong>CHANGE TO INSTRUCTION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Make the modification for Columns 5 and 6 shown below. These edit to proposal 2020-37BWG were made to the wrong column.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Column 5 – Ultimate Controlling Party</strong></td>
<td></td>
<td>H, L/F,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide the name of the ultimate controlling party all U.S. insurance groups (which is consistent with the ‘Group Name’ on Schedule Y—Part 1A) controlled by of the entity reported in Column 2. If an entity reported in Column 5 is not part of an insurance group, provide the name of the individual insurance entity. Within Schedule Y, the terms “Ultimate Controlling Party” and “Ultimate Controlling Entity(ies)/Person(s)” are used interchangeably.</td>
<td></td>
<td>P/C, T</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Column 6 – U.S. Insurance Groups or Entities Controlled by Column 5</strong></td>
<td></td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide the names of all U.S. insurance groups (which is consistent with the ‘Group Name’ on Schedule Y—Part 1A) or entities controlled by the entity reported in Column 5. If an entity reported in Column 5 is not part of an insurance group, provide the name of the individual insurance entity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statement Type</td>
<td>Description</td>
<td>Filing Type</td>
<td>Effective</td>
<td>Table Name</td>
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<tr>
<td>---------------</td>
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</tbody>
</table>

CHANGE TO INSTRUCTION

Modify the column description for Column 6 of Note 10O as shown below to match update to instructions.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
</table>
| Reporting Entity’s Share of Net Income (Loss) | Reporting Entity’s Share of Equity, including Negative Equity | Guaranteed Obligation / Commitment for Financial Support (Yes/No) | Amount of the Recognized Guarantee Under SSAP No. 5R | Reporting Entity’s Share of Net Income (Loss) | Guara...
# NAIC BLANKS (E) WORKING GROUP

## Blanks Agenda Item Submission Form

<table>
<thead>
<tr>
<th>CONTACT PERSON:</th>
<th>____________________________</th>
<th>FOR NAIC USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>TELEPHONE:</td>
<td>____________________________</td>
<td>Agenda Item # 2021-10BWG</td>
</tr>
<tr>
<td>EMAIL ADDRESS:</td>
<td>____________________________</td>
<td>Year 2022</td>
</tr>
<tr>
<td>ON BEHALF OF:</td>
<td>____________________________</td>
<td>Changes to Existing Reporting [ X ]</td>
</tr>
<tr>
<td>NAME:</td>
<td>____________________________</td>
<td>New Reporting Requirement [ ]</td>
</tr>
<tr>
<td>TITLE:</td>
<td>____________________________</td>
<td>REVIEWED FOR ACCOUNTING</td>
</tr>
<tr>
<td>AFFILIATION:</td>
<td>____________________________</td>
<td>PRACTICES AND PROCEDURES IMPACT</td>
</tr>
<tr>
<td>ADDRESS:</td>
<td>____________________________</td>
<td>No Impact [ X ]</td>
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**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**

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<tr>
<th>DISPOSITION</th>
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<tbody>
<tr>
<td>[ ] Rejected For Public Comment</td>
<td></td>
</tr>
<tr>
<td>[ ] Referred To Another NAIC Group</td>
<td></td>
</tr>
<tr>
<td>[ ] Received For Public Comment</td>
<td></td>
</tr>
<tr>
<td>[ X ] Adopted Date 07/22/2021</td>
<td></td>
</tr>
<tr>
<td>[ ] Rejected Date</td>
<td></td>
</tr>
<tr>
<td>[ ] Deferred Date</td>
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</tr>
<tr>
<td>[ ] Other (Specify)</td>
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</tr>
</tbody>
</table>

### BLANK(S) TO WHICH PROPOSAL APPLIES

- [ X ] ANNUAL STATEMENT
- [ X ] QUARTERLY STATEMENT
- [ X ] INSTRUCTIONS
- [ X ] CROSSCHECKS
- [ X ] Life, Accident & Health/ Fraternal
- [ X ] Property/Casualty
- [ X ] Health
- [ X ] Separate Accounts
- [ X ] Protected Cell
- [ X ] Health (Life Supplement)

Anticipated Effective Date: 1st Quarter 2022

### IDENTIFICATION OF ITEM(S) TO CHANGE

Remove language in quarterly General Interrogatories Part 1, line 4.1 that requires filing of a quarterly merger/history form. The annual form shall still be required.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

Proposal 2017-21BWG added language to the General Interrogatories to require filing a merger/history form for annual and quarterly statements. The annual form works as intended. It is used for IRIS calculations, as well as validations. The quarterly form does not function with the database system as currently designed. Therefore, the requirement to file quarterly should be removed.

### NAIC STAFF COMMENTS

Comment on Effective Reporting Date: ____________________________

Other Comments:

** This section must be completed on all forms. Revised 7/18/2018

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GENERAL INTERROGATORIES

PART 1 – COMMON INTERROGATORIES

1.1 Did the reporting entity experience any material transactions requiring the filing of Disclosure of Material Transactions with the State of Domicile, as required by the Model Act?

Yes [ ] No [ ]

1.2 If yes, has the report been filed with the domiciliary state?

Yes [ ] No [ ]

2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity?

Yes [ ] No [ ]

2.2 If yes, date of change:

__________________________

3.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer?

Yes [ ] No [ ]

If yes, complete Schedule Y, Parts 1 and 1A.

3.2 Have there been any substantial changes in the organizational chart since the prior quarter end?

Yes [ ] No [ ]

3.3 If the response to 3.2 is yes, provide a brief description of those changes.

...............................................................................................................................................................................................................................

...............................................................................................................................................................................................................................

3.4 Is the reporting entity publicly traded or a member of a publicly traded group?

Yes [ ] No [ ]

3.5 If the response to 3.4 is yes, provide the CIK (Central Index Key) code issued by the SEC for the entity/group.

__________________________

4.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement?

Yes [ ] No [ ]

If yes, complete and file the merger history data file with the NAIC.

Detail Eliminated to Conserve Space
## Blanks (E) Working Group

### Editorial Revisions to the Blanks and Instructions

*Presented at the July 22, 2021, Meeting*

Statement Type:
- **H** = Health
- **L/F** = Life/Fraternal Combined
- **P/C** = Property/Casualty
- **SA** = Separate Accounts
- **T** = Title

<table>
<thead>
<tr>
<th>Effective</th>
<th>Statement Type</th>
<th>Filing Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>2021</td>
<td><strong>CHANGE TO BLANK</strong></td>
<td>L/F</td>
</tr>
<tr>
<td></td>
<td><strong>Int. 1.01: Block entry for column 4, all total lines as it is a Yes/No response. Lines numbers updated to accommodate electronic data collection. (e.g., line 1.01A is presented as 1.01A0001 and total lines presented as 1.01A9999)</strong></td>
<td>Annual</td>
</tr>
<tr>
<td>2021</td>
<td><strong>CHANGE TO BLANK</strong></td>
<td>H, L/F, P/C, T</td>
</tr>
<tr>
<td></td>
<td><strong>With adoption of new Schedule Y Part 3, added reference to line 1.1. Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? If yes, complete Schedule Y, Parts 1, 1A, 2 and 3.</strong></td>
<td>Annual</td>
</tr>
<tr>
<td>2021</td>
<td><strong>CHANGE TO BLANK</strong></td>
<td>P</td>
</tr>
<tr>
<td></td>
<td><strong>Change column heading for column 19 to Ceded and column 20 to Direct. These were changed erroneously. This corrects them to align with Parts 1A and 1B.</strong></td>
<td>Annual</td>
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<td>2021</td>
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<td></td>
<td><strong>Block entry for columns 30 through 32, line 12. No need to sum ratio columns.</strong></td>
<td>Annual</td>
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<tr>
<td>2021</td>
<td><strong>CHANGE TO BLANK</strong></td>
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<tr>
<td></td>
<td><strong>Column 23 reads “Total net adjusting and other expenses unpaid”. The word “Total” is being removed so that it simply reads “net adjusting and other expenses unpaid”</strong></td>
<td>Annual</td>
</tr>
<tr>
<td>Effective</td>
<td>Statement Type</td>
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<td>Mortgage Guaranty Insurance Summary Part 1A and Part 1B</td>
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<td>2021</td>
<td>Mortgage Guaranty Insurance Summary Part 1A and Part 1B</td>
<td>P</td>
</tr>
</tbody>
</table>

**CHANGE TO BLANK**

Clarify the data being requested for Column 32, the title of that column is "Net Loss and LAE Coverage" to make it clear what is being requested the title is being changed to "Net Loss and LAE as a % of Original Risk in Force".

**CHANGE TO INSTRUCTIONS**

Duplication in the data is being requested. Columns 24 asks for "Total net losses and LAE unpaid" and Column 33 which asks for "Net Reserves", Column 33 is being removed.
June 1, 2021

TO: Jacob Garn, Chair
    Blanks (E) Working Group
FROM: Marti Hooper, Chair
    Health Actuarial (B) Task Force
DATE: June 1, 2021
SUBJECT: Health Actuarial Statement of Opinion Guidance for the 2021 Reporting Year

Dear Mr. Garn,

The Actuarial Standards Board received comments while exposing Actuarial Standard of Practice (ASOP) No. 28 that indicated some actuaries felt the NAIC Health Annual Statement instructions regarding Statements of Actuarial Opinion were not in concert with the proposed ASOP. The Annual Statement instructions specifically addressed the treatment of actuarial liabilities, but not actuarial assets. To avoid future confusion on the matter, we intend to update the wording for the 2022 instructions to clarify that both actuarial liabilities and assets should be considered in the opinion. We view this as a clarification and not a change in practice; actuaries should be considering actuarial assets when making Statements of Actuarial Opinion.

Thank You,
Marti Hooper

Cc: Paul Lombardo, Jaak Sundberg, Mary Caswell, Calvin Ferguson, Eric King

w:\national meetings\2021\summer\tf\app\blankswg\minutes\att two-d_health sao 2021 guidance memo.docx
2022 PROPOSED CHARGES

ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE

The mission of the Accounting Practices and Procedures (E) Task Force is to identify, investigate and develop solutions to accounting problems with the ultimate goal of guiding insurers in properly accounting for various aspects of their operations; modify the Accounting Practices and Procedures Manual [AP&P Manual] to reflect changes necessitated by Task Force action; and study innovative insurer accounting practices that affect the ability of state insurance regulators to determine the true financial condition of insurers.

Ongoing Support of NAIC Programs, Products or Services

1. The Accounting Practices and Procedures (E) Task Force will:

2. The Blanks (E) Working Group will:
   A. Consider improvements and revisions to the various annual/quarterly statement blanks to:
      1. Conform these blanks to changes made in other areas of the NAIC to promote uniformity in reporting of financial information.
      2. Develop reporting formats for other entities subject to the jurisdiction of state insurance departments.
      3. Conform the various NAIC blanks and instructions to adopted NAIC policy.
      4. Oversee the development of additional reporting formats within the existing annual financial statements as needs are identified.
   B. Continue to monitor state filing checklists to maintain current filing requirements.
   C. Continue to monitor and improve the quality of financial data filed by insurance companies by recommending improved or additional language for the Annual Statement Instructions.
   D. Continue to monitor and review all proposals necessary for the implementation of statutory accounting guidance to ensure proper implementation of any action taken by the Accounting Practices and Procedures (E) Task Force affecting annual financial statements and/or instructions.
   E. Continue to coordinate with other task forces of the NAIC to ensure proper implementation of reporting and instructions changes as proposed by these taskforces.
   F. Coordinate with the Life Actuarial (A) Task Force to use any special reports developed and avoid duplication of reporting.
   G. Review requests for investment schedule blanks and instructions changes in connection with the work being performed by the Capital Adequacy (E) Task Force and its working groups.
   H. Review changes requested by the Valuation of Securities (E) Task Force relating to its work on other invested assets reporting for technical consistency within the investment reporting schedules and instructions.

3. The Statutory Accounting Principles (E) Working Group will:
   A. Maintain codified statutory accounting principles by providing periodic updates to the guidance that address new statutory issues and new generally accepted accounting principles (GAAP) pronouncements. Provide authoritative responses to questions of application and clarifications for existing statutory accounting principles. Report all actions and provide updates to the Accounting Practices and Procedures (E) Task Force.
   B. At the discretion of the Working Group chair, develop comments on exposed GAAP and International Financial Reporting Standards (IFRS) pronouncements affecting financial accounting and reporting. Any comments are subject to review and approval by the chair of the Accounting Practices and Procedures (E) Task Force and the Financial Condition (E) Committee.
   C. Coordinate with the Life Actuarial (A) Task Force on changes to the AP&P Manual related to the Valuation Manual VM-A, Requirements, and VM-C, Actuarial Guidelines, as well as other Valuation Manual requirements. This process will include the receipt of periodic reports on changes to the Valuation Manual on items that require coordination.
   D. Obtain, analyze and review information on permitted practices, prescribed practices or other accounting treatments suggesting that issues or trends occurring within the industry may compromise the consistency and uniformity of statutory accounting, including, but not limited to, activities conducted by insurers for which there is currently no statutory accounting guidance or where the states have prescribed statutory accounting that differs from the guidance issued by the NAIC. Use this information to consider possible changes to statutory accounting.
Communication of Internal Control Related Matters Noted in an Audit (Section 11)

In addition to the annual Audited financial report, each insurer must furnish the Commissioner with a written communication as to any unremediated material weakness in its internal control over financial reporting noted during the audit. The communication is prepared by the accountant within 60 days after the filing of the annual Audited financial report and is filed by the insurer. Recognizing it may not always be practical, insurers are encouraged to file the communication concurrently with the filing of the annual Audited financial report for those years in which the insurer is aware that a financial condition examination has been scheduled. The insurer is required to provide a description of remedial actions taken or proposed to correct unremediated material weaknesses, if the actions are not described in the accountant’s communication.

The Model requires that the Commissioner be notified when unremediated material weaknesses in internal control over financial reporting were noted during the audit. Previous versions of the Model required such communication when any significant deficiencies in internal control over financial reporting were noted during the audit, whether remediated or not. This distinction is important because of the level of severity of the internal control deficiency that is applicable to each term. The terms “material weakness” and “significant deficiency” have the same meaning respectively as used in PCAOB or American Institute of Certified Public Accountants (AICPA) auditing literature - PCAOB Auditing Standard No. 5, An Audit of Internal Control over Financial Reporting That is Integrated With an Audit of Financial Statements or AICPA AU Section 325, Communicating Internal Control Matters Identified in an Audit (see Section 17E of this Guide for the definitions of material weakness and significant deficiency that are included in the auditing literature). However, the insurer is expected to maintain information about significant deficiencies that were communicated by its auditors and such information should be available for review during the financial condition examination.

Effective for audits as of 12/31/21 and thereafter, the information required in Section 12 of the MAR required to be communicated by the accountant should be supplemented by providing both the name of the current lead audit partner and the year at which he or she began serving in that capacity. For the purpose of maintaining confidentiality, this information will not be included in the annual letter of qualifications, but instead shall be included in the internal control communication required in Section 11 of the MAR by the accountant as a footer or under the firm signature as follows:

The engagement partner, [name], has served in that capacity with respect to the Company since [year that current term started].
Consistent with the Drafting Note\(^1\) to Section 11 of the MAR, the information provided on the engagement partner shall remain confidential.

The following is an example of the type of communication that an insurer should prepare to communicate the remedial actions taken or proposed to correct a material weakness in its internal control over financial reporting noted during an audit.

\(^1\) The insurer is expected to maintain information about significant deficiencies communicated by the independent certified public accountant. Such information should be made available to the examiner conducting a financial condition examination for review and kept in such a manner as to remain confidential.
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The Capital Adequacy (E) Task Force met July 28, 2021. The following Task Force members participated: Judith L. French, Chair, represented by Tom Botsko (OH); Doug Slape, Vice Chair, represented by Rachel Hemphill (TX); Lori K. Wing-Heier represented by David Phifer (AK); Jim L. Ridling represented by Shelia Travis (AL); Ricardo Lara represented by Perry Kupferman (CA); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by Philip Barlow (DC); David Almdahl represented by Virginia Christy and Robert Ridenour (FL); Doug Ommen represented by Tish Becker (KS); Sharon P. Clark represented by Russell Coy (KY); Grace Arnold represented by John Rehagen and William Leung (MO); Eric Dunning represented Lindsay Crawford (NE); Marlene Caride represented by Diana Sherman (NJ); Glen Mulready (OK); Raymond G. Farmer represented by Michael Shull (SC); Mike Kreidler represented by Steve Drutz (WA); and Mark Afable represented by Amy Malm (WI).

1. **Adopted its June 30, April 29 and Spring National Meeting Minutes**

The Task Force met June 30, April 29 and March 23. During its June 30 meeting, the Task Force adopted the following proposals: 1) 2021-04-CA (investment income in health underwriting factors); 2) 2021-07-CA (receivables for securities factors); 3) 2021-06-L (real estate factors); 4) 2021-08-P (property and casualty bond factors); 5) 2021-09-H (health bond factors); 6) 2021-11-L (life bond factors); and 7) 2021-13-L (longevity risk factors and instructions). Mr. Barlow noted that a typo on the second page of the June 30 minutes, end of the paragraph for item 5, should reflect 2.4 as the factor for the first 50 assets and not 2.9. During its April 29 meeting, the Task Force took the following action: 1) adopted the real estate structure; 2) adopted the managed care credit incentives; 3) adopted the credit risk instruction modification; 4) adopted its working agenda and working group reports; and 5) exposed the receivables for securities factors and investment income in health underwriting factors, with comments due May 21 and May 28, respectively.

Mr. Barlow made a motion, seconded by Mr. Chou to adopt the Task Force’s June 30 (Attachment One), April 29 (Attachment Two), and March 23 (see NAIC Proceedings – Spring 2021, Capital Adequacy (E) Task Force) minutes. The motion passed unanimously.

2. **Adopted the Reports and Minutes of its Working Groups**

a. **Health Risk-Based Capital (E) Working Group**

Mr. Drutz noted some items of interest from the Health Risk-Based Capital (E) Working Group’s July 12 minutes, which include interest in health risk-based capital in the underwriting risk charge and re-evaluating the bond factors. The Working Group also adopted its 2021 newsletter and 2020 health risk-based capital (RBC) statistics.

b. **Life Risk-Based Capital (E) Working Group**

Mr. Barlow said that the Life Risk-Based Capital (E) Working Group met July 21 and took the following action: 1) adopted various minutes reflecting a busy last quarter; 2) adopted the life RBC newsletter; and 3) the 2020 life and fraternal RBC statistics.

c. **Catastrophe Risk (E) Subgroup**

Mr. Chou noted that the Catastrophe Risk (E) Subgroup met July 15 and took the following action: 1) adopted its June 1 and April 26 minutes; 2) adopted its working agenda items; 3) heard an update from its Catastrophe Model Technical Review Ad Hoc Group; and 4) heard a presentation from AIR Worldwide regarding the wildfire model.

d. **Property and Casualty Risk-Based Capital (E) Working Group**

Mr. Botsko said that the Property and Casualty Risk-Based Capital (E) Working Group met July 22 and took the following action: 1) adopted its June 9 and April 27 minutes; 2) adopted the Catastrophe Risk (E) Subgroup’s July 15 minutes; 3) adopted its 2021 property/casualty (P/C) RBC newsletter; 4) adopted its 2020 P/C RBC statistics; 5) adopted its 2021 working agenda;
and 6) heard an update on different projects related to calibrating various components of the underwriting risk and reserve risk from the American Academy of Actuaries (Academy).

Ms. Hemphill made a motion, seconded by Mr. Chou, to adopt the reports of the Health Risk-Based Capital (E) Working Group (Attachment Three), the Life Risk-Based Capital (E) Working Group (Attachment Four), and the Property and Casualty Risk-Based Capital (E) Working Group (Attachment Five). The motion passed unanimously.

3. **Adopted Proposal 2021-04-CA**

Mr. Drutz said the Task Force adopted proposal 2021-04-CA (Modified for Rounding) June 30. The proposal revised the underwriting risk for the investment income adjustment, which carried the factor to four decimal places. During implementation, NAIC staff noted a system constraint in which all ratios reported in a column must round to the same number of decimal places. This includes the underwriting risk claims ratio and managed care discount factor, (Lines 12 and 15 in health and Lines 9 and 12 in P/C and life).

Mr. Drutz made a motion, seconded by Mr. Leung, to adopt proposal 2021-04-CA (Modified for Rounding) (Attachment Six). The motion passed unanimously. Mr. Botsko added that the rounding made a small negligible difference.

4. **Adopted its Working Agenda**

Mr. Barlow noted that the life section of the working agenda removed several items that were previously adopted by its Working Group, modified the description regarding longevity risk transfers, and added two new items regarding guidance on the potential impact of the bond factor changes and reviewing companies in action level to determine its drivers.

Mr. Drutz said that the health section of the working agenda clarified the description regarding investment income by including a process for reviewing investment income, as well as determining the frequency of adjustments and if other lines of business are affected.

Mr. Chou reported that the Catastrophe Risk (E) Subgroup received a referral from the Climate and Resiliency (EX) Task Force and will make that referral a priority for 2022.

Mr. Botsko said the P/C items were updated to reflect recent adoptions, and the expected completion dates were updated for 2022. He also said that the Task Force items were also updated with recent adoption information, and the expected completion dates were also updated.

Mr. Chou made a motion, seconded by Mr. Leung, to adopt its working agenda (Attachment Seven). The motion passed unanimously.

5. **Discussed Other Matters**

Mr. Botsko said he wanted to thank Randy Milquet (WI) for his dedication to the Property and Casualty Risk-Based Capital (E) Working Group and various RBC-related ad hoc groups, as well as for his participation with the Capital Adequacy (E) Task Force. Mr. Botsko said will be greatly missed.

Mr. Barlow added that John Robinson (MN) is also retiring and wanted to thank him for his dedication and participation with the Life Risk-Based Capital (E) Working Group and the Capital Adequacy (E) Task Force.

Having no further business, the Capital Adequacy (E) Task Force adjourned.
The Capital Adequacy (E) Task Force met June 30, 2021. The following Task Force members participated: Judith L. French, Chair, represented by Tom Botsko (OH); Doug Slape, Vice Chair, represented by Rachel Hemphill (TX); Lori K. Wing-Heier represented by Wally Thomas (AK); Jim L. Ridling represented by Richard Ford (AL); Ricardo Lara represented by Thomas Reedy (CA); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by Philip Barlow (DC); David Altmair represented by Carolyn Morgan (FL); Doug Ommen represented by Carrie Mears (IA); Dana Popish Severinghaus represented by Kevin Fry (IL); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Russell Coy (KY); Chlora Lindley-Myers represented by John Rehagen and William Leung (MO); Mike Causey represented by Jackie Obusek (NC); Eric Dunning represented Rhonda Ahrens (NE); Marlene Caride represented by Diana Sherman (NJ); Mike Kreidler represented by Steve Drutz (WA); and Mark Afable represented by Randy Milquet (WI).

1. **Adopted Proposal 2021-04-CA (Investment Income Health Underwriting Factors)**

Mr. Drutz said proposal 2021-04-CA was developed to adjust the health underwriting risk factors to incorporate a 0.5% investment income adjustment into the Comprehensive Medical, Medicare Supplemental, and Dental/Vision. The revised factors will be included in the health, life, and property/casualty (P/C) formulas. The proposal was exposed at both the working group and task force level. Comments were received and supported the adoption of the 0.5% investment income adjustment.

Mr. Drutz added that there was a minor editorial correction to the life and P/C blanks to reflect the factors on Line 10.1 and Line 10.2 on page LR020 and PR020, respectively. The Health Risk-Based Capital (E) Working Group will continue to discuss the development of a benchmarking system to use in updating the factors, as well as the frequency for updates.

Mr. Drutz made a motion, seconded by Mr. Chou, to adopt proposal 2021-04-CA with the editorial change to reflect the factors on Line 10.1 and Line 10.2 on page LR020 and PR020 (Attachment One-A). The motion passed unanimously.

2. **Adopted Proposal 2021-07-CA (Receivables for Securities Factors)**

Mr. Botsko said the receivables for securities factors were exposed for a 30-day public comment period ending May 28. No comments were received. The Task Force agreed to update the factors every three years.

Mr. Thomas made a motion, seconded by Mr. Chou, to adopt proposal 2021-07-CA (Attachment One-B). The motion passed unanimously.

3. **Adopted Proposal 2021-09-H (Health Bond Factors)**

The Health Risk-Based Capital (E) Working Group adopted the five-year time horizon bond factors developed by the American Academy of Actuaries (Academy) during its May 25 meeting. The health factors have incorporated the bond portfolio adjustment within the factors.

Mr. Drutz made a motion, seconded by Ms. Ahrens, to adopt proposal 2021-09-H (Attachment One-C). The motion passed unanimously.

4. **Adopted Proposal 2021-06-L (Real Estate Factors – Modified)**

Mr. Barlow said proposal 2021-06-L was modified with the factor for the market value adjustment set to zero and will work further with the Statutory Accounting Principles (E) Working Group, the Risk-Focused Surveillance (E) Working Group and the American Council of Life Insurers (ACLI) to set the market value adjustment.

Mr. Barlow made a motion, seconded by Ms. Hemphill, to adopt proposal 2021-06-L (Attachment One-D). The motion passed unanimously.
5. **Adopted Proposal 2021-11-L (Life Bond Factors)**

Mr. Barlow said that the proposal being considered also includes an adjustment to reduce the burden on smaller companies, which is to change the bond size adjustment to use factors that have a break point at up to the current 50 assets and would revise the factor for the first 50 assets to be 2.4.

Mr. Barlow made a motion, seconded by Mr. Leung, to adopt proposal 2021-11-L (Attachment One-E). The motion passed.

6. **Adopted Proposal 2021-12-L (Reinsurance)**

Mr. Barlow stated that the Life Reinsurance Proposal intends to address the 2019 revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786).

Mr. Barlow made a motion, seconded by Mr. Thomas, to adopt proposal 2021-12-L (Attachment One-F). The motion passed unanimously.

7. **Adopted Proposal 2021-13-L (Longevity Risk Factors and Instructions)**

Mr. Barlow said that the proposal for longevity risk includes tiered after-tax factors of 1.35% down to 0.70%, negative 0.25 covariance, and no guardrail. He said it will be effective for year-end 2021, and any future work regarding the reserve should be considered by the Life Actuarial (A) Task Force.

Mr. Barlow made a motion, seconded by Ms. Ahrens, to adopt proposal 2021-13-L (Attachment One-G). The motion passed unanimously.

8. **Adopted Proposal 2021-03-P (Credit Risk Instruction Modification)**

Mr. Botsko said the purpose of this proposal is to provide examples to clarify how the reporting companies should select the designation in the Annual Statement Schedule F, Part 3, Reinsurer Designation Equivalent Rating column if the reporting entities subscribe to one or multiple rating agencies. He also stated that the Property and Casualty Risk-Based Capital (E) Working Group received no comments during the exposure period.

Mr. Milquet made a motion, seconded by Mr. Chou, to adopt proposal 2021-03-P (Attachment One-H). The motion passed unanimously.


Mr. Botsko said the purpose of this proposal is to provide a routine annual update to the Line 1 premium and reserve industry underwriting factors in the P/C risk-based capital (RBC) formula. He also stated that the Property and Casualty Risk-Based Capital (E) Working Group received no comments during the exposure period.

Mr. Chou made a motion, seconded by Mr. Drutz, to adopt proposal 2021-05-P (Attachment One-I). The motion passed unanimously.

10. **Adopted Proposal 2021-08-P (P/C Bond Factors)**

Mr. Botsko said the purpose of this proposal is to modify the P/C RBC forecasting and instructions to: 1) incorporate 20 NAIC designation category bond factors; 2) modify the bond size factor formula; and 3) reclassify hybrid securities in PR006, PR011, and PR015. He also stated that the expansion of 20 NAIC designation categories will provide more robust and accurate results, primarily as it increases the granularity of the formula and reduces the cliffs between the different factors for the different categories. Mr. Botsko also stated that the Property and Casualty Risk-Based Capital (E) Working Group received no comments during the exposure period.

Mr. Chou made a motion, seconded by Mr. Thomas, to adopt proposal 2021-08-P (Attachment One-J). The motion passed unanimously.

Having no further business, the Capital Adequacy (E) Task Force adjourned.
## Capital Adequacy (E) Task Force

### RBC Proposal Form

| [ ] | Catastrophe Risk (E) Subgroup | [ ] | Investment RBC (E) Working Group | [ ] | Longevity Risk (A/E) Subgroup |
| [ ] | C3 Phase II/ AG43 (E/A) Subgroup | [ ] | P/C RBC (E) Working Group |

**DATE:** 3-17-21

**CONTACT PERSON:** Crystal Brown

**TELEPHONE:** 816-783-8146

**EMAIL ADDRESS:** cbrown@naic.org

**ON BEHALF OF:** Health RBC (E) Working Group

**NAME:** Steve Drutz

**TITLE:** Chief Financial Analyst/Chair

**AFFILIATION:** WA Office of Insurance Commissioner

**ADDRESS:** PO Box 40255

Olympia, WA 98504-0255

---

**FOR NAIC USE ONLY**

<table>
<thead>
<tr>
<th>Agenda Item # 2021-04-CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2021</td>
</tr>
</tbody>
</table>

**DISPOSITION**

- [ ] ADOPTED
- [ ] REJECTED
- [ ] DEFERRED TO
- [ ] REFERRED TO OTHER NAIC GROUP
- [x] EXPOSED 4-16-21
- [ ] OTHER (SPECIFY)

---

**IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED**

- [x] Health RBC Blanks
- [x] Property/Casualty RBC Blanks
- [x] Life and Fraternal RBC Instructions
- [x] Health RBC Instructions
- [x] Property/Casualty RBC Instructions
- [x] Life and Fraternal RBC Blanks
- [ ] OTHER ____________________________

---

**DESCRIPTION OF CHANGE(S)**

Incorporate investment income into the Underwriting Risk – Experience Fluctuation Risk factors for columns 1-3. The base underwriting factors would be adjusted for Comprehensive Medical, Medicare Supplement and Dental and Vision.

---

**REASON OR JUSTIFICATION FOR CHANGE **

Incorporated investment income into Columns 1-3 on the Underwriting Risk – Experience Fluctuation Risk page. The American Academy of Actuaries provided recommended factors to the Working Group. The Academy found that due to no claims lag in Stand-Alone Medicare Part D coverage, the investment income adjustment would be negligible and the RBC factors would not be impacted.

The Working Group will continue to work with the Academy to look at the potential to incorporate an investment income adjustment to the factors for the other health lines of business for 2022 or later.

---

**Additional Staff Comments:**

These changes will also need to be incorporated into the Life and P/C formula.

3-17-21 cgb The Working Group exposed the proposal for 30-days with comments due back on April 16, 2021.

---

**This section must be completed on all forms.**

---

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Underwriting Risk is the largest portion of the risk-based capital charge for most reporting entities. The Underwriting Risk page generates the RBC requirement for the risk of fluctuations in underwriting experience. The credit that is allowed for managed care in this page comes from the Managed Care Credit Calculation page.

Underwriting risk is present when the next dollar of unexpected claim payments comes directly out of the reporting entity’s capital and surplus. It represents the risk that the portion of premiums intended to cover medical expenses will be insufficient to pay such expense. For example, a reporting entity may charge an individual $100 in premium in exchange for a guaranty that all medical costs will be paid by that reporting entity. If the individual incurs $101 in claims costs, the reporting entity’s surplus will decline because it did not charge a sufficient premium to pick up the additional risk for that individual.

There are other arrangements where the reporting entity is not at risk for excessive claims payments, such as when an HMO agrees to serve as a third-party administrator for a self-insured employer. The self-insured employer pays for actual claim costs, so the risk of excessive claims experience is borne by the self-insured employer, not the reporting entity. The underwriting risk section of the formula, therefore, requires some adjustments to remove non-underwriting risk business (both premiums and claims) before the RBC requirement is calculated. Appendix 1 contains commonly used terms for general types of health insurance.

Refer to INT 05-05: Accounting for Revenue under Medicare Part D Cover for terms specifically used with respect to Medicare Part D coverage of prescription drugs.

Claims Experience Fluctuation

The RBC requirement for claims experience fluctuation is based on the greater of the following calculations:

A. Underwriting risk revenue, times the underwriting risk claims ratio, times a set of tiered factors. The tiered factors are determined by the underwriting risk revenue volume.

or

B. An alternative risk charge that addresses the risk of catastrophic claims on any single individual. The alternative risk charge is equal to multiple of the maximum retained risk on any single individual in a claims year. The maximum retained risk (level of potential claim exposure) is capped at $750,000 per individual and $1,500,000 total for medical coverage; $25,000 per individual and $50,000 total for all other coverage except Medicare Part D coverage and $25,000 per individual and $150,000 total for Medicare Part D coverage. Additionally, for multi-line organizations (e.g., writing more than one coverage type), the alternative risk charge for each subsequent line of business is reduced by the amount of the highest cap. For example, if an organization is writing both comprehensive medical (with a cap of $1,500,000) and dental (with a cap of $50,000), then only the larger alternative risk charge is considered when calculating the RBC requirement (i.e., the alternative risk charges for each line of business are not cumulative).

For RBC reports to be filed by a health organization commencing operations in this reporting year, the health organization shall estimate the initial RBC levels using operating (revenue and expense) projections (considering managed care arrangements) for its first full year (12 months) of managed care operations. The projections, including the risk-based capital requirement, should be the same as those filed as part of a comprehensive business plan that is submitted as part of the application for licensure. The Underwriting, Credit (capitation risk only), and Business Risk sections of the first RBC report submitted shall be completed using
the health organization’s actual operating data for the period from the commencement of operations until year-end, plus projections for the number of months necessary to provide 12 months of data. The affiliate, asset and portions of the credit risk section that are based on balance sheet information shall be reported using actual data. For subsequent years’ reports, the RBC results for all of the formula components shall be calculated using actual data.

L(1) through L(21)

There are six lines of business used in the formula for calculating the RBC requirement for this risk: (1) Comprehensive Medical and Hospital; (2) Medicare Supplement; (3) Dental/Vision; (4) Stand-Alone Medicare Part D Coverage; and (5) Other Health; and (6) Other Non-Health. Each of these lines of business has its own column in the Underwriting Risk – Experience Fluctuation Risk table. The categories listed in the columns of this page include all risk revenue and risk revenue that is received from another reporting entity in exchange for medical services provided to its members. The descriptions of the items are described as follows:

Column (1) - Comprehensive Medical & Hospital. Includes policies providing for medical coverages including hospital, surgical, major medical, Medicare risk coverage (but NOT Medicare Supplement), and Medicaid risk coverage. This category DOES NOT include administrative services contracts (ASC), administrative services only (ASO) contracts, or any non-underwritten business. These programs are reported in the Business Risk section of the formula. Neither does it include Federal Employees Health Benefit Plan (FEHBP) or TRICARE, which are handled in Line 24 of this section. Medicaid Pass-Through Payments reported as premiums should also be excluded from this category and should be reported in Line 25.2 of this section. The alternative risk charge, which is twice the maximum retained risk after reinsurance on any single individual, cannot exceed $1,500,000. Prescription drug benefits included in major medical insurance plans (including Medicare Advantage plans with prescription drug coverage) should be reported in this line. These benefits should also be included in the Managed Care Credit calculation.

Column (2) - Medicare Supplement. This is business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement and includes Medicare Select. Medicare risk business is reported under comprehensive medical and hospital.

Column (3) - Dental & Vision. This is limited to policies providing for dental-only or vision-only coverage issued as a stand-alone policy or as a rider to a medical policy, which is not related to the medical policy through deductibles or out-of-pocket limits.

Column (4) - Stand-Alone Medicare Part D Coverage. This includes both individual coverage and group coverage of Medicare Part D coverage where the plan sponsor has risk corridor protection. See INT 05-05: Accounting for Revenue under Medicare Part D Coverage for definition of these terms. Medicare drug benefits included in major medical plans or benefits that do not meet the above criteria are not to be included in this line. Supplemental benefits within Medicare Part D (benefits in excess of the standard benefit design) are addressed separately on page XR014. Employer-based Part D coverage that is in an uninsured plan as defined in SSAP No. 47—Uninsured Plans is not to be included here.

Column (5) - Other Health Coverages. This includes other health coverages such as other stand-alone prescription drug benefit plans, NOT INCLUDED ABOVE that have not been specifically addressed in the other columns listed above.

Column (6) - Other Non-Health Coverages. This includes life and property and casualty coverages.

The following paragraphs explain the meaning of each line of the table for computing the experience fluctuation underwriting risk RBC.
<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Premium</td>
<td>This is the amount of money charged by the reporting entity for the specified benefit plan. It is the earned amount of prepayments (usually on a per member per month basis) made by a covered group or individual to the reporting entity in exchange for services to be provided or offered by such organization. However, it does not include receipts under administrative services only (ASO) contracts; or administrative services contracts (ASC); or any non-underwritten business. Nor does it include federal employees health benefit programs (FEHBP) and TRICARE. Report premium net of payments for stop-loss or other reinsurance. The amounts reported in the individual columns should come directly from Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement. For Stand-Alone Medicare Part D Coverage the premium includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D payment demonstration amounts and risk corridor payment adjustments. See INT 05-05: Accounting for Revenue under Medicare Part D Coverage for definition of these terms. It does not include revenue received for reinsurance payments or low-income subsidy (cost-sharing portion), which are considered funds received for uninsured plans in accordance with Emerging Accounting Issues Working Group (EAIWG) INT. No. 05-05. Also exclude the beneficiary premium (supplemental benefit portion) for Stand-Alone Medicare Part D coverage. &lt;br&gt;NOTE: Where premiums are paid on a monthly basis, they are generally fully earned at the end of the month for which coverage is provided. In cases where the mode of payment is less frequent than monthly, a portion of the premium payment will be unearned at the end of any given reporting period.</td>
</tr>
<tr>
<td>2. Title XVIII Medicare</td>
<td>This is the earned amount of money charged by the reporting entity (net of reinsurance) for Medicare risk business where the reporting entity, for a fee, agrees to cover the full medical costs of Medicare subscribers. This includes the beneficiary premium and federal government’s direct subsidy for prescription drug coverage under MA-PD plans. The total of this line will tie to the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement.</td>
</tr>
<tr>
<td>3. Title XIX Medicaid</td>
<td>This is the earned amount of money charged by the reporting entity for Medicaid risk business where the reporting entity, for a fee, agrees to cover the full medical costs of Medicaid subscribers. The total of this line will tie to the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement. Stand-Alone Medicare Part D coverage of low-income enrollees is not included in this line.</td>
</tr>
<tr>
<td>4. Other Health Risk Revenue</td>
<td>This is earned amounts charged by the reporting entity as a provider or intermediary for specified medical (e.g., full professional, dental, radiology, etc.) services provided to the policyholders, or members of another insurer or health entity. Unlike premiums, which are collected from an employer group or individual member, risk revenue is the prepaid (usually on a capitated basis) payments, made by another insurer or health entity to the reporting entity in exchange for services to be provided or offered by such organization. Payments to providers under risk revenue arrangements are included in the RBC calculation as underwriting risk revenue and are included in the calculation of managed care credits. Exclude fee-for-service revenue received by the reporting entity from another reporting entity. This revenue is reported in the Business Risk section of the formula as non-underwritten and limited risk revenue. The amounts reported in the individual columns will come directly from Page 7, Line 4 of the annual statement.</td>
</tr>
<tr>
<td>5. Medicaid Pass-Through Payments Reported as Premiums</td>
<td>Medicaid Pass-Through Payments that are included as premiums in the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 should be reported in this line.</td>
</tr>
<tr>
<td>6. Underwriting Risk Revenue</td>
<td>The sum of Lines (1) through (4) minus Line (5).</td>
</tr>
</tbody>
</table>
| 7. Net Incurred Claims | Claims incurred (paid claims + change in unpaid claims) during the reporting year (net of reinsurance) that are arranged for or provided by the reporting entity. Paid claims include capitation and all other payments to providers for services to members of the reporting entity, as well as reimbursement directly to members for covered services. Paid claims also include salaries paid to reporting entity employees that provide medical services to
members and related expenses. Do not include ASC payments or federal employees health benefit program (FEHBP) and TRICARE claims. These amounts are found on Page 7, Line 17 of the annual statement.

For Stand-Alone Medicare Part D Coverage, net incurred claims should reflect claims net of reinsurance coverage (as defined in INT 05-05: Accounting for Revenue under Medicare Part D Coverage). Where there has been prepayment under the reinsurance coverage, paid claims should be offset from the cumulative deposits. Unpaid claims liabilities should reflect expected recoveries from the reinsurance coverage, for claims unpaid by the PDP or for amounts covered under the reinsurance coverage that exceed the cumulative deposits. Where there has not been any prepayment under the reinsurance coverage, unpaid claim liabilities should reflect expected amounts still due from CMS. Exclude the beneficiary incurred claims (supplemental benefit portion) for Stand-Alone Medicare Part D coverage and report the incurred claims amount (supplemental benefit portion) on Line (25.1) of page XR014.

Line (8) Medicaid Pass-Through Payments Reported as Claims. Medicaid Pass-Through Payments that are included as claims in the Analysis of Operations by Lines of Business, Page 7, Line 17 should be reported in this line.

Line (9) Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Claims. Line (7) minus Line (8).

Line (10) Fee-for-Service Offset. Report fee for service revenue that is directly related to medical expense payments. The fee for service line does not include revenue where there is no associated claim payment (e.g., fees from non-member patients where the provider receives no additional compensation from the reporting entity) and when such revenue was excluded from the pricing of medical benefits. The amounts reported in the individual columns should come directly from Page 7, Line 3 of the annual statement.

Line (11) Underwriting Risk Incurred Claims. Line (9) minus Line (10).

Line (12) Underwriting Risk Claims Ratio. For Columns (1) through (5), Line (11) / Line (6). If either Line (6) or Line (11) is zero or negative, Line (12) is zero.

Line (13) Underwriting Risk Factor. A weighted average factor based on the amount reported in Line (6), Underwriting Risk Revenue. The factors for Column 1-3 have incorporated investment income.

<table>
<thead>
<tr>
<th></th>
<th>$0 – $3</th>
<th>$3 – $25</th>
<th>Over $25</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Medical &amp; Hospital</td>
<td>0.150</td>
<td>0.150</td>
<td>0.090</td>
</tr>
<tr>
<td>Medicare Supplement</td>
<td>0.105</td>
<td>0.067</td>
<td>0.067</td>
</tr>
<tr>
<td>Dental &amp; Vision</td>
<td>0.120</td>
<td>0.076</td>
<td>0.076</td>
</tr>
<tr>
<td>Stand-Alone Medicare Part D Coverage</td>
<td>0.251</td>
<td>0.251</td>
<td>0.151</td>
</tr>
<tr>
<td>Other Health</td>
<td>0.130</td>
<td>0.130</td>
<td>0.130</td>
</tr>
<tr>
<td>Other Non-Health</td>
<td>0.130</td>
<td>0.130</td>
<td>0.130</td>
</tr>
</tbody>
</table>

Line (14) Base Underwriting Risk RBC. Line (6) x Line (12) x Line (13).

Line (15) Managed Care Discount. For Comprehensive Medical & Hospital, Medicare Supplement (including Medicare Select) and Dental/Vision, a managed care discount, based on the type of managed care arrangements an organization has with its providers, is included to reflect the reduction in the uncertainty about future

The factors for the highlighted items to the left will be updated based on either Option 1 or Option 2.
claim payments attributable to the managed care arrangements. The discount factor is from Column (3), Line (17) of the Managed Care Credit Calculation page. An average factor based on the combined results of these three categories is used for all three.

For Stand-Alone Medicare Part D Coverage, a separate managed care discount (or federal program credit) is included to reflect only the reduction in uncertainty about future claims payments attributable to federal risk arrangements. The discount factor is from Column (4), Line (17) of the Managed Care Credit Calculation page.

There is no discount given for the Other Health and Other Non-Health lines of business.

Line (16) RBC After Managed Care Discount Line (14) x Line (15).

Line (17) Maximum Per-Individual Risk After Reinsurance. This is the maximum after-reinsurance loss for any single individual. Where specific stop-loss reinsurance protection is in place, the maximum per-individual risk after reinsurance is equal to the highest attachment point on such stop-loss reinsurance, subject to the following:

- Where coverage under the stop-loss protection (plus retention) with the highest attachment point is capped at less than $750,000 per member, the maximum retained loss will be equal to such attachment point plus the difference between the coverage (plus retention) and $750,000.
- Where the stop-loss layer is subject to participation by the reporting entity, the maximum retained risk as calculated above will be increased by the reporting entity’s participation in the stop-loss layer (up to $750,000 less retention).

If there is no specific stop-loss or reinsurance in place, enter $9,999,999.

Examples of the calculation are presented below:

**EXAMPLE 1 (Reporting entity provides Comprehensive Care):**

- Highest Attachment Point (Retention): $100,000
- Reinsurance Coverage: 90% of $500,000 in excess of $100,000
- Maximum reinsurance coverage: $600,000 ($100,000 + $500,000)

Maximum Ret. Risk =

\[ = \frac{100,000}{150,000} + \frac{150,000}{750,000 - 600,000} + \frac{50,000}{600,000 - 100,000} \]

\[ = 300,000 \]

**EXAMPLE 2 (Reporting entity provides Comprehensive Care):**

- Highest Attachment Point (Retention): $75,000
- Reinsurance Coverage: 90% of $1,000,000 in excess of $75,000

...
Maximum reinsured coverage = $1,075,000 ($75,000 + $1,000,000)

Maximum Ret. Risk = $75,000 deductible

+ $67,500 (10% of ($750,000 – $75,000)) coverage layer

= $142,500

**Line (18) Alternate Risk Charge.** This is twice the amount in Line (17) for columns (1), (2), (3) and (5) and Column (4) is six times the amount in Line (17), subject to a maximum of $1,500,000 for Column (1), $50,000 for Columns (2), (3) and (5) and $150,000 for Column (4). Column (6) is excluded from this calculation.

**Line (19) Alternate Risk Adjustment.** This line shows the largest value in Line (18) for the column and all columns left of the column. Column (6) is excluded from this calculation.

**Line (20) Net Alternate Risk Charge.** This is the amount in Line (18), less the amount in the previous column of Line (19), but not less than zero. Column (6) is excluded from this calculation.

**Line (21) Net Underwriting Risk RBC.** This is the maximum of Line (16) and Line (20) for each of columns (1) through (5). This is the amount in Line (14), Column (6). The amount in Column (7) is the sum of the values in Columns (1) through (6).
## UNDERWRITING RISK

### Option 1 - 0.5% Investment Return

**Experience Fluctuation Risk**

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>(1) Comprehensive Medical</th>
<th>(2) Medicare Supplement</th>
<th>(3) Dental &amp; Vision</th>
<th>(4) Stand-Alone Medicare Part D Coverage</th>
<th>(5) Other Health</th>
<th>(6) Other Non-Health</th>
<th>(7) Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) † Premium</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) † Title XVIII-Medicare</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(3) † Title XIX-Medicare</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(4) † Other Health Risk Revenue</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(5) Medicaid Pass-Through Payments Reported as Premium</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(6) Underwriting Risk Revenue = Lines (1) + (2) + (3) + (4) - (5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(7) † Net Incurred Claims</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
</tr>
<tr>
<td>(8) Medicaid Pass-Through Payments Reported as Claims</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(9) Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Claims = Lines (7) - (8)</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<td>XXX</td>
</tr>
<tr>
<td>(10) † Fee-For-Service Offset</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
</tr>
<tr>
<td>(11) Underwriting Risk Incurred Claims = Lines (9) - (10)</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(12) Underwriting Risk Claims Ratio = For Column (1) through (5), Line (11)/6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.000</td>
</tr>
<tr>
<td>(13) Underwriting Risk Factor*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(14) Base Underwriting Risk RBC = Lines (6) x (12) x (13)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(15) Managed Care Discount Factor</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(16) RBC After Managed Care Discount = Lines (14) x (15)</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(17) Maximum Per-Individual Risk After Reinsurance</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(18) Alternate Risk Charge **</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
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<td>(19) Alternate Risk Adjustment</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(20) Net Alternate Risk Charge***</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(21) Net Underwriting Risk RBC (MAX{Line (16), Line (20)}) for Columns (1) through (5), Column (6), Line (14)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

### TIERED RBC FACTORS*

<table>
<thead>
<tr>
<th></th>
<th>Comprehensive Medical</th>
<th>Medicare Supplement</th>
<th>Dental &amp; Vision</th>
<th>Stand-Alone Medicare Part D Coverage</th>
<th>Other Health</th>
<th>Other Non-Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - $3 Million</td>
<td>0.1490</td>
<td>0.1040</td>
<td>0.0755</td>
<td>0.251</td>
<td>0.130</td>
<td>0.130</td>
</tr>
<tr>
<td>$3 - $25 Million</td>
<td>0.1490</td>
<td>0.0663</td>
<td>0.0755</td>
<td>0.251</td>
<td>0.130</td>
<td>0.130</td>
</tr>
<tr>
<td>Over $25 Million</td>
<td>0.0893</td>
<td>0.0663</td>
<td>0.0755</td>
<td>0.151</td>
<td>0.130</td>
<td>0.130</td>
</tr>
</tbody>
</table>

### ALTERNATE RISK CHARGE**

**The Line (15) Alternate Risk Charge is calculated as follows:**

<table>
<thead>
<tr>
<th>LESSER OF:</th>
<th>$1,500,000 or 2 x Maximum Individual Risk</th>
<th>$500,000 or 2 x Maximum Individual Risk</th>
<th>$50,000 or 2 x Maximum Individual Risk</th>
<th>$150,000 or 6 x Maximum Individual Risk</th>
<th>$50,000 or 2 x Maximum Individual Risk</th>
<th>N/A</th>
</tr>
</thead>
</table>

---

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† The Annual Statement Sources are found on page XR013.
* This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental Vision managed care discount factor.
*** Limited to the largest of the applicable alternate risk adjustments, prorated if necessary.
### UNDERWRITING RISK

#### Experience Fluctuation Risk

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>(1) Comprehensive Medical</th>
<th>(2) Medicare Supplement</th>
<th>(3) Dental &amp; Vision</th>
<th>(4) Stand-Alone Medicare Part D Coverage</th>
<th>(5) Other Health</th>
<th>(6) Other Non-Health</th>
<th>(7) Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) † Premium</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(2) † Title XVIII-Medicare</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(3) † Title XIX-Medicare</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>(4) Other Health Risk Revenue</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>(5) Medicaid Pass-Through Payments Reported as Premium</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>(6) Underwriting Risk Revenue = Lines (1) + (2) + (3) + (4) - (5)</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(7) † Net Incurred Claims</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>(8) Medicaid Pass-Through Payments Reported as Claims</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>(9) Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Claims = Lines (7) - (8)</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>(10) † Fee-For-Service Offset</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>(11) Underwriting Risk Incurred Claims = Lines (9) - (10)</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>(12) Underwriting Risk Claims Ratio = For Column (1) through (5), Line (11)/6</td>
<td>0.130</td>
<td>0.130</td>
<td>0.130</td>
<td>0.130</td>
<td>0.130</td>
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<tr>
<td>(13) Underwriting Risk Factor*</td>
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<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(14) Base Underwriting Risk RBC = Lines (6) x (12) x (13)</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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</tr>
<tr>
<td>(15) Managed Care Discount Factor</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>(16) RBC After Managed Care Discount = Lines (14) x (15)</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>(17) Maximum Per-Individual Risk After Reinsurance</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(18) Alternate Risk Charge **</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(19) Alternate Risk Adjustment</td>
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<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>(20) Net Alternate Risk Charge***</td>
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<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
</tbody>
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#### TIERED RBC FACTORS*

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<td>0.1480</td>
<td>0.1040</td>
<td>0.0656</td>
<td>0.0750</td>
<td>0.251</td>
<td>0.130</td>
<td>0.130</td>
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<table>
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<th>$450,000 or 6 x Maximum Individual Risk</th>
</tr>
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NAIC Proceedings – Summer 2021
DATE: 4/29/2021

CONTACT PERSON: Jane Barr

TELEPHONE: ____________________________

EMAIL ADDRESS: ____________________________

ON BEHALF OF: Capital Adequacy Task Force

NAME: Tom Botsko

TITLE: Chair

AFFILIATION: Ohio Department of Insurance

ADDRESS: 50 West Town Street, Suite 300
Columbus, OH 43215

FOR NAIC USE ONLY

Agenda Item # 2021-07-CA

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

[ x ] Health RBC Blanks [ x ] Property/Casualty RBC Blanks [ ] Life and Fraternal RBC Instructions
[ ] Health RBC Instructions [ ] Property/Casualty RBC Instructions [ x ] Life and Fraternal RBC Blanks
[ ] OTHER ____________________________

DESCRIPTION OF CHANGE(S)

Update the RBC factors for Receivables for Securities.

REASON OR JUSTIFICATION FOR CHANGE **

Based on a weighted average calculation of bonds, common, preferred and hybrid stock investments, the receivable for securities factors were adjusted for all RBC forecasting blanks.

Additional Staff Comments:

6/30/21 Factors were adopted by the Task Force.

** This section must be completed on all forms. Revised 2-2019
<table>
<thead>
<tr>
<th>Category</th>
<th>Proposed 2021</th>
<th>2018</th>
<th>2016</th>
<th>2014</th>
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<tbody>
<tr>
<td>Life</td>
<td>0.015</td>
<td>0.014</td>
<td>0.014</td>
<td>0.014</td>
</tr>
<tr>
<td>Health</td>
<td>0.024</td>
<td>0.025</td>
<td>0.024</td>
<td>0.024</td>
</tr>
<tr>
<td>P/C</td>
<td>0.020</td>
<td>0.025</td>
<td>0.023</td>
<td>0.024</td>
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</table>
Proposed 2021 Life RBC Factor for Receivables for Securities

<table>
<thead>
<tr>
<th></th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
<th>(6)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Statement Value</td>
<td>Allocation % by Class Type</td>
<td>RBC Factors by Class Type</td>
<td>Weighted Avg RBC Factor by Class type</td>
<td>Allocation % by Asset type</td>
<td>Weighted Avg RBC by Asset type</td>
</tr>
<tr>
<td>Bonds and Hybrids</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exempt Obligations</td>
<td>203,681,899,268</td>
<td>5.93%</td>
<td>0.0000</td>
<td>0.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAIC 1</td>
<td>1,755,070,452,018</td>
<td>51.06%</td>
<td>0.0039</td>
<td>0.002</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAIC 2</td>
<td>1,266,205,845,000</td>
<td>36.84%</td>
<td>0.0126</td>
<td>0.005</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAIC 3</td>
<td>138,002,043,541</td>
<td>4.02%</td>
<td>0.0446</td>
<td>0.002</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAIC 4</td>
<td>54,220,375,402</td>
<td>1.58%</td>
<td>0.0970</td>
<td>0.002</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAIC 5</td>
<td>17,360,937,037</td>
<td>0.51%</td>
<td>0.2231</td>
<td>0.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAIC 6</td>
<td>2,419,944,866</td>
<td>0.07%</td>
<td>0.3000</td>
<td>0.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td>3,436,961,497,132</td>
<td>100.00%</td>
<td>0.011</td>
<td>98.32%</td>
<td>0.011</td>
<td></td>
</tr>
<tr>
<td>Preferred stock</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAIC 1</td>
<td>3,236,974,611</td>
<td>21.34%</td>
<td>0.0040</td>
<td>0.001</td>
<td></td>
<td></td>
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<tr>
<td>NAIC 2</td>
<td>8,058,180,267</td>
<td>53.14%</td>
<td>0.0130</td>
<td>0.007</td>
<td></td>
<td></td>
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<tr>
<td>NAIC 3</td>
<td>1,626,957,797</td>
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<td>0.0460</td>
<td>0.005</td>
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<td></td>
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<tr>
<td>NAIC 4</td>
<td>954,076,003</td>
<td>6.29%</td>
<td>0.1000</td>
<td>0.006</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAIC 5</td>
<td>825,983,462</td>
<td>5.45%</td>
<td>0.2300</td>
<td>0.013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAIC 6</td>
<td>462,924,058</td>
<td>3.05%</td>
<td>0.3000</td>
<td>0.009</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td>15,165,096,198</td>
<td>100.00%</td>
<td>0.041</td>
<td>0.43%</td>
<td>0.000</td>
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</tr>
<tr>
<td>Common stock (subtotal)</td>
<td>43,472,175,917</td>
<td>100.00%</td>
<td>0.3000</td>
<td>0.300</td>
<td>1.24%</td>
<td>0.004</td>
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<tr>
<td>Total</td>
<td>3,495,598,769,247</td>
<td>100.00%</td>
<td>0.3000</td>
<td>0.300</td>
<td>100.00%</td>
<td>0.015</td>
</tr>
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</table>
## Proposed 2021 P&C RBC Factor for Receivables for Securities

<table>
<thead>
<tr>
<th>Allocation % by Class Type</th>
<th>RBC Factors by Class Type</th>
<th>Weighted Avg RBC Factor by Class type (2)(3)</th>
<th>Allocation % by Asset type (1)/Total (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statement Value</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Bonds

- **Exempt Obligations**
  - NAIC 1: 198,077,770,204 (14.73%) 0.000 0.000
  - NAIC 2: 892,606,935,183 (66.40%) 0.003 0.002
  - NAIC 3: 196,155,056,615 (14.59%) 0.010 0.001
  - NAIC 4: 29,627,422,364 (2.20%) 0.020 0.000
  - NAIC 5: 22,407,220,194 (1.67%) 0.045 0.001
  - NAIC 6: 4,921,385,393 (0.37%) 0.100 0.000
  - Subtotal: 1,344,371,047,889 (100.00%) 0.005 88.49% 0.005

### Preferred stock

- NAIC 1: 268,672,231 (2.06%) 0.003 0.000
  - NAIC 2: 5,385,911,971 (41.35%) 0.010 0.004
  - NAIC 3: 1,610,172,447 (12.36%) 0.020 0.002
  - NAIC 4: 5,454,937,067 (41.88%) 0.045 0.019
  - NAIC 5: 167,040,637 (1.28%) 0.100 0.001
  - NAIC 6: 137,185,850 (1.05%) 0.300 0.003
  - Subtotal: 13,023,920,203 (100.00%) 0.030 0.86% 0.000

### Hybrid Securities

- NAIC 1: 195,915,508 (5.41%) 0.003 0.000
  - NAIC 2: 2,602,668,840 (71.83%) 0.010 0.007
  - NAIC 3: 796,155,236 (21.97%) 0.020 0.004
  - NAIC 4: 28,186,843 (0.78%) 0.045 0.000
  - NAIC 5: 629,783 (0.02%) 0.100 0.000
  - NAIC 6: 16,321 (0.00%) 0.300 0.000
  - Subtotal: 3,623,572,531 (100.00%) 0.012 0.24% 0.000

### Common stock (subtotal)

<table>
<thead>
<tr>
<th>Allocation % by Class Type</th>
<th>RBC Factors by Class Type</th>
<th>Weighted Avg RBC Factor by Class type (2)(3)</th>
<th>Allocation % by Asset type (1)/Total (1)</th>
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<tbody>
<tr>
<td>Common stock (subtotal)</td>
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### Total

<table>
<thead>
<tr>
<th>Allocation % by Class Type</th>
<th>RBC Factors by Class Type</th>
<th>Weighted Avg RBC Factor by Class type (2)(3)</th>
<th>Allocation % by Asset type (1)/Total (1)</th>
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</thead>
<tbody>
<tr>
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<td></td>
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</tr>
<tr>
<td>Statement Value</td>
<td>Allocation % by Class Type</td>
<td>RBC Factors by Class Type</td>
<td>Weighted Avg RBC by Asset Type</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------------------------</td>
<td>--------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Bonds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAIC 1</td>
<td>26,978,694,441</td>
<td>16.82%</td>
<td>0.000</td>
</tr>
<tr>
<td>NAIC 2</td>
<td>92,171,622,315</td>
<td>57.45%</td>
<td>0.003</td>
</tr>
<tr>
<td>NAIC 3</td>
<td>31,516,331,303</td>
<td>19.45%</td>
<td>0.002</td>
</tr>
<tr>
<td>NAIC 4</td>
<td>5,719,209,690</td>
<td>3.56%</td>
<td>0.005</td>
</tr>
<tr>
<td>NAIC 5</td>
<td>3,540,121,585</td>
<td>2.21%</td>
<td>0.045</td>
</tr>
<tr>
<td>NAIC 6</td>
<td>369,787,474</td>
<td>0.23%</td>
<td>0.010</td>
</tr>
<tr>
<td>Subtotal</td>
<td>160,431,522,002</td>
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<td>0.006</td>
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<tr>
<td>Preferred stock</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAIC 1</td>
<td>16,895,298</td>
<td>2.64%</td>
<td>0.003</td>
</tr>
<tr>
<td>NAIC 2</td>
<td>409,146,343</td>
<td>63.86%</td>
<td>0.010</td>
</tr>
<tr>
<td>NAIC 3</td>
<td>185,064,846</td>
<td>28.88%</td>
<td>0.020</td>
</tr>
<tr>
<td>NAIC 4</td>
<td>2,342,560,701</td>
<td>0.12%</td>
<td>0.045</td>
</tr>
<tr>
<td>NAIC 5</td>
<td>5,410,086</td>
<td>0.08%</td>
<td>0.010</td>
</tr>
<tr>
<td>Subtotal</td>
<td>640,711,603</td>
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<td>0.030</td>
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<tr>
<td>Hybrid Securities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAIC 1</td>
<td>3,273,508</td>
<td>6.51%</td>
<td>0.003</td>
</tr>
<tr>
<td>NAIC 2</td>
<td>356,767,701</td>
<td>7.02%</td>
<td>0.010</td>
</tr>
<tr>
<td>NAIC 3</td>
<td>108,648,195</td>
<td>21.62%</td>
<td>0.020</td>
</tr>
<tr>
<td>NAIC 4</td>
<td>1,008,743</td>
<td>0.19%</td>
<td>0.045</td>
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<td>NAIC 5</td>
<td>2,600,202</td>
<td>0.52%</td>
<td>0.010</td>
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<td>Subtotal</td>
<td>5,024,825,021</td>
<td>100.00%</td>
<td>0.030</td>
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<tr>
<td>Common stock (subtotal)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>NAIC 1</td>
<td>23,167,522,031</td>
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<td>0.013</td>
</tr>
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<td>NAIC 2</td>
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<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Capital Adequacy (E) Task Force

#### RBC Proposal Form

| [ ] Catastrophe Risk (E) Subgroup | [ ] Investment RBC (E) Working Group | [ ] SMI RBC (E) Subgroup |
| [ ] C3 Phase II/ AG43 (E/A) Subgroup | [ ] P/C RBC (E) Working Group | [ ] Stress Testing (E) Subgroup |

**DATE:** 04/23/2021

**CONTACT PERSON:** Crystal Brown

**TELEPHONE:** 816-783-8146

**EMAIL ADDRESS:** cbrown@naic.org

**ON BEHALF OF:** Health RBC (E) Working Group

**NAME:** Steve Drutz

**TITLE:** Chief Financial Analyst/Chair

**AFFILIATION:** WA Office of Insurance Commissioner

**ADDRESS:** 5000 Capitol Blvd SE, Tumwater, WA 98501

---

**IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED**

| [ x ] Health RBC Blanks | [ x ] Health RBC Instructions | [ ] Other |
| [ ] Life and Fraternal RBC Blanks | [ ] Life and Fraternal RBC Instructions |
| [ ] Property/Casualty RBC Blanks | [ ] Property/Casualty RBC Instructions |

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**DESCRIPTION OF CHANGE(S)**

Incorporate the factors for the 20 NAIC Designation Category Bonds based on a five-year time horizon for page XR006, XR007 and XR012. Modify the instructions to incorporate references for the bonds.

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**REASON OR JUSTIFICATION FOR CHANGE **

The reason for the change is to incorporate the new bond factors for the 20 NAIC Designation Categories for a five-year time horizon in both the blank and instructions. The factor includes the bond portfolio adjustment.

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**Additional Staff Comments:**

4-23-21 cgb The WG exposed the proposal for a 25-day comment period ending on May 21.

5-25-21 cgb No comments were received. The WG adopted the proposal with the 5-year time horizon factors.

6/30/21 jdb Factors were adopted by the Task Force.

**This section must be completed on all forms.**

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OFF-BALANCE SHEET SECURITY LENDING COLLATERAL AND SCHEDULE DL, PART 1 ASSETS
XR006

Security lending programs are required to maintain collateral. Some entities post the collateral supporting security lending programs on their financial statements and incur the related risk charges on those assets. Other entities have collateral that is not recorded on their financial statements. While not recorded on the financial statements of the company, such collateral has risks that are not otherwise captured in the RBC formula.

The collateral in these accounts is maintained by a third party (typically a bank or other agent). The collateral agent maintains on behalf of the company detail asset listings of the collateral assets, and this data is the source for preparation of this schedule. The company should maintain such asset listings, at a minimum CUSIP, market value, book/adjusted carrying value, and maturity date.

The asset risk charges are derived from existing RBC factors for bonds, preferred and common stocks, other invested assets, and invested assets not otherwise classified (aggregate write-ins).

Specific Instructions for Application of the Formula


Off-balance sheet collateral included in General Interrogatories Part 1, Lines 24.05 and 24.06 of the annual statement should agree with Line (40), Column (1).

Lines (1) through (27) – Bonds – Bond factors described on page XR007 – Fixed Income Assets.

Line (28) through (34) – Preferred Stock – Preferred stock factors described on page XR010 – Equity Assets.

Line (35) – Common Stock – Common stock factors described on page XR010 – Equity Assets.


Line (37) – Other Invested Assets – Other invested assets factor described on page XR008 – Fixed Income Assets.

Line (38) – Mortgage Loans on Real Estate – Mortgage Loans on Real Estate factors described on page XR008 – Fixed Income Assets.

Line (39) – Cash, Cash Equivalents and Short-Term Investments – Cash, Cash Equivalents and Short-Term Investments factors described on page XR008 – Fixed Income Assets.

FIXED INCOME ASSETS
XR007 AND XR008

The RBC requirement for fixed income assets is largely driven by the default risk on those assets. There are two major subcategories: Bonds and Miscellaneous. Bonds include item that meet the definition of a bond, regardless if the bond is long-term (reported on Schedule D-1), short-term (reported on schedule DA) or a cash equivalent...
(reported on Schedule E-2.) Miscellaneous fixed income assets include non-bond items reported on the cash equivalent and short-term schedules, derivatives, mortgage loans, collateral loans, and other items reported on Schedule BA: Other Long-Term Invested Assets.

**Bonds (XR007)**

The bond factors for investment grade bonds (NAIC Designation Category (1.A-2.C) are based on cash flow modeling. Each bond of a portfolio was annually tested for default (based on a “roll of the dice”) where the default probability varies by NAIC Designation Category and that year’s economic environment. The default probabilities were based on historical data intended to reflect a complete business cycle of favorable and unfavorable credit environments. The risk of default was measured over a five-year time horizon, based on the duration of assets held for health companies.

The factors for NAIC Designation Category 3.A to 6 recognize that these non-investment grade bonds are reported at the lower of amortized cost or fair value. These bond risk factors are based on the market value fluctuation for each of the NAIC designation category compared to the market value fluctuation of stocks during the 2008-2009 financial crisis.

While the life and property/casualty formulas have a separate calculation for the bond size factor (based on the number of issuers in the RBC filer’s portfolio), the health formula does not include a separate calculation, instead a bond size component was incorporated into the bond factors. A representative portfolio of 382 issuers was used in calculating the bond risk factors.

There is no RBC requirement for bonds guaranteed by the full faith and credit of the United States, Other U.S. Government Obligations, and securities on the NAIC U.S. Government Money Market Fund List because it is assumed that there is no default risk associated with U.S. Government issued securities.

The book/adjusted carrying value of all bonds should be reported in Columns (1), (2) or (3). The bonds are split into twenty-one different risk classifications. These risk classifications are based on the NAIC Designation Category as defined and permitted in the Purposes and Procedures Manual of the NAIC Investment Analysis Office. The subtotal of Columns (1), (2) and (3) will be calculated in Column (4). The RBC requirement will be automatically calculated in Column (5).

**Miscellaneous Fixed Income Assets (XR008)**

The factor for cash is 0.3 percent. It is recognized that there is a small risk related to possible insolvency of the bank where cash deposits are held. This factor was based on the original unaffiliated NAIC 01 bond risk factor prior to the increased granularity of the NAIC Designation Categories in 2021, and reflects the short-term nature of this risk. The required risk-based capital for cash will not be less than zero, even if the company’s cash position is negative.

The Short-Term Investments to be included in this section are those short-term investments not reflected elsewhere in the formula. The 0.3 percent factor is equal to the factor for cash. The amount reported in Line (35) reflects the total from Schedule DA: Short-Term Investments (Line 33), less the short-term bonds (Line 34). (The short-term bonds reported in Line (34) should equal Schedule DA, Part 1, Column 7, Line 8399999.)

Mortgage loans (reported on Schedule B) and Derivatives (reported on Schedule DB) receive a factor of 5 percent, consistent with other risk-based capital formulas studied by the Working Group.

The following investment types are captured on Schedule BA: Other Long-Term Invested Assets. Specific factors have been established for certain Schedule BA assets based on the nature of the investment. Those Schedule BA assets not specifically identified below receive a 20 percent factor (Line (43)).

- Collateral Loans reported on Line (40) receive a factor of 5 percent, consistent with other risk-based capital formulas studied by the Working Group.
- Working Capital Finance Investments: The book adjusted carrying value of NAIC 01 and 02 Working Capital Finance Investments, Lines (41) and (42), should equal the Notes to Financial Statement, Lines 5M(01a) and 5M(01b), Column 3 of the annual statement.

- Low income housing tax credit investments are reported in Column (1) in accordance with SSAP No. 93—Low Income Housing Tax Credit Property Investments.
  o Federal Guaranteed Low-Income Housing Tax Credit (LIHTC) investments are to be included in Line (44). There must be an all-inclusive guarantee from an ARO-rated entity that guarantees the yield on the investment.
  o Federal Non-Guaranteed LIHTC investments with the following risk mitigation factors are to be included in Line (45):
    a) A level of leverage below 50 percent. For a LIHTC Fund, the level of leverage is measured at the fund level.
    b) There is a tax credit guarantee agreement from general partner or managing member. This agreement requires the general partner or managing member to reimburse investors for any shortfalls in tax credits due to errors of compliance, for the life of the partnership. For an LIHTC fund, a tax credit guarantee is required from the developers of the lower-tier LIHTC properties to the upper-tier partnership.
  o State Guaranteed LIHTC investments that at a minimum meet the federal requirements for guaranteed LIHTC investments are to be included in Line (46).
  o State Non-Guaranteed LIHTC investments that at a minimum meet the federal requirements for non-guaranteed LIHTC investments are to be included on Line (47).
  o All Other LIHTC investments, state and federal LIHTC investments that do not meet the requirements of Lines (44) through (47) would be reported on Line (48).

**EQUITY ASSETS**

**XR010**

**Unaffiliated Preferred Stocks**

Experience data to develop preferred stock factors is not readily available; however, it is believed that preferred stocks are somewhat more likely to default than bonds. The loss on default would be somewhat higher than that experienced on bonds; however, formula factors are equal to bond factors.

The RBC requirements for unaffiliated preferred stocks are based on the NAIC designation. Column (1) amounts are from Schedule D, Part 2, Section 1 not including affiliated preferred stock. The preferred stocks must be broken out by asset designation (NAIC 01 through NAIC 06) and these individual groups are to be entered in the appropriate lines. The total amount of unaffiliated preferred stock reported should equal annual statement Page 2, Column 3, Line 2.1, less any affiliated preferred stock in Schedule D Summary by Country, Column 1, Line 18.

**Unaffiliated Common Stock**

Federal Home Loan Bank Stock has characteristics more like a fixed income instrument rather than common stock. A 2.3 percent factor was chosen. The factor for other unaffiliated common stock is based on studies which indicate that a 10 percent to 12 percent factor is needed to provide capital to cover approximately 95 percent of the greatest losses in common stock over a one-year future period. The higher factor of 15 percent contained in the formula reflects the increased risk when testing a period in excess of one year. This factor assumes capital losses are unrealized and not subject to favorable tax treatment at the time of loss in market value.
The purpose of the asset concentration calculation is to reflect the additional risk of high concentrations of certain types of assets in single exposures, termed “issuers.” An issuer is a single entity, such as IBM or the Ford Motor Company. When the reporting entity has a large portion of its asset portfolio concentrated in only a few issuers, there is a heightened risk of insolvency if one of those issuers should default. An issuer may be represented in the reporting entity’s investment portfolio by a single security designation, such as a large block of NAIC Designation Category 2.A bonds, or a combination of various securities, such as common stocks, preferred stocks, and bonds. The additional RBC for asset concentration is applied to the ten largest issuers.

Concentrated investments in certain types of assets are not expected to represent an additional risk over and above the general risk of the asset itself. Therefore, prior to determining the ten largest issuers, you should exclude those assets that are exempt from the asset concentration factor. Asset types that are excluded from the calculation include: NAIC 06 bonds, unaffiliated preferred stock; affiliated common stock; affiliated preferred stock; property and equipment; U.S. government full faith and credit, other U.S. government obligations, and NAIC U.S. government money market fund list securities; NAIC 01 bonds and unaffiliated preferred stock; any other asset categories with risk-based capital factors less than 1 percent, and investment companies (mutual funds) and common trust funds that are diversified within the meaning of the federal Investment Company Act of 1940 [Section 5(b)(1)]. The pro rata share of individual securities within an investment company (mutual fund) or common trust fund are to be included in the determination of concentrated investments, subject to the exclusions identified.

With respect to investment companies (mutual funds) and common trust funds, the reporting entity is responsible for maintaining the appropriate documentation as evidence that such is diversified within the meaning of the federal Investment Company Act and providing this information upon request of the Commissioner, Director or Superintendent of the Department of Insurance. The reporting entity is also responsible for maintaining a listing of the individual securities and corresponding book/adjusted carrying values making up its investment companies (mutual funds) and common trust funds portfolio, in order to determine whether a concentration charge is necessary. This information should be provided to the Commissioner, Director or Superintendent upon request.

The assets that **ARE INCLUDED** in the calculation when determining the 10 largest issuers are as follows:

- NAIC Designation Category 2.A – 2.C Bonds
- NAIC Designation Category 5.A – 5.C Bonds
- Collateral Loans
- Mortgage Loans
- NAIC 02 Unaffiliated Preferred Stock
- NAIC 03 Unaffiliated Preferred Stock
- NAIC 04 Unaffiliated Preferred Stock
- NAIC 05 Unaffiliated Preferred Stock
- Other Long-Term Assets
- NAIC 02 Working Capital Finance Investments
- Federal Guaranteed Low Income Housing Tax Credits
- Federal Non-Guaranteed Low Income Housing Tax Credits
- State Guaranteed Low Income Housing Tax Credits
- State Non-Guaranteed Low Income Housing Tax Credits
All Other Low Income Housing Tax Credits
Unaffiliated Common Stock

The concentration factor basically doubles the risk-based capital factor (up to a maximum of 30 percent) for assets held in the 10 largest issuers. Since the risk-based capital of the assets included in the concentration factor has already been counted once in the basic formula, this factor itself only serves to add an additional risk-based capital requirement on these assets.

The name of each of the largest 10 issuers is entered at the top of the table and the appropriate statement amounts are entered in Column (2), Lines (1) through (26). Aggregate all similar asset types before entering the amount in Column (2). To determine the 10 largest issuers, first pool all of the assets subject to the concentration factor. From this pool, aggregate the various securities by issuer. The aggregate book/adjusted carrying values for the assets are computed, and the 10 largest are subject to the concentration factor. For example, an organization might own $6,000,000 in NAIC Designation Category 2.A bonds of IBM, plus $4,000,000 in NAIC Designation Category 2.C plus $5,000,000 of common stock. The total investment in that issuer is $15,000,000. If that is the largest issuer, then the identifier (“IBM Corporation”) would be entered in the space allowed for the first Issuer Name, and the $6,000,000 would be entered under the book/adjusted carrying value column for Line (1) (NAIC Designation Category 2.A Bonds) $4,000,000 would be entered on Line (3) (NAIC Designation Category 2.C Bonds) and the $5,000,000 would be entered on Line (22) (Unaffiliated Common Stock).

Replicated assets other than synthetically created indices should be included in the asset concentration calculation in the same manner as other assets.
### Off-Balance Sheet Security Lending Collateral and Schedule DL, Part I Assets

<table>
<thead>
<tr>
<th>Asset Category</th>
<th>Annual Statement Source</th>
<th>(1) Off-Balance Sheet Collateral Book/Adjusted Carrying Value</th>
<th>(2) Schedule DL, Part I Book/Adjusted Carrying Value</th>
<th>(3) Subtotal</th>
<th>(4) Factor</th>
<th>RBC Requirement</th>
</tr>
</thead>
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<tr>
<td>Fixed Income Assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bonds</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) NAIC 1.A - U.S. Government Full Faith and Credit, Other U.S. Government Obligations, and NAIC U.S. Government Money Market Fund List (Refer to A/S Instructions)</td>
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<td>0</td>
<td>0.000</td>
<td>0</td>
<td>0</td>
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<tr>
<td>RBC Requirement</td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Equity Assets</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred Stock - Unaffiliated Bonds</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>(28) NAIC 01 Unaffiliated Preferred Stock</td>
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<td>0</td>
<td>0.003</td>
<td>0</td>
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<td>(29) NAIC 02 Unaffiliated Preferred Stock</td>
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<td>0.010</td>
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<td>(32) NAIC 05 Unaffiliated Preferred Stock</td>
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<tr>
<td>(34) Total Unaffiliated Preferred Stock</td>
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<tr>
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<td>0.150</td>
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<td>(36) Real Estate and Property &amp; Equipment Assets</td>
<td>Company Records</td>
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<td>0</td>
<td>0.100</td>
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<td>0</td>
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<td>(37) Other Invested Assets</td>
<td>Company Records</td>
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<td>0.200</td>
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<td>(38) Mortgage Loans on Real Estate</td>
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<td>0.500</td>
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<td>(39) Cash, Cash Equivalents and Short-Term Investments (Net reported on Bonds above)</td>
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<td>(40) Total Line 9 + (13) + (17) + (21) + (25) + (26)</td>
<td>Lines (27) + (34) + (35) + (36) + (37) + (38) + (39)</td>
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Denotes items that must be manually entered on the filing software
### Fixed Income Assets

**Bonds**

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<tr>
<th>Category</th>
<th>Description</th>
<th>Factor</th>
<th>RBC Requirement</th>
</tr>
</thead>
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<tr>
<td>(1) NAIC Designation Category 1 A</td>
<td>U.S. Government Full Faith and Credit, Other U.S. Government Obligations, and INSC U.S. Government Money Market Mutual Fund List (Refer to A/S Instructions)</td>
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<td>(2) NAIC Designation Category 1 A</td>
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<td>(3) NAIC Designation Category 1 B</td>
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<td>(4) NAIC Designation Category 1 C</td>
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<td>(5) NAIC Designation Category 1 D</td>
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<td>(7) NAIC Designation Category 1 F</td>
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<tr>
<td>(8) NAIC Designation Category 1 G</td>
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<tr>
<td>(9) Total NAIC 01 Bonds</td>
<td>Sum of (1) through (8)</td>
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<td>(10) NAIC Designation Category 2 A</td>
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<td>(13) Total NAIC 02 Bonds</td>
<td>Sum of (9) through (12)</td>
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<td>(15) NAIC Designation Category 3 B</td>
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<td>(16) NAIC Designation Category 3 C</td>
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<td>(17) Total NAIC 03 Bonds</td>
<td>Sum of (13) through (16)</td>
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<td>(25) Total NAIC 05 Bonds</td>
<td>Sum of (21) through (24)</td>
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<td>(26) Total NAIC 06 Bonds</td>
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<tr>
<td>(27) Total Bonds RBC</td>
<td>(L2 + L(13) + L(17) + L(21) + L(25) + L(26))</td>
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<td>0</td>
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</table>

Denotes items that must be vendor linked.
### ASSET CONCENTRATION

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<thead>
<tr>
<th>Issuer</th>
<th>Issuer Name</th>
<th>Bk/Adj Carrying Value Factor</th>
<th>Additional RBC</th>
</tr>
</thead>
<tbody>
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<td>01</td>
<td>(1) NAIC Designation Category 2.A Bonds</td>
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</table>

Denotes items that must be manually entered on filing software.
Capital Adequacy (E) Task Force

RBC Proposal Form

DATE: February 26, 2021(mod)

CONTACT PERSON: Steve Clayburn
TELEPHONE: (202) 624-2197
EMAIL ADDRESS: steveclayburn@acli.com
ON BEHALF OF: American Council of Life Insurers (ACLI)
NAME: Steve Clayburn
TITLE: Senior Actuary, Health Insurance & Reinsurance
AFFILIATION: ACLI
ADDRESS: 

FOR NAIC USE ONLY
Agenda Item # 2021-06-L
Year 2021

DISPOSITION
[    ] ADOPTED 6/30/21
[    ] REJECTED
[    ] DEFERRED TO
[    ] REFERRED TO OTHER NAIC GROUP
[    ] EXPOSED 4/6/21, 4/29/21
[    ] OTHER (SPECIFY)

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

[    ] Health RBC Blanks  [    ] Property/Casualty RBC Blanks  [    ] Life and Fraternal RBC Instructions
[    ] Health RBC Instructions  [    ] Property/Casualty RBC Instructions  [    ] Life and Fraternal RBC Blanks
[    ] OTHER ______________________

DESCRIPTION OF CHANGE(S)
To update the RBC calculation for Real Estate to reflect updated experience and analysis since RBC was first developed. This proposal presents the instructions and factors for the structure in proposal 2021-01-L.

REASON OR JUSTIFICATION FOR CHANGE **
When RBC was developed, there was limited experience on the default and loss for commercial real estate. Since then data sources have been compiled and tracked in the industry, and can now be accessed to provide more meaningful analysis and information for development of capital standards.

Additional Staff Comments:
This proposal was adopted by the Working Group on 5/27/21. The fair value adjustment is set to zero for yearend 2021 RBC filings.
6/30/21- jdb Factors were adopted by the Task Force.

** This section must be completed on all forms.  Revised 2-2019
1. **REAL ESTATE**

**LR007**

*Basis of Factors*

The base factor for equity real estate of 11% was developed by adding a margin for conservatism to the results of an analysis of real estate performance over the period of 1978 – 2020. The analysis was conducted by a group of life insurance company real estate investment professionals coordinated by the ACLI. The data used was a national database of real property owned by investment fiduciaries and supplemented by data on real estate backing mortgage securities. The analysis is documented in a report to the NAIC dated March 29, 2021. In addition to modifying the factor for company owned and investment real estate, this updated factor will also be used for real estate acquired in satisfaction of debt (Foreclosed real estate). Foreclosed real estate is recognized in the statutory statements as having acquisition cost equal to market value at time of foreclosure. For assets with the characteristics of real held estate (partnership or other structure) reported on Schedule BA, a higher factor of 13% is used to account for the lower transparency involved with these structures. Schedule BA real estate was originally given a higher factor under a presumption that it was more highly levered. Analysis has shown these assets to have experience very similar to directly held and will therefore use a modestly higher factor.

While the experience analysis was done based on analysis of fair value impacts, Real Estate is reported at depreciated cost in the Statutory statements. The difference in values impacts the risk to statutory surplus. Therefore, an adjustment is made to the factor based on the difference between fair value and statutory carrying value on a property by property basis. The adjustment is defined as

\[
\text{Adj Factor} = \text{RE Factor} \times (1 - \text{factor} \times (\text{MV} - \text{BV}_g)/\text{BV}_g)
\]

*factor* is [0] This zero factor for the fair value adjustment is for yearend 2021 RBC filings.

The resulting adjusted RBC factor is subject to a minimum of zero. In the RBC calculation, see Figure 7, fair value is taken from Schedule A Column 10 plus encumbrances, or from Schedule BA column 11 plus encumbrances, respectively, while BV$_g$ is the net Book Adjusted Carrying Value plus the encumbrance.

Encumbrances have been included in the real estate base since the value of the property is held net of the encumbrance, but the entire value is subject to loss. Encumbrances receive the base real estate factor of 11% reduced by the average factor for commercial mortgages of 1.75 percent pre-tax. In the past this was computed as a base factor applied to the net real estate value plus a separate factor applied to the amount of the encumbrance. Beginning in 2021, the equivalent result will be obtained by applying a base factor to the gross statutory value of the property, and a credit provided for the amount of the encumbrance.

The final RBC amount is subject to a minimum of the Baa bond factor 1.30% applied to the BACV, and a maximum of 45% of the BACV.

*Specific Instructions for Application of the Formula*

**Column (1)**

Calculations are done on an individual property or joint venture basis in the worksheets and then the summary amounts are entered in this column for each class of real estate investment. Refer to the real estate calculation worksheet (Figure 7) for how the individual property or joint venture calculations are completed.

Line (1) should equal Page 2, Column 3, Line 4.1.
Line (2) should equal Page 2, inside amount, Line 4.1.
Line (4) should equal AVR Equity Component Column 1 Line 20.
Line (5) should equal AVR Equity Component Column 3 Line 20.
Line (7) should equal AVR Equity Component Column 1 Line 19.
Line (8) should equal AVR Equity Component Column 3 Line 19.
Line (14) should equal Schedule BA, Part 1, Column 12, Line 2199999 plus Line 2299999, in part.
Line (15) should equal Schedule BA, Part 1, Column 12, Line 1799999 plus Line 1899999, in part.
Line (17) should equal AVR Equity Component Column 1 Line 75.
Line (18) should equal AVR Equity Component Column 1 Line 76.
Line (19) should equal AVR Equity Component Column 1 Line 77.
Line (20) should equal AVR Equity Component Column 1 Line 78.
Line (21) should equal AVR Equity Component Column 1 Line 79.

Low income housing tax credit investments are reported in Column (1) in accordance with SSAP No. 93—Low Income Housing Tax Credit Property Investments.

Column (2)
The average factor column is calculated as Column (3) divided by Column (1).

Column (3)
Summary amounts are entered for Column (3) based on calculations done on an individual property or joint venture basis. Refer to Column (8) of the real estate calculation worksheet (Figure 7).

Line (17)
Guaranteed federal low-income housing tax credit (LIHTC) investments are to be included in Line (17). There must be an all-inclusive guarantee from an ARO-rated entity that guarantees the yield on the investment.

Line (18)
Non-guaranteed federal LIHTC investments with the following risk mitigation factors are to be included in Line (18):
   a) A level of leverage below 50 percent. For a LIHTC Fund, the level of leverage is measured at the fund level.
   b) There is a tax credit guarantee agreement from general partner or managing member. This agreement requires the general partner or managing member to reimburse investors for any shortfalls in tax credits due to errors of compliance, for the life of the partnership. For an LIHTC fund, a tax credit guarantee is required from the developers of the lower-tier LIHTC properties to the upper-tier partnership.

Line (19)
State LIHTC investments that at a minimum meet the federal requirements for guaranteed LIHTC investments.

Line (20)
State LIHTC investments that at a minimum meet the federal requirements for non-guaranteed LIHTC investments.

Line (21)
State and federal LIHTC investments that do not meet the requirements of lines (17) through (20) would be reported on Line (21).
### Real Estate Worksheet

#### Fair value adjustment factor \[\text{factor}\]

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<td>Encumbrance credit Factor</td>
<td>Adjusted RBC Factor</td>
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Note that column (2) is the book/adjusted carrying value net of any encumbrances, while column (4) is the fair value of the property not reduced for any encumbrances.

† For each category, each property should be listed individually, including those for which there is no encumbrance.

& Column (7) is Column (5) times \((1 - \text{factor}) \times (\text{Column (4)} - (\text{Column (2)} + \text{Column (3)})) / (\text{Column (2)} + \text{Column (3)})\), but not less than zero.

‡ Column (8) is calculated as \((\text{Column (2)} + \text{Column (3)}) \times \text{Column (7)}\).

§ Column (9) is calculated as \(\text{Column (3)} \times \text{Column (6)}\).

* Column (10) is calculated as Column (8) minus Column (9), but not less than 1.3% nor more than 45% of column (2), and not less than zero.

---

**ASSET CONCENTRATION FACTOR**

**LR010**

*Basis of Factors*

The purpose of the concentration factor is to reflect the additional risk of high concentrations in single exposures (represented by an individual issuer of a security or a holder of a mortgage, etc.) The concentration factor doubles the risk-based capital pre-tax factor (with a maximum of 45 percent pre-tax) of the 10 largest asset exposures excluding various low-risk categories or categories that already have a maximum factor. Since the risk-based capital of the assets included in the concentration factor has already been counted once in the basic formula, the asset concentration factor only serves to add in the additional risk-based capital required. The calculation is completed on a consolidated basis; however, the concentration factor is reduced by amounts already included in the concentration factors of subsidiaries to avoid double-counting.

*Specific Instructions for Application of the Formula*
The 10 largest asset exposures should be developed by consolidating the assets of the parent with the assets of the company’s insurance and investment subsidiaries. The concentration factor component on any asset already reflected in the subsidiary’s RBC for the concentration factor should be deducted from Column (4). This consolidation process affects higher tiered companies only. Companies on the lowest tier of the organizational chart will prepare the asset concentration on a “stand alone” basis.

The 10 largest exposures should exclude the following: affiliated and non-affiliated common stock, affiliated preferred stock, home office properties, policy loans, bonds for which AVR and RBC are zero, NAIC 1 bonds, NAIC 1 unaffiliated preferred stock, NAIC 1 Hybrids, CM 1 Commercial and Farm Mortgages and any other asset categories with RBC factors less than 0.8 percent post-tax (this includes residential mortgages in good standing, insured or guaranteed mortgages, and cash and short-term investments).

In determining the asset subjects to the concentration factor for both C-1o and C-1cs, the ceding company should exclude any asset whose performance inures primarily (>50 percent) to one reinsurer under modified coinsurance or funds withheld arrangements. The reinsurer should include 100 percent of such asset. Any asset where no one reinsurer receives more than 50 percent of its performance should remain with the ceding company.

Assets should be aggregated by issuer before determining the 10 largest exposures. Aggregations should be done separately for bonds and preferred stock (the first six digits of the CUSIP number can be used as a starting point) (please note that the same issuer may have more than one unique series of the first six digits of the CUSIP), mortgages and real estate. Securities held within Schedule BA partnerships should be aggregated by issuer as if the securities are held directly. Likewise, where joint venture real estate is mortgaged by the insurer, both the mortgage and the joint venture real estate should be considered as part of a single exposure. Tenant exposure is not included. For bonds and unaffiliated preferred stock, aggregations should be done first for classes 2 through 6. After the 10 largest issuer exposures are chosen, any NAIC 1 bonds, NAIC 1 unaffiliated preferred stock or NAIC 1 hybrids from any of these issuers should be included before doubling the risk-based capital. For some companies, following the above steps may generate less than 10 “issuer” exposures. These companies should list all available exposures.

Replicated assets other than synthetically created indices should be included in the asset concentration calculation in the same manner as other assets.

The book/adjusted carrying value of each asset is listed in Column (2).

The RBC factor will correspond to the risk-based capital category of the asset reported previously in the formula before application of the size factor for bonds. The RBC filing software automatically allows for an overall 45 percent RBC cap.

**Lines (17) through (22)**

The Asset Concentration RBC Requirement for a particular property plus the Real Estate RBC Requirement for a particular property cannot exceed the book/adjusted carrying value of the property. Any properties exceeding the book/adjusted carrying value must be adjusted down to the book/adjusted carrying value in Column (6) of the Asset Concentration.

Line (18), Column (4) is calculated as Line (17), Column (2) multiplied by 0.1100 plus Line (18), Column (2) multiplied by 0.092500, but not greater than Line (17), Column (2). Line (20), Column (4) is calculated as Line (19), Column (2) multiplied by 0.1100 plus Line (20), Column (2) multiplied by 0.0925, but not greater than Line (19), Column (2). Line (22), Column (4) is calculated as Line (21), Column (2) multiplied by 0.1300 plus Line (22), Column (2) multiplied by 0.1125, but not greater than Line (21), Column (2).
Executive Summary

The following recommendations are the product of analyses conducted or sponsored by the ACLI, the NAIC, and industry real estate specialists. These recommendations represent the final product of discussions and deliberations that began in 2012 and are inclusive of changes meant to address questions and recommendations posed by members of the Investments Risk Based Capital (IRBC) and Life Risk Based Capital (LRBC) NAIC working groups, the American Academy of Actuaries (AAA) and other interested parties.

Implementation of the recommendations described below will ensure that the RBC assessment methodology and charges for the real estate sector more accurately reflect the sector’s underlying risks and will promote consistency with the methodology used in other asset sectors.

A. Schedule A Real Estate Factor. Update the C-1 factor for real estate assets held on Schedule A to be a base factor of 11%. This recommended factor is based on an estimated worst cumulative loss at a 95th – 96th percentile confidence level based on historical experience, which suggested a base factor of 9.5%. As was done with common stock, we used values at 2 years loss horizon. An additional 1.5% charge is recommended to account for potential disparity in individual life company real estate portfolio composition and uncertainty surrounding the longer-term implications of the COVID-19 pandemic on the commercial real estate sector. The proposed factor would be applicable for all categories of real estate reported in Schedule A of the Life and Health Annual Statement. (See Section A)

B. Unrealized Capital Gains/Losses. Recognize that the factors are based on analysis of market values while the statutory accounting basis is depreciated cost. Since RBC is to account for possible loss of statutory capital, when the statutory asset value is lower than market value, the risk of loss from that lower value is lower than the factors developed using market value performance data. To adjust for this discrepancy within RBC, reflect the impact of the margin from unrealized gains and losses on the potential for loss of statutory surplus. (See Section B)

C. Encumbrances. Revise the RBC factor for real estate encumbrances following the principles of the current RBC with factors to be consistent with the commercial mortgage RBC framework adopted in 2013. (See Section C)

D. Schedule BA Real Estate Factor. Revise the factor for Schedule BA real estate to 13%, equivalent to the proposed factor for Schedule A plus a premium of about 20% over the Schedule A factor. All other mechanics would parallel the proposal for Schedule A Real Estate. (See Section D)

Scope

This proposal is developed for the Life and Fraternal Risk Based Capital formulas. This proposal does not address possible adjustment to the Asset Valuation Reserve (AVR) or tax adjustments for these assets. Finally, this proposal does not directly address the factors for the Health Risk Based Capital or for the Property & Casualty Risk Based Capital.
Background

RBC is used to measure potential future excess losses and their effect on statutory capital. The goal is to help regulators identify weakly capitalized companies, given risks that individual companies are taking. This proposal is consistent in methodology with recent RBC development work for common stock and bonds in areas such as the confidence levels for statistical analyses, while recognizing real estate’s unique characteristics.

There is limited historical perspective available on the original construction methodology supporting the currently applied RBC factors for real estate investments. The following general description is taken from a 1991 report covering RBC C-1 (default) factors:

“There is little data upon which to base requirements for this asset group. Company practice, as shown by the 1990 intercompany survey, indicates factors in the range of 5 percent to 20 percent. An article in the May-June 1991 Financial Analysts Journal (Ennis and Burk) proposes that real estate volatility is about 60 percent of that for common stock, suggesting a factor in the range of 18 percent. If one assumes full tax credit for losses, this converts to a factor of about 10 percent which is the Subcommittee’s recommendation for all real estate subcategories, except real estate acquired by foreclosure for which the factor is 15 percent. This is one of several asset groups which deserve continuing study to assure that risk-based capital requirements are adequate and appropriate.”

Since the original real estate factor estimation, which was based on the somewhat rudimentary analysis described above, there has been a very significant improvement in the availability of performance data for the sector. While there have been additional analyses conducted for this sector since the initial methodology and factor adoption (i.e., AAA proposals in September and December 2000), to date there have been no significant changes made to the C-1 factor for real estate.

Since 2000, the pre-tax base C-1 factor for real estate applied in the sector has been 15%. The derivation of this factor, as described above, was based on 60% of the common stock factor, adjusted for taxes. The logic at the time was that the volatility of real estate was assumed to be around 60% of common stock volatility. This assumption was reportedly based on inferences made from historical real estate investment trust (REIT) performance, as a robust private market performance history was not available at that time. REITs are companies that use debt in owning and managing properties and have performance characteristics different from that of the underlying commercial real estate. The same 15% C-1 factor currently applies to virtually all directly held real estate, including company occupied properties, investment properties for long-term hold, and properties held for sale, but excludes properties acquired through foreclosure which were perceived to be riskier.

It is also important to note, that while real estate is considered an equity asset, statutory accounting requires it to be valued at depreciated cost. Any capital improvements are added to the statutory book value, and then depreciated from that time. If and when there is an other-than-temporary impairment, the book value is revised down to then market value, if lower, and depreciated going forward. Throughout this document this is referred to as depreciated cost.

The real estate sector has matured significantly in the last 30 plus years, as institutional investment has become prevalent and public capital markets have become more developed. Information transparency has increased materially and the market has become much more “efficient”. Valuation and accounting policies and standards,

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1 Various studies have since shown that equity real estate in general has volatility well less than 60% of that of the S&P 500.
2 The volatility of REIT performance is higher than the volatility of direct property performance primarily because REITs are leveraged investments, which results in greater volatility of results. Further, privately held property is not marked-to-market daily, trades infrequently, and tends to exhibit price changes rather slowly.
and increased regulation, have also increased standardization and invest ability. Ownership of commercial real
estate is now much more widespread across institutions, including pension funds, than in the earlier period.

A. Review of Base C-1 RBC Factor – Support for Change to 11%

Analyses conducted or sponsored by the ACLI, the NAIC, and industry specialists suggest that the base C-1 RBC
factor applicable to Schedule A real estate (including investment, foreclosed and held for sale real estate) should be
set at 9.5%. An additional 1.5% cushion is recommended to account for potential disparities between the
composition of the index used and individual life insurance company real estate portfolios, plus uncertainty
surrounding the impact of COVID-19 on the longer term performance of commercial real estate. This
recommendation is based primarily upon the NCREIF National Property Index (NPI) Price Variation Analysis
presented below.3 Note that the support presented in this Section A represents an updated methodology meant
to address certain concerns expressed by the American Academy of Actuaries regarding representation of the
Global Financial Crisis in the data set.

The primary methodology employed to determine the recommended charge is analyses based on actual historical
real estate investment performance data from the NCREIF Property Index (NPI), appended by data from
FRC/Kelleher to extend the series through earlier years of 1961-1977.4 This data set is collectively referred to as
“NPI” in this analysis.

<table>
<thead>
<tr>
<th>Results of Price Variation Model of NCREIF Property Index (“NPI”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 YR HP Cumulative Loss</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>95-PCT</td>
</tr>
<tr>
<td>96-PCT</td>
</tr>
</tbody>
</table>

The above table presents the results of analyses of historical NPI total return data. The table presents the results of
analyses based on both 95th percentile (PCT) and 96th PCT worst results in the historical data set. Further, the table
presents cumulative losses at varying periods ranging from 1 to 4 years. Historically, downturns in real estate tend
to last less than 3 years, so this period also represents the worst cumulative decline that would be observed even if
the assumed period was extended further. The “cumulative” observations represent the largest cumulative loss
experienced at any point in the period.

The recommendation of 9.5% is based on consideration of the maximum cumulative losses at both the 95th and
96th percentiles (“PCT”) during the observed period. This assumed period of loss is consistent with the assumption
used for common stock. Importantly, based on historical performance data for the sector, the 11% recommended
base factor would cover cumulative losses during a 2-year period at a 96.8% confidence level.

We also note that in using cumulative losses over time, there is no discounting for time value of money, and all
analysis are conducted without any consideration of the federal income tax impact of the losses.

The use of actual historic quarterly returns across 60 years of industry experience provides for the incorporation of
the impact of several economic cycles on supply and demand for commercial real estate and the impact on market

3 See Appendix 1 for a detailed description of NCREIF and the NPI.
values. This lengthy time period also allows for incorporation of the effects from earlier governmental impact on prices, such as from changes in the tax code in the 1980s.

Considerations

1. **Applicability of Index to Individual Life Company Portfolios**

   The recommended decrease in the RBC factor for Real Estate is based on the performance of a large and well diversified commercial real estate benchmark performance index (i.e., NCREIF-National Property Index, NPI). The index includes quarterly data from all the major property types (office, retail, industrial, multifamily and hotel) across all regions of the US, which makes it broadly applicable to all of these major property types nationwide. Additionally, we compared the distribution of properties by type and by geographical region in the NCREIF database to the distribution of those held by the life insurance companies and found the distributions to be quite similar.

   The question of the potential need for increased granularity for the RBC factor was considered thoroughly. In particular, we considered a different factor for company occupied as a class with lower risk than investment properties. However, granularity beyond the single factor representative of all US commercial real estate was deemed inappropriate due to 1) the relatively small size of the asset class, 2) the alignment of composition between the NPI and the life industry portfolio, and 3) regulations separate from RBC factors that address concentration risks and assure diversification of life company real estate portfolios.

   Additionally, segmenting the NPI dataset into smaller granularities can be problematic. The NPI as of Q4-2020 consisted of just over 9,000 properties but roughly 30,000 properties have been in the index at some point during its 30+ year history. Over that history, the geographic and property type distribution of NPI has been constantly evolving. While the database of properties is large in total, segmenting it into more granular levels can produce sample sizes too small to be statistically sound. Beyond this, segmenting can add only limited additional value. The primary driver of real estate property performance is the national real estate cycle\(^5\) as portrayed in the NPI. The pattern of real estate losses for both the industry and for individual companies is aligned with that cycle. In other words, the overall real estate cycle tends to dominate other effects including geography and property type. The strength of that national real estate cycle has been found in academic research to explain roughly 50% of the variation in property performance across all properties in the index.

2. **Impact of Select Key Assumptions**

   - **Loss Horizon:** The period of time assumed for the accumulation of losses in the analysis (loss horizon) plays an important role in determining the appropriate amount of required capital. In this updated proposal, we suggest an 11% RBC factor, which is based on cumulative losses over 2 years. Real estate assets are typically held longer-term, often five years or greater. As the assets are more illiquid than publicly traded bonds or other securities, they are often used to back surplus, or longer-term liabilities. Liquidity is managed such that the timing of sale of real estate assets can often be strategically determined, thus avoiding realization of the larger maximum potential losses. The key focus is the length of economic cycles with losses. In past real estate cycles, the duration of losses typically spans a 2 to 3-year period, with the majority of losses during past downturns being materially concentrated within one year. Average holding periods for real estate assets are typically much longer than one year, averaging 10 years or longer, based on analysis periods and investment targets for most institutional investors. Given the statutory accounting for the asset class with declining book value and rigorous impairment requirements, it is normal for the

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actual recognized impairment rates by insurance companies to be lower in both frequency and severity than market averages. This is primarily related to the existence of unrealized gains that must be exhausted prior to any recognition of losses.

- **Confidence Level:** The confidence level also plays an important role in determining the appropriate amount of required capital. The 9.5% suggested base factor generally corresponds to the losses modeled at between the 95th and 96th percentiles (PCT) over a worst cumulative period. The recommended 11% factor covers losses at a 96.8% confidence level, assuming maximum cumulative losses during a 2-year period.

- **Reserve Offset:** The development of the bond factors includes an offset for expected losses based on the principle that expected losses are covered by reserves. Real estate and common stock are both treated as equity assets which are generally viewed as supporting surplus and not reserves, and for which expected loss is not considered. The current RBC methodology for real estate equity does not include an offset for expected loss, as the basic contribution to AVR used as a proxy for expected loss is zero. Similarly, this proposal does not include an offset for expected loss. The rationale for excluding the mitigating effects of the expected loss include:
  - There is no basic contribution to AVR for real estate investments.
  - Real estate is a small asset class, and analyses required to develop appropriate offsets for expected loss are deemed unnecessary.
  - Discussions around the appropriate relationship between expected loss, AVR, and RBC are ongoing. In the future, as precedent is set in the other larger asset classes where the effects are likely even more important, the potential integration of an offset in the real estate equity sector should be reconsidered.

- **Income:** In the development of RBC factors for bonds, income in excess of the expected loss offset discussed above is not included in the modeling and is assumed to be used for policyholder liabilities and not available as a loss offset. For common stock, and for real estate as equity investments, the total return is used. First, since the equity assets are generally presumed to back surplus and not policyholder reserves, the policyholder does not have claim to the income. Consistent with the lack of offset for expected loss, the income is available. When bonds default there is no subsequent income available to the investor. Real estate does not default, and even if subject to impairment, continues to produce income. The Real Estate values were therefore developed consistent with common stock using a total return view of the assets.

- **Taxes:** All of the modeling discussed in this project was done on a “cash” basis. No consideration has been given to the effect of these losses on the tax liability of the investor. Since losses reduce taxes that otherwise would be paid by the investor, this will result in a lower post-tax RBC factor than the recommended level.

- **Property acquired through foreclosure:** Property acquired through foreclosure should be treated the same as any other real estate. If the insurer forecloses on a mortgage and obtains the property, statutory accounting requires the property to be brought onto the company’s books at then current market value. As a result, the value is no different than any other property purchased in the course of business. If the property has low income potential, that will be reflected in its market value.

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6 There are currently discussions at the NAIC regarding whether RBC assessments should be adjusted to remove the expected losses for sectors. In real estate equity’s case, we are uncertain as to the materiality of adjusting for expected losses. The same could be said for common stock, as expected loss is a fixed income concept and would be difficult to apply to equities.
3. **Application of stochastic approaches**: While we considered stochastic approaches, a fully stochastic model was deemed inappropriate by the working group due in large part to the limited amount of quarterly historical observations (limited when compared to the amount of daily transaction data available for public stocks and bonds). It is possible that a stochastic analysis could be performed wherein an algorithm would be built and calibrated to actual history. However, if the algorithm is calibrated to historical performance, we believe that the results of such an analysis would be consistent with our work, which includes periods of very significant market stress in the sector. Note that the work performed in both common stocks and bonds excluded significant periods of stress in those markets, given changes in the economy from the advent of the creation of the Federal Reserve. Both asset classes have public data going back to early in the 19th century, though of varying quality. We used the full historic track record for commercial real estate (CRE) that is available and includes the downturn in CRE from the S&L crisis in the 1990s, the effects of the dot-com bubble, the global financial crisis and the most recent effects of COVID-19 pandemic in 2020.

**B. Adjust RBC to recognize risk impact of unrealized gains and losses**

We also recommend implementation of an adjustment to individual property RBC that will account for the cushion against statutory losses that is often created in real estate assets as they are held through time. The RBC factor that is recommended in Section A is calibrated based on volatility of market values through time. However, real estate assets are reported for statutory accounting using depreciated cost. In real estate, the assets depreciate annually, so each year the asset’s statutory value will be adjusted downward, even though the actual market value of the asset is more likely to be increasing. Annual depreciation rates in real estate are often 2% or higher. This creates an “unrealized gain” that serves as a cushion that must be completely eroded as market values fall before there would be any risk of loss of statutory capital. Since risk to statutory capital varies based on the size of this margin, a single factor applied to the statutory value does not appropriately measure the risk. This adjustment reflects the varying amount of risk resulting from this margin.

Fair value of real estate assets held by Life Companies is reported in Schedule A for each individual property. This fair value includes the changing market value of the asset and the impact of any improvements that have been capitalized. This excess of market value over the statutory value is a cushion against loss of statutory capital.

We propose that the applied base RBC factor be adjusted using a ratio of 1/2 of the difference between the reported fair value and statutory book value, to the statutory book value. Note that in situations where fair value is less than statutory, the RBC factor will be increased. We recommend that the final RBC for any property not be less than the amount determined using the factor for a Baa bond applied to the BACV.

Examples of the application of the adjustment are presented in the below table and are hypothetical. If a market value were lower than book value, that property would be reviewed for possible impairment. If the value were down temporarily, this adjustment would provide a short-term increase in RBC. If the value is down on a permanent basis, this may provide an early increase in RBC prior to taking an impairment.

The specific formula including adjustment would be:

\[
RBC\% = \text{Max} \left[ \text{NAIC2}\%, \ 11.0\% \times (1 - \frac{1}{2} \times \frac{(MV-BVg)}{BVg}) \right]
\]
### In an effort to assess the effects of statutory accounting on actual life insurance company experience, a simulation was constructed to analyze hypothetical life company portfolio performance given statutory accounting. The results of this study demonstrate the materially lower statutory losses as compared to market value losses during downturns, and thus provide support for the proposed adjustment.

In 2013 the ACLI, NAIC, and Industry real estate specialists engaged Jeff Fisher (Academic Consultant), who is a special academic consultant to NCREIF, to use the historical property level performance data in the NPI to construct simulated historical performance under statutory accounting rules. The analysis leveraged all available NPI data history at the required level of granularity at that time, which included the period of 1978Q2 through 2013Q1. This analysis was performed to provide additional insight around the impact of statutory accounting (recognition of depreciation, impairment rules, etc.) on the historical performance and risk to capital for insurance companies.

The simulation used the actual historical market experience of the NPI at the individual property level, wherein estimates of statutory accounting were applied. This hypothetical exercise was not intended to serve as the primary basis for determination of an appropriate RBC factor. Rather, the results of this hypothetical exercise illustrate the effect that statutory accounting (i.e., with depreciating book values and impairment rules/requirements) can have on the timing and severity of loss recognition relative to market value changes and provide additional evidence that the primary analysis is reasonable, if not conservative, given the effect of statutory accounting.

The simulation made the following assumptions:

1. Beginning Book Value for statutory accounting when properties enter the data set is set equal to then current market value.
2. For Book Value projections, depreciation is over 20 years (5% per year) for all properties.
3. Properties are tested for impairment quarterly, with impaired properties removed from index after recognizing the loss from the impairment. Any income received to that point is retained in the modeling.
4. As in statutory accounting, there is no accounting for property value increases, only losses are recognized in the analysis.
5. There is no offset related to expected loss (i.e., there is no accounting for AVR).
Example of Simulated Statutory Property Performance: In the simulation, individual asset market values are recorded in the quarter a property enters the index. At this beginning quarter, book value is set equal to market value, which is assumed to be the cost to acquire and is therefore consistent with statutory accounting. Every quarter forward, NCREIF has updated estimates of market value for the asset.\(^7\) Future statutory carrying value of the asset (depreciated book value) is estimated using the generic depreciation assumptions listed above. In every quarter, we estimate whether an impairment would have been recognized using statutory accounting rules, the then current market value, anticipated future property cash flows as implied from that market value, and then current statutory carrying value. Aggregate impairment rates by quarter are tracked through time, which are useful for comparison to actual market value losses reported for the index.

Using the above assumptions in the simulation model and including all properties over the entire history of the NPI, the following chart presents quarterly total losses as a percent of market value. As the chart below illustrates, the largest quarterly loss rate for the simulated index performance was just slightly over 2% during the recent Great Recession. Further, over this entire simulated history there are only a few quarters with significant simulated statutory losses. Losses were concentrated in the real estate market downturns of the early 1990s and in 2009 following the Great Recession.

The largest one-year loss for the full history of the simulated data occurred during the Great Recession, when the simulated one-year cumulative statutory loss was approximately 7% during the year 2009.\(^8\) During 2009, the actual recorded total return for properties in the NPI was a cumulative loss of 17%. This decline occurred amid the most severe downturn in history, based on its intensity. However, the value decline during this period was relatively short-lived, as the negative quarterly total returns persisted for only six quarters.

Given the event was an extreme outlier in the history of real estate performance, the probability of it reoccurring is extremely low within the modeled random sampling. In simple terms, since the 17% decline in one year occurred once in the 36-year exposure, the implied frequency is 2.8% probability (i.e., one year out of 36) while RBC is set to a 5% (or 95% confidence) level. In addition, this temporary reduction in market value would not necessarily have led to equal statutory impairments both since market value is typically in excess of book value, and requirements for statutory impairments do not immediately recognize all changes to market price. Thus, statutory accounting can lessen the severity of recognized losses during market downturns.

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\(^7\) The NCREIF database relies on appraisals to establish value where there has not been a transaction. The simulation projected MV could be viewed as projected appraised value. Various studies of CRE appraisals have been performed and show that the appraisals are good estimates of MV, though they may lag actual market changes. This assumption does not affect the validity or applicability of the results.

\(^8\) While the 7% maximum simulated loss should provide a degree of comfort in the reasonableness of the proposed factor, it is not directly comparable in concept to either the proposed factor or the cited actual historic market value based index returns.
As further evidence of the impact of statutory accounting, we examined actual losses incurred during the Global Financial Crisis, which is the most severe real estate market downturn within the 60-year data analysis period. The ACLI conducted an analysis of the life insurance industry’s actual performance during 2008 through 2012. The analysis examined all impairments of real estate investments, along with recognized losses on sale of real estate investments, during the period using data from Annual Statement exhibits Schedule A Parts 1 and 2. The industry reported cumulative losses of about 3.5% over that 5-year period, significantly lower than the 9.5% recommended factor. These reported industry losses include Other-Than-Temporary Impairments and losses on sale as reported in the Annual Statement schedule. Note that the analyses did not account for the declines in value of assets that are reported at fair value for statutory purposes.

C. Update RBC charge on real estate encumbrances

Under Statutory Accounting rules, real estate is held at depreciated cost net of encumbrances. Under the current proposal, RBC will be assessed by estimating the risk on the total property, then providing a credit for the value of the encumbrance based on the equivalent risk of the mortgage. The rationale for this is that the total underlying risk of loss on the property is the same whether or not there is an encumbrance, but the holder of the encumbrance bears part of the risk and the holder of the property bears the balance. Therefore, the risk is split effectively by developing the risk for the entire real estate value, then subtracting the amount of risk ascribed to the mortgage. We chose the approach of a reduced factor based on the average factor for mortgages in light of the small size of the real estate asset class, and the even smaller amount of encumbrances. For implementation, we recommend changing the RBC worksheet to show the RBC for the entire real estate, then a credit for the amount of the encumbrance.

The current encumbrance factors were based on the current RE factor of 15% reduced by the average RBC for commercial mortgages, which was 3.00% under the prior RBC formula. The proposed factor for Real Estate is 11.0%, and the average commercial mortgage factor that was developed as part of the commercial mortgage RBC proposal in 2013 was 1.75%. As an example, consider the following:
<table>
<thead>
<tr>
<th>Property Value</th>
<th>Amount</th>
<th>RBC factor</th>
<th>$RBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>No encumbrance</td>
<td>100</td>
<td>11.0%</td>
<td>11.0</td>
</tr>
<tr>
<td>With 60% LTV mortgage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Property Value</td>
<td>100</td>
<td>11.0%</td>
<td>11.0</td>
</tr>
<tr>
<td>- Equity value</td>
<td>40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Encumbrance</td>
<td>60</td>
<td>-1.75%</td>
<td>-1.05</td>
</tr>
<tr>
<td>- Real Estate RBC</td>
<td>40</td>
<td>24.9%*</td>
<td>9.95</td>
</tr>
<tr>
<td>- Mortgage RBC¹</td>
<td>60</td>
<td>1.75%</td>
<td>1.05</td>
</tr>
<tr>
<td>- Total</td>
<td>100</td>
<td></td>
<td>11.0</td>
</tr>
</tbody>
</table>

* Equals the RBC value (9.95) divided by the real estate equity value (40).

¹ This is an estimate of the value of the risk attributable to the mortgage by assuming that the mortgage was held by a life insurance company and estimating the resulting RBC.

This table illustrates our suggestion that the same amount of total capital be held whether a property is held with no encumbrance, or if it has an encumbrance, to reflect the constant level of risk of loss at the property irrespective of the capital stack. The RBC calculated on the encumbrance derives from the price risk of the property. It is to reflect that there is more risk as a percent of the equity investment, though not in total risk, to the equity investment of an investor in a property when leverage is used compared to when there is no leverage and a property is owned outright. In the case of having an encumbrance, the RBC held by the lender, when added to the RBC held by the owner on its equity and its encumbrance, sum to the same amount as if the property was held with no encumbrance.

In the current RBC, the result of this formula on encumbrances includes a maximum amount equal to 100% of the book adjusted carrying value of the real estate. While recognizing that the loss is generally limited to 100% of the carrying value, we believe that an RBC factor of 100% is excessive, and that the limit should be set at 45% of the carrying value. We note that for common stock, the combined factor at the maximum Beta is 45%.

D. Update Schedule BA Real Estate Factor

Real Estate held in joint ventures (JVs), limited liability companies (LLCs) or similar structures are recorded in Schedule BA, on lines 2199999 and 2299999. Currently, these assets are assessed RBC with a factor (23%) that is 50% higher than the factor for wholly owned real estate reported in Schedule A. The documentation for Schedule BA assets from the original RBC development articulates a premium over the RBC for Schedule A assets to account for additional risk associated with potentially lower transparency and control within the structures. However, since that time, data availability and industry experience has provided evidence that this premium is overly conservative, if not altogether unnecessary for the assets classified as real estate. We propose that the factor for Schedule BA real estate be adjusted to 13%, equivalent to the proposed factor for Real Estate recorded on Schedule A plus a premium of about 20% of the Schedule A factor for conservatism. All of the other mechanics and components described above for Schedule A real estate would also apply consistently for the real estate recorded on Schedule BA. This proposal is supported by the following:

- Real estate investments today are very often executed through corporate structures such as LLCs simply to mitigate risks. Institutional investors regularly use these structures to reduce the risk of loss from contingent liabilities. Contingent liabilities could be associated with the operations of the property (e.g.,
slip-and-falls), disputes with vendors or tenants, or debt. LLCs insulate investors from losses above the value of the net equity in an individual investment. Institutional investors also often use LLCs as holding companies for a series of single-asset LLCs, in order to better organize a portfolio in a manner that limits liabilities along each level of the corporate ownership structure.

- The NAIC recently approved the reclassification of certain wholly owned single owner, single asset LLCs to be reported on Schedule A. This was due to the recognition that the LLC structure itself did not produce additional risk. In this approval, the NAIC also agreed that additional reclassification could be proposed and approved when additional supporting materials were submitted. Rather than seeking a change in the accounting, we are proposing to adjust the RBC to reflect the risk.

- Partnership structures are often used to align interests between the life insurance company and local partners who have superior access to the market and property development, asset management and property management skills, while still maintaining control of significant investment decisions, especially around liquidity. This better execution and alignment of interest can result in better investment performance and even lower market risk.

- Partnership structures reduce the capital commitment of the life insurance company to an individual transaction, and thus can add portfolio diversification.

- A study was performed to compare the actual realized risk of institutional real estate investments held through JV’s to those of directly-held real estate investments. Jeffrey Fisher, a Ph.D. and consultant for NCREIF, broke down all properties in the NCREIF Property Index into joint venture and wholly owned properties to compare the performance since 1983. Mr. Fisher’s analysis found as follows:
  - Since 1983, the average quarterly return for JV properties was 2.35% versus wholly owned properties at 1.97%. This performance gap widened over time.
  - The standard deviation of returns for JV properties (2.4%) was only modestly higher than the standard deviation of wholly owned properties (2.2%).
  - Values of the wholly owned properties fell more than the values of JV properties from peak-to-trough during the Global Financial Crisis (GFC).
  - In terms of return dispersion during the GFC’s worst quarter, wholly owned properties had the largest negative return and JV properties had the highest positive return.
  - JV properties were found to have shorter average holding periods than wholly owned properties, suggesting potentially higher liquidity in JV structures.

In summary, real estate held through joint ventures has performed consistently with and perhaps even slightly better than, wholly owned real estate. Based on this research, and in recognition of the several legitimate risk/return benefits of ownership through structures, we propose that real estate held on schedule BA use a factor of 13%, which is the factor for wholly owned real estate held on schedule A with a modest premium.
Appendix 1

The historical National Council of Real Estate Investment Fiduciaries (NCREIF) database goes back to December 31, 1977, and as of Q4-2020 consisted of approximately 9,000 properties. NCREIF collects 67 data fields each quarter that consist of financial information such as Market Value, NOI, Debt, and Cap Ex, as well as descriptor data such as Property Type and Subtype, Number of Floors, Square Footage, Number of Units, and Location.

The flagship index of NCREIF is the NCREIF Property Index (NPI), which is a quarterly index tracking the performance of core institutional property markets in the U.S. The objective of the NPI is to provide a historical measurement of property-level returns to increase the understanding of, and lend credibility to, real estate as an institutional investment asset class. The NPI is comprised exclusively of operating properties acquired, at least in part, on behalf of tax-exempt institutions and held in a fiduciary environment. Each property’s return is weighted by its market value. The NPI includes properties with leverage, but all returns are reported on an unleveraged basis. The NPI includes Apartment, Hotel, Industrial, Office and Retail properties, and sub-types within each type. The index covers all regions of the US, which makes it broadly applicable to all of these major property types nationwide. Additionally, we have also done a comparison of the distribution of properties by type and by geographical region between those in the NCREIF database and those held by the life insurance companies and found them to be quite similar.

Over the history of the NPI data, there have been two severe downturns, in the 1990s and the recent GFC; as well as a shallow recession corresponding to the 2001 economic recession that did not produce negative total returns for real estate. Given the time series of the data, the index does reflect ‘tail events’ such as the Great Recession thus appropriately capturing the downturn in the employed primary methodology for estimation of the appropriate RBC charge.

Additional information on NCREIF and the NCREIF Property Index (NPI) can be found here: https://www.ncreif.org/data-products/property/
Appendix 2

The difference between market value and statutory value (depreciated cost) is not included in surplus within statutory accounting. As a result, the risk of future impairments of statutory value would be much less for a company where the current market value of its portfolio of properties is well in excess of statutory carrying value, especially compared to one where market value is much closer to statutory carrying value.

Our primary analysis was based on market values, and therefore overstates the risk relative to statutory accounting. We are not proposing that statutory accounting for commercial real estate should change, but rather partially leveling the playing field for properties that have been held for extended periods with market value well in excess of statutory carrying value, versus recent acquisitions with no such unrealized gains. And we are proposing a floor charge equal to that for an NAIC 2 bond (currently 1.30%) so that capital will never be lower.

The following provides a numerical example. Assume a property held at a book value of $100 with a market value of $150. The NCREIF data measures changes in market value, and the 11% proposed factor would make provision for a loss of value to a value down to $133.50. Under the RBC process, factors are applied to the book value and normally do not recognize that unrealized gain. Since real estate is held at book value which in this case is $100, and is below this market value, effectively there an increased margin against the loss of statutory capital in excess of the amount of RBC.

For an asset with a market value well in excess of the carrying value, the reduction in RBC is minimal compared to the large-implied reserve. Similarly, in those relatively few circumstances where an asset will have a market value less than book value, the RBC amount would increase, to reflect the increased likelihood of a loss to carrying value. This increase in RBC would likely be in advance of an actual impairment, which would provide earlier visibility and recognition of weakening market conditions.
This proposal incorporates bond factors proposed by the American Council of Life Insurers (ACLI) which are based on the work of Moody’s Analytics for the expanded presentation of bond designation categories in the annual statement and risk-based capital (RBC) schedules.

**REASON OR JUSTIFICATION FOR CHANGE**

The expanded presentation of bonds is a result of the work of the Investment Risk-Based Capital (E) Working Group. This proposal presents alternative factors to those proposed by the American Academy of Actuaries (Academy).

**Additional Staff Comments:**

4-22-21: Proposal was exposed for comments (DBF)
6-11-21: Proposal was adopted with the base factors as presented in the April 2021 report, the inclusion of the adjusted tax factors for LR030 and Moody’s Analytics’ revised bond size factors as presented in the June 2021 report (DBF)

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*(Columns (1) should equal Page 2 Column 3 Line 1 + Schedule DL Part 1 Column 6 Line 709999)*
| Line | Description | NAIC Designation | Column 1 Line 18 | Column 1 Line 19.1 | Column 1 Line 19.2 | Column 1 Line 19.3 | Column 1 Line 19.4 | Column 1 Line 19.5 | Column 1 Line 19.6 | Column 1 Line 19.7 | Column 1 Line 20.1 | Column 1 Line 20.2 | Column 1 Line 20.3 | Column 1 Line 20.4 | Column 1 Line 20.5 | Column 1 Line 20.6 | Column 1 Line 20.7 | Column 1 Line 20.8 | Column 1 Line 20.9 | Column 1 Line 20.10 |
|------|-------------|------------------|------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|
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| 10.2 | NAIC Designation Category B | AVR Default Component | Column 1 Line 19.2 |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |
| 10.3 | NAIC Designation Category C | AVR Default Component | Column 1 Line 19.3 |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |
| 10.4 | NAIC Designation Category D | AVR Default Component | Column 1 Line 19.4 |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |
| 10.5 | NAIC Designation Category E | AVR Default Component | Column 1 Line 19.5 |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |
| 10.6 | NAIC Designation Category F | AVR Default Component | Column 1 Line 19.6 |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |
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- **Total Short-Term Bonds**: Sum of Lines (9) + (10.8) + (11.4) + (12.4) + (13.4) + (14.4) + (15)
- **Total Long-Term and Short-Term Bonds**: Line (8) + (16)
- **Credit for Hedging**: LR014 Hedged Asset Bond Schedule Column 13 Line (0) - (16) or (14.4) + (13.4) + (14.4) + (13)
- **Non-exempt U.S. Government Agency Notes**: Schedule D Part 1 or Schedule DA Column 1 Line (0) - (16) or (14.4) + (13.4) + (14.4) + (13)

1. Only investments in U.S. Government agency bonds previously reported in Line (2.8) and (10.8), net of those included on Line (19), plus the portion of Line (2.8) attributable to certain companies Line (2.8) and (10.8) should be included on Line (19). No other bonds should be included in this line. Enter U.S. Government agency bonds shown on Lines (1) and (9) should not be included on Line (19). Refer to the bond section of the risk-based capital instructions for more clarification.

2. Denotes items that must be manually entered on the filing software.
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† After the ten largest issuer exposures are chosen, any NAIC 1 bonds or preferred stocks from any of these issuers should be included.

‡ Refer to the instructions for the Asset Concentration Factor for details of this calculation.

| Denotes items that must be manually entered on the filing software. |
### ASSET CONCENTRATION FACTOR (CONTINUED)

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**NOTE:** This issue number and signed report will be available on the filing software. The grand total page is calculated as the sum of issuers 1-10 by asset type.

‡ Refer to the instructions for the Asset Concentration Factor for details of this calculation.

Denotes items that must be manually entered on the filing software.

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## HEDGED ASSET BOND SCHEDULE

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### Notes:

- **Note:** For the intermediate category of hedging, we recommend that the risk mitigation and resulting RBC credit be determined as if each specific security common to both the index/basket hedge and the portfolio is a basic hedge with the entire basic hedge methodology applied to each matching name. This includes the application of the maturity mismatch formula and the maximum RBC credit of 94% of the C-1 asset charge for fixed income hedges.

- **† Columns are derived from Investment schedules.**

- **‡ The portion of Column (2) Notional Amount of the Hedging Instrument that hedges Column (7) Book / Adjusted Carrying Value. This amount cannot exceed Column (7) Book / Adjusted Carrying Value.**

- **§ Factor based on Column (10) NAIC Designation and NAIC C-1 RBC factors table.**

- *** Column (7) Book / Adjusted Carrying Value multiplied by Column (11) RBC Factor.**

- **£ Column (13) is calculated according to the risk-based capital instructions.**

- ****Column (12) Gross RBC Charge minus Column (13) RBC Credit for Hedging Instruments.

Denotes manual entry items that do not come directly from the annual statement.
### Fixed Income - Bonds

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### Fixed Income - Preferred Stock

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### General

- The factor for common stock can vary depending on the type of stock. The factor would be subject to a minimum of 22.5 percent and a maximum of 45 percent.

Denotes items that must be manually entered on the filing software.
### CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL

#### Asset Risks

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#### Preferred Stock

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#### Notes

- Denotes lines that are deducted from the total rather than added.

### CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)

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<td>L000 Other Long-Term Assets Column (5 Line (52.3) + L000 Off-Balance</td>
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<td>(087) BA Mergers - 90 Days Overdue</td>
<td>L000 Schedule BA Mergers Column (6 Line (15)</td>
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<td>L010 Miscellaneous Assets Column (8 Line (9))</td>
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† Denotes items that must be manually entered on the filing software.
**CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)**

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<td>(102) Requisitions</td>
<td>LR013 Requisition (Synthetic Asset) Transactions and Mandates</td>
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<tr>
<td>(103) Reimbursement</td>
<td>LR016 Reimbursement (Column 17) Line (17)</td>
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<td>(104) Investment Affiliates</td>
<td>LR042 Summary for Affiliated Investments (Column 4) Line (6)</td>
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<td>(105) Investment in Parent</td>
<td>LR042 Summary for Affiliated Investments (Column 4) Line (10)</td>
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<td>(106) Other Affiliate: Property and Casualty Insurers not Subject to Risk-Based Capital</td>
<td>LR042 Summary for Affiliated Investments (Column 4) Line (13)</td>
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<td>(107) Other Affiliate: Life Insurers not Subject to Risk-Based Capital</td>
<td>LR042 Summary for Affiliated Investments (Column 4) Line (15)</td>
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<td>(108) Publicly Traded Insurance Affiliates</td>
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<td>(109) Subtotal for C-0 Assets</td>
<td>LR018 Off-Balance Sheet Collateral (Column 3) Line (16)</td>
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<td>(110) Off-Balance Sheet and Other Items</td>
<td>LR010 Off-Balance Sheet and Other Items (Column 27)</td>
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<td>(111) Off-Balance Sheet Items Reduction - Reinsurance</td>
<td>LR010 Off-Balance Sheet and Other Items (Column 28)</td>
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<td>(112) Off-Balance Sheet Items Non-Insurance - Reinsurance</td>
<td>LR010 Off-Balance Sheet and Other Items (Column 29)</td>
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<td>(113) Affiliated US Property - Casualty Insurers Directly Owned</td>
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<td>(114) Affiliated US Life Insurers Directly Owned</td>
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<tr>
<td>(115) Affiliated US Health Insurers Directly and Indirectly Owned</td>
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<td>(116) Affiliated US Property - Casualty Insurers Indirectly Owned</td>
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<tr>
<td>(117) Affiliated US Life Insurers Indirectly Owned</td>
<td>LR042 Summary for Affiliated Investments (Column 4) Line (5)</td>
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<td>(118) Affiliated Alien Life Insurers - Canada</td>
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<td>(119) Affiliated Alien Life Insurers - All Others</td>
<td>LR042 Summary for Affiliated Investments (Column 4) Line (9)</td>
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<td>(120) Subtotal for C-1cs Assets</td>
<td>LR019 All Life Insurers - All Subsidiary Lines (110 through 114) X 0.2100</td>
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**Common Stock**

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<td>(122) Credit for Hedging - Common Stock</td>
<td>LR005 Off-Balance Sheet Collateral (Column 3) Line (5)</td>
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<td>(123) Stock Reduction - Reinsurance</td>
<td>LR005 Unaffiliated Preferred and Common Stock (Columns 5 through 11)</td>
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<td>(124) Derivatives - Reinsurance</td>
<td>LR005 Unaffiliated Preferred and Common Stock (Columns 5 through 11)</td>
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<td>(125) BA Common Stock, Unaffiliated</td>
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<td>(126) BA Common Stock, Affiliated - C-1cs</td>
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<td>(127) Common Stock Concentration Factor</td>
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<td>(128) NAIC 01 Working Capital Finance Notes</td>
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<td>(131) &amp; Holding Company in Excess of Indirect Subs</td>
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<td>(132) Total for C1cs Assets</td>
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**Denotes items that must be manually entered on the filing software.**

**CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)**

† Denotes items that are deducted from the total rather than added.
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<td>134</td>
<td>Long-Term Care Health Premiums Column (2) Line (28) + LR025 Long-Term Care Column (4) Line (7)</td>
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<td>Life Insurance C-2 Risk</td>
<td>LR025 Life Insurance Column (2) Line (9) X 0.2100 -</td>
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<td>136</td>
<td>Group Insurance C-2 Risk</td>
<td>LR025 Group Insurance Column (2) Lines (20) and (21) X 0.2100 -</td>
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<td>137</td>
<td>Longevity C-2 Risk</td>
<td>LR025A Longevity Risk Column (2) Line (5) X 0.2100 -</td>
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<tr>
<td>138</td>
<td>Disability and Long-Term Care Health Claims Reserves</td>
<td>LR024 Health Claims Reserves Column (4) Line (9) + Line (15) X 0.2100 -</td>
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<td>Premium Stabilization Credit</td>
<td>LR025 Premium Stabilization Reserves Column (2) Line (10) X 0.0000 -</td>
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<td>Total C-2 Risk</td>
<td>L(135) + L(136) + L(137) + L(138) + Greatest of (Guardrail Factor * (L(135) + L(136)) - Guardrail Factor * L(136) ) + (TBD Correlation Factor * (L(135) + L(136)) - (TBD Correlation Factor))</td>
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<tr>
<td>141</td>
<td>Interest Rate Risk</td>
<td>LR027 Interest Rate Risk Column (3) Line (36) X 0.2100 -</td>
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<tr>
<td>142</td>
<td>Health Credit Risk</td>
<td>LR025 Health Credit Risk Column (2) Line (9) X 0.0000 -</td>
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<td>LR027 Interest Rate Risk Column (3) Line (37) X 0.2100 -</td>
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<td>Business Risk</td>
<td>LR025 Business Risk Column (2) Line (40) X 0.2100 -</td>
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<td>Health Administrative Expenses</td>
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<td>Total Tax Effect</td>
<td>Lines (109) + (129) + (139) + (140) + (141) + (142) + (143) + (144) -</td>
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BONDS
LR002

Basis of Factors

The bond factors are based on cash flow modeling using historically adjusted default rates for each bond category. For each of 2,000 trials, annual economic conditions were generated for the 10-year modeling period. Each bond of a 400-bond portfolio was annually tested for default (based on a “roll of the dice”) where the default probability varies by designation category and that year’s economic environment. When a default takes place, the actual loss considers the expected principal loss by category, the time until the sale actually occurs and the assumed tax consequences.

Actual surplus needs are reduced by incorporating anticipated annual contributions to the asset valuation reserve (AVR) as offsetting cash flow. Required surplus for a given trial is calculated as the amount of initial surplus funds needed so that the accumulation with interest of this initial amount and subsequent cash flows will not become negative at any point throughout the modeling period. The factors chosen for the proposed formula produce a level of surplus at least as much as needed in 92 percent of the trials by category and a 96 percent level for the entire bond portfolio.

The factor for NAIC 6 bonds recognizes that the book/adjusted carrying value of these bonds reflects a loss of value upon default by being marked to market.

Specific Instructions for Application of the Formula

Lines (1) through (7)
The book/adjusted carrying value of all bonds and related fixed-income investments should be reported in Column (1). The bonds are split into seven different risk classifications. For long-term bonds, these classifications are found on Lines 1 through 7 of the Asset Valuation Reserve Default Component, Page 30 of the annual statement.

Line (8)
The total should equal long-term bonds and other fixed-income instruments reported on Page 2, Column 3, Line 1 plus Schedule DL Part 1, Column 6, Line 7099999 minus Schedule D, Part 1A, Section 1, Column 7, Line 7.7 of the annual statement.

Lines (9) through (15)
The book/adjusted carrying value of all bonds and related fixed-income investments should be reported in Column (1). The bonds are split into seven different risk classifications. For short-term bonds, these classifications are found on Lines 18 through 24 of the Asset Valuation Reserve Default Component, Page 30 of the annual statement.

Line (16)
The total should equal short-term bonds reported on Schedule DA, Part 1, Line 8399999 plus Schedule DL Part 1, Column 6, Line 8999999 plus LR012 Miscellaneous Assets Column (1) Line (2.2).

Line (22)
Class 1 bonds (highest quality) issued by a U.S. government agency that are not backed by the full faith and credit of the U.S. government should be reported on this line. The loan-backed securities of the Federal National Mortgage Association (FNMA) and the Federal Home Loan Mortgage Corporation (FHLMC) would be examples of the securities reported on this line. Line (22) should not be larger than the sum of Lines (2) and (10). Exempt obligations should not be included on this line.

Line (24)
Bonds should be aggregated by issuer (the first six digits of the CUSIP number can be used). Exempt U.S. government bonds and bonds reported on Line (22) are not counted in determining the size factor. The RBC for those bonds will not be included in the base to which the size factor is applied. If this field is left blank, the maximum size factor adjustment of 2.52.40 will be used.
The size factor reflects the higher risk of a bond portfolio that contains relatively fewer bonds. The overall factor decreases as the portfolio size increases. Portfolios with more than 1,300 issuers will receive a discount. The size factor is based on the weighted number of issuers. (The calculation shown below will not appear on the RBC filing software but will be calculated automatically.)

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<td>Next 50 records</td>
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<tr>
<td>Over 500 records</td>
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Total Number of Issuers from Line (23)

Total Weighted Issuers

Size Factor = Total Weighted Issuers divided by Total Number of Issuers
**ASSET CONCENTRATION FACTOR**

**LR010**

**Basis of Factors**

The purpose of the concentration factor is to reflect the additional risk of high concentrations in single exposures (represented by an individual issuer of a security or a holder of a mortgage, etc.) The concentration factor doubles the risk-based capital pre-tax factor (with a maximum of 45 percent pre-tax) of the 10 largest asset exposures excluding various low-risk categories or categories that already have a maximum factor. Since the risk-based capital of the assets included in the concentration factor has already been counted once in the basic formula, the asset concentration factor only serves to add in the additional risk-based capital required. The calculation is completed on a consolidated basis; however, the concentration factor is reduced by amounts already included in the concentration factors of subsidiaries to avoid double-counting.

**Specific Instructions for Application of the Formula**

The 10 largest asset exposures should be developed by consolidating the assets of the parent with the assets of the company’s insurance and investment subsidiaries. The concentration factor component on any asset already reflected in the subsidiary’s RBC for the concentration factor should be deducted from Column (4). This consolidation process affects higher tiered companies only. Companies on the lowest tier of the organizational chart will prepare the asset concentration on a “stand alone” basis.

The 10 largest exposures should exclude the following: affiliated and non-affiliated common stock, affiliated preferred stock, home office properties, policy loans, bonds for which AVR and RBC are zero, NAIC 1 bonds, NAIC 1 unaffiliated preferred stock, NAIC 1 Hybrids, CM 1 Commercial and Farm Mortgages and any other asset categories with RBC factors less than 0.8 percent post-tax (this includes residential mortgages in good standing, insured or guaranteed mortgages, and cash and short-term investments).

In determining the assets subject to the concentration factor for both C-1o and C-1cs, the ceding company should exclude any asset whose performance inures primarily (>50 percent) to one reinsurer under modified coinsurance or funds withheld arrangements. The reinsurer should include 100 percent of such asset. Any asset where no one reinsurer receives more than 50 percent of its performance should remain with the ceding company.

Assets should be aggregated by issuer before determining the 10 largest exposures. Aggregations should be done separately for bonds and preferred stock (the first six digits of the CUSIP number can be used as a starting point) (please note that the same issuer may have more than one unique series of the first six digits of the CUSIP), mortgages and real estate. Securities held within Schedule BA partnerships should be aggregated by issuer as if the securities are held directly. Likewise, where joint venture real estate is mortgaged by the insurer, both the mortgage and the joint venture real estate should be considered as part of a single exposure. Tenant exposure is not included. For bonds and unaffiliated preferred stock, aggregations should be done first for classes 2 through 6. After the 10 largest issuer exposures are chosen, any NAIC 1 bonds, NAIC 1 unaffiliated preferred stock or NAIC 1 hybrids from any of these issuers should be included before doubling the risk-based capital. For some companies, following the above steps may generate less than 10 “issuer” exposures. These companies should list all available exposures.

Replicated assets other than synthetically created indices should be included in the asset concentration calculation in the same manner as other assets.

The book/adjusted carrying value of each asset is listed in Column (2).

The RBC factor will correspond to the risk-based capital category of the asset reported previously in the formula before application of the size factor for bonds. The RBC filing software automatically allows for an overall 45 percent RBC cap.
The Asset Concentration RBC Requirement for a particular property plus the Real Estate RBC Requirement for a particular property cannot exceed the book/adjusted carrying value of the property. Any properties exceeding the book/adjusted carrying value must be adjusted down to the book/adjusted carrying value in Column (6) of the Asset Concentration.

Line (18), Column (4) is calculated as Line (17), Column (2) multiplied by 0.2300 plus Line (18), Column (2) multiplied by 0.2000, but not greater than Line (17), Column (2).

Line (20), Column (4) is calculated as Line (19), Column (2) multiplied by 0.1500 plus Line (20), Column (2) multiplied by 0.1200, but not greater than Line (19), Column (2).

Line (22), Column (4) is calculated as Line (21), Column (2) multiplied by 0.2300 plus Line (22), Column (2) multiplied by 0.2000, but not greater than Line (21), Column (2).

The Asset Concentration RBC Requirement for a particular mortgage plus the LR004 Mortgages RBC Requirement or LR009 Schedule BA Mortgages RBC Requirement or LR004 Schedule BA Mortgages RBC Requirement cannot exceed 45 percent of the book/adjusted carrying value of the mortgage. Any mortgages exceeding 45 percent of the book/adjusted carrying value must be adjusted down in Column (6) of the Asset Concentration.

Line (32), Column (4) is calculated as the greater of 0.1800 multiplied by (Line (31) plus Line (32)) less Line (32) or Line (31) multiplied by the appropriate factor for the CM class to which the loan is assigned.

Line (34), Column (4) is calculated as the greater of 0.0140 multiplied by (Line (33) plus Line (34)) less Line (34) or Line (33) multiplied by 0.0068.

Line (36), Column (4) is calculated as the greater of 0.1800 multiplied by (Line (35) plus Line (36)) less Line (36) or Line (35) multiplied by the appropriate factor for the CM class to which the loan is assigned.

Line (38), Column (4) is calculated as the greater of 0.2200 multiplied by (Line (37) plus Line (38)) less Line (38) or Line (37) multiplied by the appropriate factor for the CM class to which the loan is assigned.

Line (40), Column (4) is calculated as the greater of 0.0270 multiplied by (Line (39) plus Line (40)) less Line (40) or Line (39) multiplied by 0.0068.

Line (42), Column (4) is calculated as the greater of 0.2200 multiplied by (Line (41) plus Line (42)) less Line (42) or Line (41) multiplied by the appropriate factor for the CM class to which the loan is assigned.

Line (43), Column (4) is calculated as Line (43) multiplied by the appropriate factor for the CM class to which the loan is assigned.

Line (44), Column (4) is calculated as the greater of 0.2150 multiplied by (Line (44) plus Line (45)) less Line (44) or Line (45) multiplied by the appropriate factor for the CM class to which the loan is assigned.
Hedging

The concept of hedging credit, equity and other risks is widely accepted and understood among insurers and their regulators. In order for regulators to distinguish between insurers that have effectively reduced their risks from those insurers that have not, the risk based capital computation should be sensitive to such differences. Increasing or decreasing exposure to different asset classes in relation to a benchmark asset allocation tailored to meet the long term obligations to policy owners is critical to successfully managing an insurance company. Hedging is the process of using derivative instruments to most efficiently limit risk associated with a particular asset in a manner consistent with the insurer’s long term objectives. The relative advantage of using cash market transactions versus derivative market transactions depends upon market conditions.

The NAIC model investment laws and regulations establish specific constraints on the use of derivatives. Governance of derivative use starts with approved and documented authorities from the insurer’s Board of Directors to management. These authorities are coordinated with and enhanced by limits established by the insurer’s domiciliary state.

Hedging strategies currently employed by insurers range from straightforward relationships between the hedged asset and the derivative instrument (the hedge) to more complex relationships. The purpose of this section of the RBC calculation is to measure and reflect in RBC the risk reduction achieved by an insurer’s use of the most straightforward types of hedges involving credit default and equity C-1 risks.

To avoid the possible double counting of RBC credits, excluded from this section are any RBC credits arising from hedges that are part of the Clearly Defined Hedging Strategy (CDHS) required for C-3 cash flow testing or other risk mitigation techniques (e.g. reinsurance) which produce reduced levels of RBC by operation of other parts of the RBC formula.

RBC and Measuring the Risk Reduced by Hedging

To measure the risks reduced by hedging and reflect the effects in RBC it is important to understand the characteristics and purpose of the hedge. A portfolio manager seeking to hedge a particular asset or portfolio risk must determine if the derivative instruments available will do a suitable job of risk mitigation.

Default risk - A portfolio manager may determine that the default risk of a particular debt security which matures in 8 years needs to be hedged because of a near term credit concern which may resolve before the debt matures. A credit default swap (CDS) would be the most effective hedging instrument. In some circumstances the manager may purchase a CDS with 8 years to maturity which fully mitigates the default risk and shall result in an RBC credit which fully offsets the C-1 default risk charge on the debt security. However, seeking the most liquid and cost efficient market for the purchase of such an instrument may lead to the purchase of a 5 year CDS which the manager plans to renew (roll) as the credit circumstances evolve in the coming years. In this case there is a 3 year maturity mismatch between the debt security and the hedging instrument. To account for the difference between insurers that have hedged the debt security to full maturity versus those with a mismatched position, the determination of the RBC credit shall be made in accordance with the following formula which limits the results to a fraction of the C-1 charge for the hedged asset.
RBC Credit As % of C1 Asset Charge = Min\(\left(1, \frac{\text{Time to Maturity of CDS}}{\text{Time to Maturity of Bond}}\right) \times (94\% - 10\%) + 10\%\)

This accounts for mismatched maturities and provides a regulatory margin of safety within a range of 94%-10% of the C-1 asset charge.

There may also be circumstances where default risk is reduced by hedging specific portfolios using a basket or index-based derivative (e.g. CDX family of derivatives) with the same or very similar components as the portfolio. For these hedges the risk reduction shall be measured based on the number of issuers common to both the insurer’s portfolio and the index/basket CDS. A minimum of 50% overlap of the derivative instrument notional amount and the book/adjusted carrying value of the hedged bonds shall be required to qualify for any RBC credit. Additionally, if the insurer hedges an index, each bond must be listed (e.g. if the insurer acquires a CDX that hedges 125 names equally, then the insurer must list all 125 names on the schedule), regardless if the insurer owns all the bonds in the index.

As RBC is currently measured and reported annually and to an extent provides a regulator with an indicator of capital sufficiency for the near term future; default risk protection as provided by CDS (based on a specific security or an index of securities) shall have more than 1 year remaining to maturity in order to receive any RBC credit, provided that the remaining maturity of the hedged debt security or average maturity of the hedged portfolio is greater than 1 year. When both the default risk protection and the hedged debt security have less than one year to maturity, full RBC credit shall be allowed provided that the maturity of the protection is later than the maturity of the debt security; otherwise no RBC credit is allowed.

Equity market risk - A portfolio manager may determine that the market risk of holding a particular common stock needs to be reduced. Because an outright sale at that point in time might be disadvantageous to the insurer and/or policy owners, a short futures contract may be purchased to eliminate the current market risk by establishing a sale price in the future. The C-1 RBC equity risk credit shall be limited to 94%.

There may also be circumstances where equity market risk is reduced by hedging equity portfolios using derivatives based on equity market indices (e.g. S&P 500 futures contracts). Unless the equity portfolio is exactly matched to the index, the hedge will not provide precise one-to-one protection from fluctuations in value. The insurer must list all positions in the equity index individually (e.g. all 500 common stocks that are part of the S&P 500), regardless if the insurer owns all the stocks in the index.

Definitions and Instructions for the Spreadsheet Computation of Risk Reduction

(Numeric references represent spreadsheet columns)

Bonds

1. Description - Reported on Schedule DB.

2. Notional Amount - Amount reported on Schedule DB.

3. Relationship Type of the Hedging Instrument and Hedged Asset. There are two categories; Basic and Intermediate relationships. Basic relationship = Single issuer credit default swap on a single issuer name to hedge the credit risk of a specific hedged asset. Intermediate relationship = A portfolio of insurer assets paired with a basket or index based hedging instrument with the same or very similar components as the portfolio. For intermediate relationships, a minimum of 50% overlap of the derivative instrument notional amount and the book adjusted carrying value of the hedged bonds shall be required to qualify for any RBC credit.

4. Maturity Date - Date reported on Schedule DB.
(5) **Description** - Bond description found in Schedule D. *For intermediate relationships, each bond must be listed (e.g. if the insurer acquires a credit default index that hedges 125 names equally, then the insurer must list all 125 names on the schedule.)*

(6) **CUSIP Identification** - Bond unique identifier found in Schedule D.

(7) **Book Adjusted Carrying Value** - Value found on Schedule D.

(8) **Overlap with Insurer’s Bond Portfolio** - The portion of Column (2) Notional Amount of the Hedging Instrument that hedges Column (7) Book Adjusted Carrying Value. This amount cannot exceed Column (7) Book Adjusted Carrying Value.

(9) **Maturity Date** - The date is found in Schedule D.

(10) **NAIC Designation** - Designation found in Schedule D. Necessary to determine correct RBC Factor for the Bonds.

(11) **RBC Factor** - Factor based on Column (10) NAIC Designation and NAIC C-1 RBC factors table.

(12) **Gross RBC Charge** - This is the C-1 RBC charge based on holdings at the end of the year. Calculation: Columns (7) Book Adjusted Carrying Value multiplied by (11) RBC Factor.

(13) **RBC Credit for Hedging Instruments** - If Column (8) Overlap with Insurer’s Bond Portfolio is zero; the RBC Credit would also be zero. The Hedging Instrument must have more than 1 year remaining to maturity in order to receive any RBC credit provided that the remaining time to maturity of the Hedged Asset - Bonds is greater than 1 year. If both the Hedging Instrument and the Hedged Asset - Bonds maturity dates are less than 1 year, the maximum RBC credit determined using the formula below shall be allowed provided that the maturity of the hedging instrument is equal to or later than the maturity of the bond. Calculation is Column (8) Overlap with Insurer’s Bond Portfolio multiplied by RBC Credit as % of C-1 Asset Charge formula (formula listed below) multiplied by Column (11) RBC Factor.

\[
\text{RBC Credit as % of C-1 Asset Charge} = \min\left(1, \frac{\text{Time to Maturity of Hedging Instrument}}{\text{Time to Maturity of Bond}}\right) \times (94\% - 10\%) + 10\%
\]

Time to Maturity of Hedging Instrument divided by Time to Maturity of Bond cannot exceed 1.

(14) **Net RBC Charge** - Column (12) Gross RBC Charge minus (13) RBC Credit for Hedging Instruments.

**Common Stocks**

(1) **Description** - Reported on Schedule DB.

(2) **Notional Amount** - Amount reported on Schedule DB.

(3) **Relationship Type of the Hedging Instrument and Hedged Asset**. There are two categories; Basic relationships or Intermediate relationships. Basic relationship = Single name equity Hedging Instrument paired with a specific common stock. Intermediate relationship = A portfolio of common stocks paired with a basket or index based Hedging Instrument with the same or very similar components as the portfolio. For intermediate relationships, a minimum of 50% overlap of the derivative instrument notional amount and the book adjusted carrying value of the hedged common stocks shall be required to qualify for any RBC credit.
(4) Description - Common Stock description found in Schedule D Part 2 Section 2. For intermediate relationships, each common stock must be listed (e.g. if the insurer acquires a short futures contract that hedges the S&P 500, then the insurer must list all 500 stocks on the schedule).

(5) CUSIP Identification - Common Stock unique identifier found in Schedule D Part 2 Section 2.

(6) Book Adjusted Carrying Value - Value found on Schedule D Part 2 Section 2.

(7) Overlap with Insurer’s Stock Portfolio – The portion of Column (2) Notional Amount of the Hedging Instrument that hedges Column (6) Book/Adjusted Carrying Value. This amount cannot exceed the Column (6) Book Adjusted Carrying Value.

(8) RBC Factor - Factor based on NAIC C-1 RBC factors table.

(9) Gross RBC Charge - The C-1 RBC charge based on holdings at the end of the year. Calculation: Columns (6) Book Adjusted Carrying Value multiplied by (8) RBC Factor.

(10) RBC Credit for Hedging Instruments - RBC credit for equity market risk reduction is limited to 94% of the C-1 Asset charge. Calculation: Column (7) Overlap with Insurer’s Stock Portfolio multiplied by (8) RBC Factor multiplied by 94%.

(11) Net RBC Charge - Column (9) Gross RBC Charge minus (10) RBC Credit for Hedging Instruments.
## Factors Table

As determined by the NAIC

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<tr>
<th>NAIC Designation</th>
<th>Factor</th>
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</tr>
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<td>1.C</td>
<td>0.00419</td>
</tr>
<tr>
<td>1.D</td>
<td>0.00523</td>
</tr>
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<td>1.E</td>
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</tr>
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<td>2.C</td>
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### Common Stock Type

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<td>Other Unaffiliated Public Common Stock</td>
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</tr>
<tr>
<td>Money Market Mutual Funds</td>
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</tr>
<tr>
<td>Federal Home Loan Bank Common Stock</td>
<td>0.0110</td>
</tr>
<tr>
<td>Unaffiliated Private Common Stock</td>
<td>0.3000</td>
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</table>

† - 30 percent adjusted up or down by the weighted average beta for the publicly traded common stock portfolio subject to a minimum of 22.5 percent and a maximum of 45 percent.
OFF-BALANCE SHEET COLLATERAL
(Including any Schedule DL, Part 1 Assets not Included in the Asset Valuation Reserve)
LR018

Basis of Factors
Security lending programs are required to maintain collateral. Some entities post the collateral supporting security lending programs on their financial statements, and incur C-1 risk charges on those assets. Other entities have collateral that is not recorded on their financial statements. While not recorded on the financial statements of the company, such collateral has risks that are not otherwise captured in the RBC formula.

Annual Statement Schedule DL, Part 1, Securities Lending Collateral Assets reported on the balance sheet (Assets Page, Line 10) should be included on the schedule with the Off-Balance Sheet Collateral if they are not already reflected in the Asset Valuation Reserve and are reflected in another portion of the Life RBC formula.

The collateral in these accounts is maintained by a third-party (typically a bank or other agent). The collateral agent maintains on behalf of the company detail asset listings of the collateral assets, and this data is the source for preparation of this schedule. The company should maintain such asset listings, at a minimum CUSIP, market value, book/carrying value, and maturity date. The asset risk charges are derived from existing RBC factors for bonds, preferred and common stocks, other invested assets, and invested assets not otherwise classified (aggregate write-ins).

Specific Instructions for Application of the Formula
Off-balance sheet collateral included in General Interrogatories, Part 1, Lines 24.05 and 24.06 of the annual statement should agree with Line (19).

Lines (1) through (8) – Bonds
Bond factors are described on page LR002 Bonds.

Line (9) through (15) – Preferred Stocks
Preferred stock factors are described on page LR005 Unaffiliated Preferred and Common Stock.

Line (16) – Common Stock
Common stock factors are described on page LR005 Unaffiliated Preferred and Common Stock.

Line (17) – Schedule BA – Other Invested Assets
Other invested assets factors are described on page LR008 Other Long Term Assets.

Line (18) – Aggregate Write-ins for Other Invested Assets
Aggregate write-ins for other invested assets factors are described on page LR012 Miscellaneous Assets.
Moody's (NYSE:MCO) is a global integrated risk assessment firm that empowers organizations to make better decisions. Its data, analytical solutions and insights help decision-makers identify opportunities and manage the risks of doing business with others. We believe that greater transparency, more informed decisions, and fair access to information open the door to shared progress. With over 11,400 employees in more than 40 countries, Moody's combines an international presence with local expertise and more than a century of experience in financial markets. Learn more at moody.com/about.

Moody's Corporation is comprised of two separate companies: Moody's Investors Service (MIS) and Moody's Analytics (MA).

Moody's Investors Service (MIS) provides investors with a comprehensive view of global debt markets through credit ratings and research. Moody's Analytics (MA) provides data, analytics, and insights to equip leaders of financial, non-financial, and government organizations with effective tools to understand a range of risks.

Throughout this document, “MIS rating” refers to a MIS credit rating. And while references to MIS are made, the views and opinions in this document are solely of MA.
Proposing RBC C1 bond factors using data and methodologies that better reflect economic risks to better assess insolvency risk and help identify potentially weakly capitalized life insurers; the C1 factors should not incentivize poor business decisions that can adversely impact solvency.

- Methodologies and data rely entirely on public sources that are accessible and reproducible by NAIC and industry
- Articulated limitations
- NAIC to use at its discretion in setting the final C1 factors, although MA cautions isolated modifications to modeling features and parameters without considerations of the interconnected elements of the C1 modeling framework and limitations
- While the ACLI, the industry, the NAIC, and commissioners have been engaged extensively, the views are solely those of MA and based on an objective assessment of supporting documentation, and data and modeling approaches that in MA’s experience viewed as best practice

**Scope**

**What We’re Doing**

Proposing C1 factors that
- Better represent the historical experience of life insurers’ holdings
- More accurately reflect empirically observed default correlations and issuer diversification benefits

**Challenges:**
- C1 factors are cardinal, and a function of MA’s default rates estimated using MIS corporate default rates that reflect the historical experience of life insurance corporate holdings for each MIS rating, which are opinions of ordinal, horizon-free credit risk, rather than cardinal
- C1 factors are static while risks and spreads change over time, across ratings and asset classes, resulting in a potential misalignment between the C1 factors and the underlying risks of varied holdings in insurers’ portfolios.
- Applied to range of credit assets, based on their NAIC designations (i.e., the second lowest nationally recognized statistical rating organization (NRSRO) rating) with statistical properties that can be different from those estimated using MIS corporate default rates

**Heuristic Performance Criteria**

**How We’re Doing It**

**Proposing C1 factors that**
- Better represent the historical experience of life insurers’ holdings
- More accurately reflect empirically observed default correlations and issuer diversification benefits

**Past presentation to the Life Risk-Based Capital (E) Working Group**
- [Assessment of Proposed Revisions to the RBC C1 Bond Factors](#) (February 2021)
- [MA's Update on Proposed C1 Bond Factors](#) (March 2021)
- [MA's Preliminary Proposed Updates to RBC C1 Bond Factors](#) (April 15, 2021)
Agenda

1. Overview of Impactful Targeted Improvements
2. Economic State Model and the MA Proposed Correlation Model
3. Default Rates
4. Risk Premium
5. Discount Rate and Tax Rate
6. Recap

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Overview of Impactful Targeted Improvements
MA’s Proposed C1 Factors
Targeted improvements with largest impact

Economic state model, initially outside scope, limitations sufficiently material that MA recommends replacement:
- Economic state model understates default correlations and overstates diversification across issuers relative to that observed empirically, resulting in:
  - C1 base factors that potentially understate credit losses
  - PAFs that are overly punitive (lenient) to portfolios with a smaller (larger) number of issuers
- Economic Scalars result in counterfactual increases and decreases to the C1 base factors across the NAIC designation categories. They lead to an overall flattening of high yield C1 base factors relative to investment grade, and under certain parameterizations C1 base factors that are non-monotonic.
- MA proposed correlation model is calibrated to default correlations and diversification across issuers observed empirically. Resulting C1 base factors are more conservative and differentiated across MIS ratings compared with economic state model.

Corporate default rate term structures estimated to historical experience of life company holdings:
- Life company holdings differ from overall issuance; e.g., life company holdings have less weight on financial institutions that tend to issue shorter term debt.
- MA proposed default rates tend to have a steeper slope (more differentiated across MIS ratings) than those proposed by the Academy, with differentiation more closely aligning with benchmarks.

Risk Premium set at expected loss plus 0.5 standard deviation recognizing variation in industry reserving standards and to closer align with PBR and reserving standards generally aiming to cover moderately adverse conditions. A higher Risk Premium lowers the C1 base factors and mildly increases the cross-sectional variation (or slope) and should be set to better identify of weakly capitalized firms identify and mitigate risk shifting incentives with new bond purchases.

Discount Rate & Tax rate set at 3.47% (2000-2020 window) and 21% under guidance of NAIC during the Life Risk-Based Capital (E) Working Group meeting on April 22, 2021. While an alternative window start date can be justified, the discount rate enters the RBC C1 framework as a single static rate and not as impactful as some other targeted improvements, reinforced by updated tax rate offset. Potentially important term structure dynamics that interplay with credit risk are not captured within the current framework.
Economic State Model and the MA Proposed Correlation Model
Economic State Model Initially Outside Scope

Two material limitations

Economic state model is calibrated to default rates across contraction and expansion states, but it implies default correlations of ~0% for IG issuers, overstating diversification across issuers relative to that observed empirically, resulting in:

» C1 base factors that potentially understate credit losses
» PAFs that are overly punitive (lenient) to portfolios with a smaller (larger) number of issuers

Economic Scalars, that are applied to the default rate term structure in each simulated state (expansion and contraction) exhibit counterfactual increases and decreases across the NAIC designation categories.

» They lead to an overall flattening of C1 base factors for high yield relative to those of investment grade
» Contraction Economic Scalars average 2.56 for investment grade and 1.75 for high yield (1)
» Under certain parameterizations C1 base factors are non-monotonic, e.g., contraction scalar going from 1.9421 (Ba3) to 1.4958 (B1) (2).

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10-636

NAIC Proceedings – Summer 2021

Attachment One-E

Capital Adequacy (E) Task Force

7/28/21
**MA Proposed Correlation Model**

Calibrated to default correlations observed empirically

The Academy’s 10-year simulation model was adapted

» Default rate Economic Scalars set to 1 (this effectively disables the economic state model)
» Default correlations calibrated to empirically observed default correlations and issuer diversification benefits

Several benchmarks for default correlation

» Joint default events
» CDS implied
» MIS ratings implied
» Equity market and financial statement

MA proposed correlation model results in

» C1 base factors that reflect empirical default correlations and are more conservative and more differentiated across MIS ratings than those implied by the economic state model; and
» PAFs that more accurately reflect issuer diversification benefits, and that are less punitive (lenient) to portfolios with a smaller (larger) number of holdings, relative to those from Academy’s proposal

MA proposed correlation model is calibrated to reflect empirically observed joint default events across MIS rating categories

» In each period the likelihood of issuer x and y defaulting is determined by their default rates as depicted by the visualized distribution in red
» The likelihood of a joint default, captured through a single factor model, is depicted in yellow and determined by the joint distribution represented by concentric circles
» The model is continuous and not tied to 2 (or 4) discrete economic states, and generally results in higher 96 percentile loss
Proposed C1 Base Factors

Incremental effects of replacing the economic state model with MA’s proposed correlation model

» MA’s proposed correlation model generally increases C1 base factors

» (1) As part of the economic state model, Economic Scalars lead to overall flattening of high yield C1 base factors relative to investment grade. MA’s proposed correlation model
  — increases high yield factors by 28%
  — Increases investment grade factors by 24%

» (2) Economic Scalars lead to non-monotonic C1 base factors under some parameterizations, e.g., 4.952% for Ba3 to 4.920% for B1

» (3) Economic Scalars lead to more differentiation (22%) between A3 and Baa1 C1 base factors, compared to the correlation model (11%)

<table>
<thead>
<tr>
<th>MIS Rating</th>
<th>Current Factors</th>
<th>Academy’s Proposed Factors [March 2021]</th>
<th>MA’s Preliminary Proposed Base Factors with Economic State Model &amp; Academy’s Default Rates</th>
<th>MA’s Preliminary Proposed Base Factors with Correlation Model &amp; Academy’s Default Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aaa</td>
<td>0.390%</td>
<td>0.290%</td>
<td>0.254%</td>
<td>0.289%</td>
</tr>
<tr>
<td>Aa1</td>
<td>0.390%</td>
<td>0.420%</td>
<td>0.373%</td>
<td>0.412%</td>
</tr>
<tr>
<td>Aa2</td>
<td>0.390%</td>
<td>0.550%</td>
<td>0.476%</td>
<td>0.550%</td>
</tr>
<tr>
<td>Aa3</td>
<td>0.390%</td>
<td>0.700%</td>
<td>0.593%</td>
<td>0.715%</td>
</tr>
<tr>
<td>A1</td>
<td>0.390%</td>
<td>0.840%</td>
<td>0.694%</td>
<td>0.896%</td>
</tr>
<tr>
<td>A2</td>
<td>0.390%</td>
<td>1.020%</td>
<td>0.817%</td>
<td>1.046%</td>
</tr>
<tr>
<td>A3</td>
<td>0.390%</td>
<td>1.190%</td>
<td>0.921%</td>
<td>1.254%</td>
</tr>
<tr>
<td>Baa1</td>
<td>1.260%</td>
<td>1.370%</td>
<td>1.128%</td>
<td>1.388%</td>
</tr>
<tr>
<td>Baa2</td>
<td>1.260%</td>
<td>1.630%</td>
<td>1.287%</td>
<td>1.633%</td>
</tr>
<tr>
<td>Baa3</td>
<td>1.260%</td>
<td>1.940%</td>
<td>1.542%</td>
<td>1.956%</td>
</tr>
<tr>
<td>Ba1</td>
<td>4.460%</td>
<td>3.850%</td>
<td>2.848%</td>
<td>3.955%</td>
</tr>
<tr>
<td>Ba2</td>
<td>4.460%</td>
<td>4.660%</td>
<td>3.739%</td>
<td>4.840%</td>
</tr>
<tr>
<td>Ba3</td>
<td>4.460%</td>
<td>5.970%</td>
<td>4.952%</td>
<td>5.996%</td>
</tr>
<tr>
<td>B1</td>
<td>9.700%</td>
<td>6.150%</td>
<td>4.920%</td>
<td>7.854%</td>
</tr>
<tr>
<td>B2</td>
<td>9.700%</td>
<td>8.320%</td>
<td>6.614%</td>
<td>9.901%</td>
</tr>
<tr>
<td>B3</td>
<td>9.700%</td>
<td>11.480%</td>
<td>9.319%</td>
<td>12.679%</td>
</tr>
<tr>
<td>Caa1</td>
<td>22.310%</td>
<td>16.830%</td>
<td>13.364%</td>
<td>16.044%</td>
</tr>
<tr>
<td>Caa2</td>
<td>22.310%</td>
<td>22.800%</td>
<td>18.788%</td>
<td>19.870%</td>
</tr>
</tbody>
</table>
| Caa3       | 22.310%        | 33.860%                                  | 31.359%                                                                                | 28.933%                                                                               

(1) Increases high yield factors by 28%

(2) Increases investment grade factors by 24%

(3) Economic Scalars lead to more differentiation (22%) between A3 and Baa1 C1 base factors, compared to the correlation model (11%)
Proposed PAF – MA’s Findings

Implications of MA’s proposed correlation model

» PAFs calibrated to the economic state model overstate issuer diversification benefits.

» MA’s proposed correlation model is calibrated to default correlations and issuer diversification benefits observed empirically.

<table>
<thead>
<tr>
<th>Thresholds*</th>
<th>Current*</th>
<th>Academy Proposed [March 2021]</th>
<th>MA Preliminary Proposed PAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Up to) 10</td>
<td>2.50</td>
<td>7.50</td>
<td>5.87</td>
</tr>
<tr>
<td>(Next) 90</td>
<td>1.83</td>
<td>1.75</td>
<td>1.53</td>
</tr>
<tr>
<td>(Next) 100</td>
<td>1.00</td>
<td>0.90</td>
<td>0.85</td>
</tr>
<tr>
<td>(Next) 300</td>
<td>0.97</td>
<td>0.85</td>
<td>0.85</td>
</tr>
<tr>
<td>(Above) 500</td>
<td>0.90</td>
<td>0.75</td>
<td>0.82</td>
</tr>
</tbody>
</table>

*Current PAF converted to Academy’s proposed thresholds for better comparison.
**MA’s Proposed Factors**

**Impact on Post-PAF C1 RBC**

- Resulting RBC under MA’s proposal are generally more conservative than under the current formula, with an increase across life companies of different sizes.
- Under the Academy’s proposal, a disproportionate share of the C1 RBC increase is attributed to life companies with portfolios that have a small and medium number of issuers, driven largely by the economic state model implying more issuer diversification benefits (i.e., lower default correlations).

![Graph showing Total Industry Post-PAF C1 RBC (Pre-Tax)](image)

![Graph showing Ratio of Life Company’s Post-PAF C1 RBC (Pre-Tax) Under Proposed-to-Current Formula (Schedule D Part 1 Holdings)](image)

- Generally, portfolios with fewer than 10 issuers, sometimes a single issuer.
Default Rates
MA Proposed 10-Year Cumulative Default Rates

More closely reflect historical experience of life companies’ corporate holdings

Raw default rates and benchmarks are subject to data challenges:

- Non-monotonicity (1)
- Few defaults in upper end of MIS ratings spectrum (2). 3 Aaa defaults in the US since 1970; 2 were debatable and experienced near full recovery (Texaco and Getty Oil).

Historical experience of life companies’ corporate holdings differs from overall issuance (3), the resulting default rates tend to have a steeper slope (more differentiated across MIS ratings) than those proposed by the Academy.

MA proposed baseline default rates combine empirical data, anchoring, and smoothing to address data paucity and ensure conformity to economic logic.

- Anchoring:
  - 10-year cumulative default rates for Aa2, A2, Baa2, Ba2, B2, Caa are anchored to Aa, A, Baa, Ba, B, Ca sector-weighted US corporate CDRs at 1- and 10-year, with curvature adjustment.

- Interpolation:
  - Other alphanumeric ratings were interpolated geometrically between anchored ratings.

<table>
<thead>
<tr>
<th>MIS Rating</th>
<th>Proposed by Academy</th>
<th>MIS-EDGIR Rating Symbols and Definitions</th>
<th>MIS Annual Default Study (2021)</th>
<th>MA-Proposed Default Rates Based on MIS Historical Data</th>
<th>NAIC-Proposed US Sample (sector-weighted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aaa</td>
<td>0.120%</td>
<td>(1)</td>
<td>0.127%</td>
<td>0.051%</td>
<td>0.079%</td>
</tr>
<tr>
<td>Aa1</td>
<td>0.480%</td>
<td></td>
<td>0.207%</td>
<td>0.060%</td>
<td>0.204%</td>
</tr>
<tr>
<td>Aa2</td>
<td>0.730%</td>
<td></td>
<td>0.333%</td>
<td>0.090%</td>
<td>0.322%</td>
</tr>
<tr>
<td>Aa3</td>
<td>1.144%</td>
<td></td>
<td>0.500%</td>
<td>0.158%</td>
<td>0.500%</td>
</tr>
<tr>
<td>A1</td>
<td>2.700%</td>
<td></td>
<td>2.189%</td>
<td>1.255%</td>
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<tr>
<td>A2</td>
<td>4.372%</td>
<td></td>
<td>3.356%</td>
<td>2.929%</td>
<td>3.356%</td>
</tr>
<tr>
<td>Baa</td>
<td>5.955%</td>
<td></td>
<td>5.060%</td>
<td>4.481%</td>
<td>5.060%</td>
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<tr>
<td>Baa2</td>
<td>6.437%</td>
<td></td>
<td>6.000%</td>
<td>5.430%</td>
<td>6.000%</td>
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<tr>
<td>Baa3</td>
<td>6.765%</td>
<td></td>
<td>6.800%</td>
<td>6.328%</td>
<td>6.800%</td>
</tr>
<tr>
<td>Ba1</td>
<td>14.22%</td>
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<td>14.16%</td>
<td>13.67%</td>
<td>14.16%</td>
</tr>
<tr>
<td>Ba2</td>
<td>18.47%</td>
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<td>18.70%</td>
<td>17.53%</td>
<td>18.70%</td>
</tr>
<tr>
<td>Ba3</td>
<td>24.34%</td>
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<td>24.05%</td>
<td>22.95%</td>
<td>24.05%</td>
</tr>
<tr>
<td>B1</td>
<td>67.99%</td>
<td></td>
<td>67.00%</td>
<td>65.99%</td>
<td>67.00%</td>
</tr>
<tr>
<td>B2</td>
<td>82.57%</td>
<td></td>
<td>82.00%</td>
<td>81.57%</td>
<td>82.00%</td>
</tr>
<tr>
<td>B3</td>
<td>94.15%</td>
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<td>94.00%</td>
<td>93.15%</td>
<td>94.00%</td>
</tr>
<tr>
<td>Caa</td>
<td>66.85%</td>
<td></td>
<td>67.00%</td>
<td>66.85%</td>
<td>67.00%</td>
</tr>
<tr>
<td>Caa2</td>
<td>73.93%</td>
<td></td>
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<td>72.93%</td>
<td>73.00%</td>
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<tr>
<td>Caa3</td>
<td>75.75%</td>
<td></td>
<td>75.00%</td>
<td>75.00%</td>
<td>75.00%</td>
</tr>
</tbody>
</table>

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NAIC Proceedings – Summer 2021
Attachment One-E

Capital Adequacy (E) Task Force
Institutional features drive life insurers towards holdings with characteristics different from overall issuance.

Certain sectors are more suitable for life insurers across the ratings scale:
- Financial sector issued debt tends to exhibit shorter duration (3.9 average remaining maturity), with insurers holding longer dated financial sectors issues (11.1 average remaining maturity) (1).
- Insurers hold a varying proportion of debt across the rating scale (2).

Relevant in the estimation of:
- Default rates
- LGD

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sector as a Percentage of Life Corporate Holdings</td>
<td>Proportion of Corporate Issues Attributed to Sector</td>
<td>Sector as a Percentage of Life Corporate Holdings</td>
</tr>
<tr>
<td>Aaa</td>
<td>0.5%</td>
<td>5.9%</td>
<td>93.2%</td>
</tr>
<tr>
<td>Aa</td>
<td>4.2%</td>
<td>8.3%</td>
<td>73.3%</td>
</tr>
<tr>
<td>A</td>
<td>16.5%</td>
<td>17.8%</td>
<td>49.6%</td>
</tr>
<tr>
<td>Ba</td>
<td>9.6%</td>
<td>21.2%</td>
<td>71.4%</td>
</tr>
<tr>
<td>Bb</td>
<td>5.0%</td>
<td>5.9%</td>
<td>86.4%</td>
</tr>
<tr>
<td>B</td>
<td>0.1%</td>
<td>1.0%</td>
<td>96.9%</td>
</tr>
<tr>
<td>Caa</td>
<td>0.1%</td>
<td>0.6%</td>
<td>95.1%</td>
</tr>
<tr>
<td>Ca</td>
<td>0.0%</td>
<td>1.1%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Overall</td>
<td>14.9%</td>
<td>10.4%</td>
<td>65.3%</td>
</tr>
</tbody>
</table>

MOODY'S ANALYTICS

Proposed Updates to the RBC C1 Bond Factors

<table>
<thead>
<tr>
<th>U.S. Corporate Sector</th>
<th>Average Time to Maturity for life insurers' US corporate holdings (notional weighted)</th>
<th>Average Time to Maturity for US corporate issues</th>
<th>Proportion of Issuers Attributed to Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td>(1) 11.1</td>
<td>3.9</td>
<td>21.5%</td>
</tr>
<tr>
<td>Industrial</td>
<td>(2) 12.8</td>
<td>3.7</td>
<td>63.1%</td>
</tr>
<tr>
<td>Utility</td>
<td>15.9</td>
<td>11.0</td>
<td>10.4%</td>
</tr>
</tbody>
</table>
Proposed C1 Base Factors

Incremental effects of MA proposed default rates

> Default rate term structures representing experience of life insurance holdings tend to be more differentiated across MIS ratings than Academy proposed, and closer aligned to benchmarks

> The resulting C1 base factors under MA’s proposed default rates are generally more differentiated across the Aa3 to Baa3 range

> The ratio of the Baa3 factor to the Aa3 factor is
  - 2.7 under MA’s proposal with the Academy’s default rates
  - 4.1 under MA’s proposal

> The Academy’s proposed default rates result in C1 base factors being approximately 15% larger on average than under MA’s proposed default rates.

<table>
<thead>
<tr>
<th>MIS Rating</th>
<th>Current Factors</th>
<th>MA’s Preliminary Proposed Base Factors with Academy’s Default Rates</th>
<th>MA’s Preliminary Proposed Base Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aaa</td>
<td>0.390%</td>
<td>0.289%</td>
<td>0.158%</td>
</tr>
<tr>
<td>Aa1</td>
<td>0.390%</td>
<td>0.412%</td>
<td>0.271%</td>
</tr>
<tr>
<td>Aa2</td>
<td>0.390%</td>
<td>0.550%</td>
<td>0.419%</td>
</tr>
<tr>
<td>Aa3</td>
<td>0.390%</td>
<td>0.715%</td>
<td>0.523%</td>
</tr>
<tr>
<td>A1</td>
<td>0.390%</td>
<td>0.896%</td>
<td>0.657%</td>
</tr>
<tr>
<td>A2</td>
<td>0.390%</td>
<td>1.046%</td>
<td>0.816%</td>
</tr>
<tr>
<td>A3</td>
<td>0.390%</td>
<td>1.254%</td>
<td>1.016%</td>
</tr>
<tr>
<td>Baa1</td>
<td>1.260%</td>
<td>1.388%</td>
<td>1.261%</td>
</tr>
<tr>
<td>Baa2</td>
<td>1.260%</td>
<td>1.633%</td>
<td>1.523%</td>
</tr>
<tr>
<td>Baa3</td>
<td>1.260%</td>
<td>1.956%</td>
<td>2.168%</td>
</tr>
<tr>
<td>Ba1</td>
<td>4.460%</td>
<td>3.955%</td>
<td>3.351%</td>
</tr>
<tr>
<td>Ba2</td>
<td>4.460%</td>
<td>4.840%</td>
<td>4.537%</td>
</tr>
<tr>
<td>Ba3</td>
<td>4.460%</td>
<td>5.995%</td>
<td>6.017%</td>
</tr>
<tr>
<td>B1</td>
<td>9.700%</td>
<td>7.854%</td>
<td>7.386%</td>
</tr>
<tr>
<td>B2</td>
<td>9.700%</td>
<td>9.901%</td>
<td>9.535%</td>
</tr>
<tr>
<td>B3</td>
<td>9.700%</td>
<td>12.679%</td>
<td>12.426%</td>
</tr>
<tr>
<td>Caa1</td>
<td>22.310%</td>
<td>16.044%</td>
<td>16.942%</td>
</tr>
<tr>
<td>Caa2</td>
<td>22.310%</td>
<td>19.870%</td>
<td>23.798%</td>
</tr>
<tr>
<td>Caa3</td>
<td>22.310%</td>
<td>28.933%</td>
<td>32.975%</td>
</tr>
</tbody>
</table>
Risk Premium

4
Risk Premium Updates

Aligning with reserves

» C1 RBC is the minimum required capital above statutory reserves to buffer against a tail loss
  – Risk Premium acts as an offset to C1 RBC; it is the part of statutory reserves provisioned against default loss

» Variation in industry reserving standards
  – Both VM-20 and VM-21 explicitly require that reserves cover CTE 70, or approximately 88th percentile, default loss
  – VM-20 only applies to new life products after 2017. Most existing policies follow industry reserving standards that are commonly understood to cover moderately adverse conditions.

» Recognizing variation in industry reserving standards and to closer align with PBR and reserving standards generally aim to cover moderately adverse conditions, Risk Premium is proposed to be set at expected loss plus 0.5 standard deviation
  – A higher Risk Premium lowers the C1 base factors and mildly increases their differentiation across MIS ratings and should better identify weakly capitalized firms and mitigate risk shifting incentives with new bond purchases
  – On average, as we decrease (increase) the risk premium by 0.5 standard deviation from MA's proposed level, the C1 base factors increase (decrease) around 20% for investment grade and around 15% for high yield factors

» A transition to expected loss plus one standard deviation once
  – VM-20 become more widely applicable
  – VM-22 is formally updated and widely applicable
Discount Rate and Tax Rate
Discount and Tax Rate
Possible candidates

Tax rate was updated from 35% to 21%

Discount rate

» Used to calculate the net present value of projected cash flows.
» MA recognizes the need to parameterize the discount rate with a long-term perspective of long-term interest rates, and the desire for this parameter to be relatively stable while also allowing a closer reflection of the current, low-rate, environment

- 2000–2020 (3.47%) used in developing MA proposed C1 base factors under guidance of NAIC during the Life Risk-Based Capital (E) Working Group meeting on April 22, 2021

- Compared with the discount rate of 3.47%
  - 1993–2013 used by the Academy (5%) decreases C1 base factors by
    » 6-7% for investment grade
    » 3-6% for high-yield
  - 1993–2020 (4.32%) decreases C1 base factors by
    » 2-6% for investment grade
    » 2-3% for high-yield
  - 2010–2020 (2.25%) increases C1 base factors by
    » 5-7% for investment grade
    » 3-5% for high-yield
Recap
Proposed Updates to the RBC C1 Bond Factors

Post-PAF C1 RBC Industry Impact – Complete Portfolio Holdings

Post-PAF RBC proposed by MA is higher than the current level

*Data on ~94% life companies in US that have reported, which includes over 99% of the industry BACV as of 03/19/2021

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MOODY’S ANALYTICS

Proposed Updates to the RBC C1 Bond Factors

Attachment One-E

Capital Adequacy (E) Task Force

7/28/21

NAIC Proceedings – Summer 2021
Summary of MA Proposed C1 Factors and their Impact

**Impact on post-PAF C1 RBC**
- Higher post-PAF RBC, on average, across the life industry compared to current formula
- Larger post-PAF RBC increase compared to current formula, on average, for insurers with small and medium number of issuers, but much less so than that under Academy's proposal

**Limitations of economic state model and their impact on accuracy of C1 base factors & PAFs**
- The economic state model overstates diversification across issuers relative to that observed empirically, resulting in
  - Understatement of credit losses in C1 base factors, all else equal
  - PAFs that are overly punitive (lenient) to portfolios with a smaller (larger) number of issuers
- Economic Scalars, which are part of the economic state model under the Academy's proposal, result in counterfactual increases and decreases to the C1 base factors across the NAIC designation categories. They lead to an overall flattening of high yield C1 base factors relative to investment grade, and under certain parameterizations C1 base factors that are non-monotonic.

**Impact of replacing the economic state model with MA proposed correlation model**
- MA proposed correlation model more accurately reflects empirically observed default correlations and issuer diversification benefits, and that addresses all aforesaid limitations of the economic state model. As a result:
  - MA proposed C1 base factors are more conservative and more differentiated across NAIC designation categories than those implied by the economic state model.
  - MA proposed PAFs more accurately reflect issuer diversification benefits and are less punitive (lenient) to portfolios with a small (larger) number of issuers, relative to those from the Academy's proposal.

MOODY'S ANALYTICS

Proposed Updates to the RBC C1 Bond Factors
MA C1 Factors with Risk Premium (RP) Sensitivity Analysis and Override of Portfolio Adjustment Factors (PAFs) 
For Discussion with Life Risk-Based Capital (E) Working Group 

June 2021
Moody's (NYSE:MCO) is a global integrated risk assessment firm that empowers organizations to make better decisions. Its data, analytical solutions and insights help decision-makers identify opportunities and manage the risks of doing business with others. We believe that greater transparency, more informed decisions, and fair access to information open the door to shared progress. With over 11,400 employees in more than 40 countries, Moody’s combines an international presence with local expertise and more than a century of experience in financial markets. Learn more at moodys.com/about.

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Moody's Investors Service (MIS) and Moody’s Analytics (MA).

Moody’s Investors Service (MIS) provides investors with a comprehensive view of global debt markets through credit ratings and research. Moody's Analytics (MA) provides data, analytics, and insights to equip leaders of financial, non-financial, and government organizations with effective tools to understand a range of risks.

Throughout this document, “MIS rating” refers to a MIS credit rating.
And while references to MIS are made, the views and opinions in this document are solely of MA.
Requested Sensitivity Analysis of MA C1 Factors

As requested by Life Risk-Based Capital (E) Working Group on May 20, 2021

1. Sensitivity analysis of MA C1 factors with Risk Premium changed from expected loss plus 0.5 standard deviation to 60th percentile while maintaining other MA targeted modifications
   - Increases and flattens the base factors. The factors are less differentiated across NAIC designations, resulting in lower rated credit becoming more attractive on a relative basis
   - Base factors increase by ~21% for investment grade NAIC designations, and ~11% for high yield
   - The increase in Post-PAF C1 RBC range from 9% (for portfolios with lower NAIC rated issuers) to 37% (for portfolios with higher NAIC rated issuers)

2. Analysis of post-PAF RBC with portfolio adjustment factor (PAF) overridden for portfolios with fewer than 50 issuers (106 life portfolios; Book Adjusted Carrying Values range from $79K to $877M)
   - MA PAF-override post-PAF C1 RBC is, in general, higher than under the current formula, and the increase continues to be relatively evenly distributed across life companies of different sizes
   - To facilitate comparison, the Academy's PAF-override post-PAF C1 RBC is analyzed, and is found to remain disproportionately higher for small and medium sized life portfolios

For articulation of defined scope and performance criteria associated with methodology, data, and limitations associated with MA C1 factors, see 'Moody's Analytics' Report on Proposed Bond Factor Revisions'
Overview of Risk Premium (Recap)

One of several interconnected modifications with largest impact to MA C1 factors

» MA understands C1 RBC is the minimum required capital above statutory reserves to buffer against a tail loss
  – Risk Premium acts as an offset to C1 RBC

» Variation in industry reserving standards
  – VM-20 and VM-21 explicitly require that reserves cover CTE 70, or approximately 88th percentile, default loss, without accounting for any assets backing Asset Valuation Reserve (AVR)
  – VM-20 applies to new life products after 2017; with increasing coverage for new bond purchases
  – New reserve standards such as VM-22 are also expected to follow the same framework and cover CTE 70 default loss
  – Existing policies follow industry reserving standards, which generally aim to cover moderately adverse conditions; AVR used in Cash Flow Testing (CFT) of these reserves is excluded from Total Adjusted Capital (TAC), and thus functions as additional CFT reserves rather than available capital

» MA’s Risk Premium
  – Together with several other interconnected modifications, MA’s Risk Premium was set at expected loss plus 0.5 standard deviation recognizing variation in industry reserving standards and to closer align with PBR and other reserving standards generally aimed to cover moderately adverse conditions
Aligning C1 Factors with AVR (Recap)

The Academy raised concerns related to Risk Premium and AVR consistency

- AVR is an allocation of surplus to smooth the cyclicality of credit default events
- Allocation of surplus across AVR and unassigned surplus does not affect RBC Ratio
- AVR does not enter the Academy or MA’s C1 formula
- While historically the basic contribution of AVR has been set to be the same as Risk Premium, the alignment between AVR and Risk Premium is not relevant to the RBC framework, whose purpose is to help identify potentially weakly capitalized companies

![Diagram showing the calculation of Authorized Control Level RBC]

\[ \text{Authorized Control Level RBC} = \text{RBC Ratio} = \text{Unassigned Surplus} + \text{AVR} + 0.5 \times \text{Dividend Liability} \]
### C1 Base Factors

Sensitivity analysis with Risk Premium set at 60th percentile

- With the Risk Premium set at the 60th percentile, base factors increase across the board.
- The factors are less differentiated across NAIC designations, resulting in lower rated credit being more attractive on a relative basis.
- Factors increase by around 21% for investment grade NAIC designations, and around 11% for high yield.

<table>
<thead>
<tr>
<th>MIS Rating</th>
<th>Current Base Factors</th>
<th>Academy Proposed Base Factors</th>
<th>MA Base Factors with Risk Premium at 60th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aaa</td>
<td>0.390%</td>
<td>0.290%</td>
<td>0.158%</td>
</tr>
<tr>
<td>Aa1</td>
<td>0.390%</td>
<td>0.420%</td>
<td>0.271%</td>
</tr>
<tr>
<td>Aa2</td>
<td>0.390%</td>
<td>0.550%</td>
<td>0.419%</td>
</tr>
<tr>
<td>Aa3</td>
<td>0.390%</td>
<td>0.700%</td>
<td>0.523% ($\uparrow$ 20.5%)</td>
</tr>
<tr>
<td>A1</td>
<td>0.390%</td>
<td>0.840%</td>
<td>0.657%</td>
</tr>
<tr>
<td>A2</td>
<td>0.390%</td>
<td>1.020%</td>
<td>0.816%</td>
</tr>
<tr>
<td>A3</td>
<td>0.390%</td>
<td>1.190%</td>
<td>1.016%</td>
</tr>
<tr>
<td>Baa1</td>
<td>1.260%</td>
<td>1.370%</td>
<td>1.261%</td>
</tr>
<tr>
<td>Baa2</td>
<td>1.260%</td>
<td>1.630%</td>
<td>1.523%</td>
</tr>
<tr>
<td>Baa3</td>
<td>1.260%</td>
<td>1.940%</td>
<td>2.168%</td>
</tr>
<tr>
<td>Ba1</td>
<td>4.460%</td>
<td>3.650%</td>
<td>3.515%</td>
</tr>
<tr>
<td>Ba2</td>
<td>4.460%</td>
<td>4.660%</td>
<td>4.537%</td>
</tr>
<tr>
<td>Ba3</td>
<td>4.460%</td>
<td>5.970%</td>
<td>6.017% ($\uparrow$ 11.1%)</td>
</tr>
<tr>
<td>B1</td>
<td>9.700%</td>
<td>6.150%</td>
<td>7.368%</td>
</tr>
<tr>
<td>B2</td>
<td>9.700%</td>
<td>8.320%</td>
<td>9.535%</td>
</tr>
<tr>
<td>B3</td>
<td>9.700%</td>
<td>11.480%</td>
<td>12.428%</td>
</tr>
<tr>
<td>Caa1</td>
<td>22.310%</td>
<td>16.850%</td>
<td>16.942%</td>
</tr>
<tr>
<td>Caa2</td>
<td>22.310%</td>
<td>22.800%</td>
<td>23.798%</td>
</tr>
<tr>
<td>Caa3</td>
<td>22.310%</td>
<td>33.860%</td>
<td>32.975%</td>
</tr>
</tbody>
</table>

With the Risk Premium set at the 60th percentile, base factors increase across the board and the factors are less differentiated across NAIC designations, resulting in lower rated credit being more attractive on a relative basis. Factors increase by around 21% for investment grade NAIC designations, and around 11% for high yield.
PAF-Override for Portfolios with Fewer than 50 Issuers

Assigned the PAF level of a portfolio with 50 issuers

### PAFs in step function form

<table>
<thead>
<tr>
<th># of Issuers in the Portfolio</th>
<th>Current</th>
<th>Academy</th>
<th>MA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PAF</td>
<td>PAF</td>
<td>PAF Override</td>
</tr>
<tr>
<td>Up to 10</td>
<td>2.50</td>
<td>7.50</td>
<td>2.90</td>
</tr>
<tr>
<td>Next 40</td>
<td>2.50</td>
<td>1.75</td>
<td>2.90</td>
</tr>
<tr>
<td>Next 50</td>
<td>1.30</td>
<td>1.75</td>
<td>1.75</td>
</tr>
<tr>
<td>Next 100</td>
<td>1.00</td>
<td>0.90</td>
<td>0.90</td>
</tr>
<tr>
<td>Next 300</td>
<td>0.97</td>
<td>0.85</td>
<td>0.85</td>
</tr>
<tr>
<td>Over 500</td>
<td>0.90</td>
<td>0.75</td>
<td>0.75</td>
</tr>
</tbody>
</table>

### PAFs in final form

<table>
<thead>
<tr>
<th># of Issuers in the Portfolio</th>
<th>Current</th>
<th>Academy</th>
<th>MA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PAF</td>
<td>PAF</td>
<td>PAF Override</td>
</tr>
<tr>
<td>10</td>
<td>2.50</td>
<td>7.50</td>
<td>2.90</td>
</tr>
<tr>
<td>50</td>
<td>2.50</td>
<td>2.90</td>
<td>2.90</td>
</tr>
<tr>
<td>100</td>
<td>1.90</td>
<td>2.33</td>
<td>2.33</td>
</tr>
<tr>
<td>300</td>
<td>1.30</td>
<td>1.36</td>
<td>1.36</td>
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<tr>
<td>500</td>
<td>1.16</td>
<td>1.16</td>
<td>1.16</td>
</tr>
<tr>
<td>1000</td>
<td>1.03</td>
<td>0.95</td>
<td>0.95</td>
</tr>
<tr>
<td>2000</td>
<td>0.97</td>
<td>0.85</td>
<td>0.85</td>
</tr>
<tr>
<td>3000</td>
<td>0.94</td>
<td>0.82</td>
<td>0.82</td>
</tr>
</tbody>
</table>
Sensitivity Analysis with Risk Premium set at 60th percentile

Without PAF-override

- Total industry post-PAF C1 RBC increases from $41.83B to $49.16B when MA formula’s Risk Premium is set at 60th percentile
- The increase in Post-PAF C1 RBC ranges from 9% (for portfolios with lower NAIC rated issuers) to 37% (for portfolios with higher NAIC rated issuers)

Note 1: Holdings includes all exposures on Schedule D Part 1 excluding US government bonds.
Note 2: For visual ease, the right-hand graph excludes portfolios with less than $100K post-PAF RBC under the current formula.
Impact of PAF-Override for Portfolios with fewer than 50 Issuers

While keeping MA's Risk Premium set at expected loss plus 0.5 standard deviation

- PAF-override decreases Post-PAF RBC for 106 portfolios with fewer than 50 issuers; Book Adjusted Carrying Values ranges from $79K to $877M
- Total industry PAF-override post-PAF C1 RBC impact is limited under the MA and Academy factors
- MA PAF-override post-PAF C1 RBC is, in general, higher than under the current formula; the increase continues to be relatively evenly distributed across life companies of different sizes
- To facilitate comparison of the two proposals, the Academy's PAF-override post-PAF C1 RBC is analyzed and found to be, in general, higher than under the current formula; the analysis continues to show the disproportionate increase for small and medium sized life portfolios

Impact of PAF-Override for Portfolios with fewer than 50 Issuers

<table>
<thead>
<tr>
<th>Billion ($)</th>
<th>Current Factors</th>
<th>Academy Factors</th>
<th>Academy PAF-Override</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>~94.75 percentile safety level under MA factors</td>
<td>~96.25 percentile safety level under MA factors</td>
<td>~96.25 percentile safety level under MA factors</td>
</tr>
<tr>
<td>10</td>
<td>37.82</td>
<td>43.19</td>
<td>43.10</td>
</tr>
<tr>
<td>20</td>
<td>41.83</td>
<td>41.77</td>
<td></td>
</tr>
</tbody>
</table>

Ratio of Life Company's Post-PAF C1 RBC-to-Current Formula

- Current Factors
- Academy Factors
- Academy PAF-Override (Impacted Portfolios)
- MA Factors
- MA PAF-Override (Impacted Portfolios)

Note 1: Holdings includes all exposures on Schedule D Part 1 excluding US government bonds.
Note 2: For visual ease, the right-hand graph excludes portfolios with less than $100K post-PAF RBC under the current formula.
Combined Impact
With Risk Premium set at the 60th percentile and PAF-override

» MA formula with Risk Premium and PAF-override set at the 60th percentile results in post-PAF C1 RBC that is, in general, meaningfully higher than under the current formula, and relatively evenly distributed across life companies of different sizes

» To facilitate comparison of the two proposals, the Academy’s PAF-override post-PAF C1 RBC is analyzed and found to be higher than under the current formula and the increase remains disproportionately larger for small and medium sized life portfolios

Note 1: Holdings includes all exposures on Schedule D Part 1 excluding US government bonds.
Note 2: For visual ease, the right-hand graph excludes portfolios with less than $100K post-PAF RBC under the current formula.
Attachment One-E
Capital Adequacy (E) Task Force
7/28/21
MOODY'S ANALYTICS
Risk Premium Sensitivity Analysis and PAF-Override, June 2021
**Capital Adequacy (E) Task Force**

**RBC Proposal Form**

| [ ] Catastrophe Risk (E) Subgroup   | [ ] Investment RBC (E) Working Group | [ ] Operational Risk (E) Subgroup |
| [ ] C3 Phase II/ AG43 (E/A) Subgroup | [ ] P/C RBC (E) Working Group | [ ] Longevity Risk (A/E) Subgroup |

**DATE:** 4/29/21

**CONTACT PERSON:** Dave Fleming

**TELEPHONE:** 816-783-8121

**EMAIL ADDRESS:** dfleming@naic.org

**ON BEHALF OF:** Life Risk-Based Capital (E) Working Group

**NAME:** Philip Barlow, Chair

**TITLE:** Associate Commissioner of Insurance

**AFFILIATION:** District of Columbia

**ADDRESS:** 1050 First Street, NE Suite 801

**Washington, DC 20002**

---

**IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED**

- [ ] Health RBC Blanks
- [ ] Property/Casualty RBC Blanks
- [ X ] Life and Fraternal RBC Instructions
- [ ] Health RBC Instructions
- [ ] Property/Casualty RBC Instructions
- [ x ] Life and Fraternal RBC Blanks
- [ ] OTHER ____________________________

---

**DESCRIPTION OF CHANGE(S)**

This proposal changes the description on line 15 on LR016 to allow for inclusion of amounts held for reciprocal jurisdiction reinsurance.

---

**REASON OR JUSTIFICATION FOR CHANGE **

The purpose of the credit in the life RBC formula is to avoid having both the total adjusted capital decreased by amounts re-established as liabilities and the authorized control level increased for the charge on reserve credit and recoverable amounts.

---

**Additional Staff Comments:**

- 4-29-21: Proposal was exposed for comments (DBF)
- 6/30/21 (jdb) Instructions Adopted by the Task Force.

---

**FOR NAIC USE ONLY**

- Agenda Item # 2021-12-L
- Year 2021

---

**DISPOSITION**

- [ X ] ADOPTED 6/30/21
- [ ] REJECTED
- [ ] DEFERRED TO
- [ ] REFERRED TO OTHER NAIC GROUP
- [ ] EXPOSED
- [ ] OTHER (SPECIFY)
# REINSURANCE

|--------------------|--------------------------------------|--------------------------------------|---------------------------------------|---------------------------------------|----------------------------|--------------------------|------------------------|

Reinsurers and Trusteed Collateral Supporting Authorized Reinsurance | 16. Other Reinsurance Recoverable or Reserved "Reestablished" on Page 3 | 17. Total Reinsurance |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Statement Value</td>
<td></td>
<td></td>
<td>Factor</td>
<td>Requirement</td>
<td></td>
<td>Statement Value</td>
<td></td>
<td>Statement Value</td>
<td></td>
<td>Statement Value</td>
</tr>
<tr>
<td>X 0.0078</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X 0.0078</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

† Statement values should be net of policy loans if policy loans are part of the reinsurance transaction.

[Denotes items that must be manually entered on the filing software.]

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NAIC Proceedings – Summer 2021
REINSURANCE
LR016

Basis of Factors

There is a risk associated with recoverability of amounts from reinsurers. The risk is deemed comparable to that represented by bonds between risk classes 1 and 2 and is assigned a pre-tax factor of 0.78 percent. To avoid an overstatement of risk-based capital, the formula gives a 0.78 percent pre-tax credit for reinsurance with non-authorized and certified companies, for reinsurance among affiliated companies, for reinsurance with funds withheld or reinsurance with authorized reinsurers that is supported by equivalent trustee collateral that meets the requirements stipulated in Appendix A-785 (Credit for Reinsurance), where there have been regular bona fide withdrawals from such trustee collateral to pay claims or recover payments of claims during the calendar year covered by the RBC report, and for reinsurance involving policy loans. Withdrawals from trustee collateral that are less than the amounts due the ceding company shall be deemed to not be bona fide withdrawals.

Specific Instructions for Application of the Formula

Lines (1) through (7)
The first seven components of the reinsurance formula are charged against all reinsurance recoverables and ceded reserve credits as reported in Schedule S.

Lines (8) through (12)
A negative 0.78 percent pre-tax factor is applied to these five components. These adjustments should only be applied to business assumed from subsidiaries of the company. The adjustment should be multiplied by the proportion of the ceding company owned by the parent. The subsidiary’s RBC is part of the individual company’s RBC, and sister affiliate reinsurers should NOT be included. In addition, no adjustment should be made where an adjustment has already been taken in the re-established liability components above. This would be the case if the subsidiary insurer was unauthorized or the treaty with the company involved funds held.

Lines (13) through (16)
The last four components are primarily Page 3 liabilities (including Line 24.02 – Reinsurance in Unauthorized and Certified Companies and Line 24.03 – Funds Held under Reinsurance Treaties with Unauthorized and Certified Reinsurers, Line 24.07 – Funds Held under Coinsurance and Line 25 – Aggregate Write-ins for Liabilities). Line (15) is also to include amounts in support of Lines (1) through (7) and subject to the provisions of Credit for Reinsurance Model Regulation (#786). A pre-tax factor of negative 0.78 percent is applied. This considers that these liabilities reported on Page 3 have been reestablished in the balance sheet offsetting the reinsurance ceded reserve credits taken elsewhere.
This proposal presents base factors and correlation and guardrail factors for the longevity risk charge.

**REASON OR JUSTIFICATION FOR CHANGE **

The Longevity Risk (A/E) Subgroup was charged with providing recommendations for recognizing longevity risk in statutory reserves and/or RBC, as appropriate. The Subgroup’s recommendation for the structure necessary was adopted by the Life Risk-Based Capital (E) Working Group on 2-14-20 in proposal 2019-13-L and factors of zero were adopted in proposal 2020-06-L for year end 2020.

Additional Staff Comments:

*6/30/21 (jdb) Instructions and Factors adopted by the Task Force.

** This section must be completed on all forms.
LONGEVITY RISK
LR025-A

Basis of Factors

The factors chosen represent surplus needed to provide for claims in excess of reserves resulting from increased policyholder longevity calibrated to a 95th percentile level. For the purpose of this calibration aggregate reserves were assumed to provide for an 85th percentile outcome.

Longevity risk was considered over the entire lifetime of the policies since these annuity policies are generally not subject to repricing. Calibration of longevity risk considered both trend risk based on uncertainty in future population mortality improvements, as well as level or volatility risk which derives from misestimation of current population mortality rates or random fluctuations. Trend risk applies equally to all populations whereas level and volatility risk factors decrease with larger portfolios consistent with the law of large numbers.

Statutory reserve was chosen as the exposure base as a consistent measure of the economic exposure to increased longevity. Factors were also scaled by reserve level since number of insured policyholders is a less accessible measure of company specific volatility risk. Factors provided are pre-tax and were developed assuming a 21% tax adjustment would be subsequently applied.

Specific Instructions for Application of the Formula

Annual statement reference is for the total life contingent reserve for the products in scope. The scope includes annuity products with life contingent payments where benefits are to be distributed in the form of an annuity. The entire reserve amount for contracts in scope that include any life contingent payments are in scope. For example, under a certain-and-life style annuity, the entire reserve for both the certain payments and life contingent payments are in scope. Variable immediate annuity reserves under VM-21 are also in scope where there are life contingent payments. Scope does not include annuity products that are not life contingent, or deferred annuity products where the policyholder has a right but not an obligation to annuitize. A certain-and-life style annuity, where only certain payments remain (such as following the death of the annuitant), is out of scope. Variable deferred annuity contract reserves under VM-21 are out of scope, including reserves valued under VM-21 for any contracts where policyholder account value has reached zero, but a lifetime benefit may still be payable by the insurer. Line (3) for General Account Life Contingent Miscellaneous reserves is included in the event there are any reserves for products in scope reported on Exhibit 5 line 079999; it is not meant to include cash flow testing reserves reported on this line. Included in scope are:

- Single Premium Immediate Annuities (SPIA) and other payout annuities in pay status
- Deferred Payout Income Annuities which will enter annuity pay status in the future upon annuitization
- Structured Settlements for annuitants with any life contingent benefits
- Group Annuities, such as those associated with pension liabilities with both immediate and deferred benefits

The total reserve exposure is then further broken down by size as in a tax table. This breakdown will not appear on the RBC filing software or on the printed copy, as the application of factors to reserves is completed automatically. The calculation is as follows:

<table>
<thead>
<tr>
<th>Line (5)</th>
<th>Life Contingent Annuity Reserves</th>
<th>Statement Value</th>
<th>Factor</th>
<th>RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 250 Million</td>
<td>Life Contingent Annuity Reserves</td>
<td>Statement Value</td>
<td>Factor</td>
<td>RBC Requirement</td>
</tr>
<tr>
<td>Next 250 Million</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Next 500 Million</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over 1,000 Million</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The amount ultimately included in the authorized control level will be subject to a guardrail factor of 0 and a correlation factor of -.25.
## Longevity Risk

<table>
<thead>
<tr>
<th>Life Contingent Annuity Reserves</th>
<th>(1) General Account Life Contingent Annuity Reserves</th>
<th>Exhibit 5 Column 2 Line 0299999, in part‡</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2) General Account Life Contingent Supplemental Contract Reserves</td>
<td>Exhibit 5 Column 2 Line 0399999, in part‡</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>(3) General Account Life Contingent Miscellaneous Reserves</td>
<td>Exhibit 5 Column 2 Line 0799999, in part‡</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>(4) Separate Account (SA) Life Contingent Annuity Reserves</td>
<td>SA Exhibit 5 Column 2 Line 0299999, in part‡</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>(5) Total Life Contingent Annuity Reserves</td>
<td>Lines (1) + (2) + (3) + (4)</td>
<td>$0</td>
<td></td>
</tr>
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</table>

Base Factors are from Longevity Risk Task Force’s Spring 2019 report

<table>
<thead>
<tr>
<th></th>
<th>(1)</th>
<th>(2)</th>
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</thead>
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<td>Value</td>
<td>Rate</td>
</tr>
<tr>
<td>up to $250M</td>
<td>1.71%</td>
<td>0.0171</td>
</tr>
<tr>
<td>next $250M</td>
<td>1.08%</td>
<td>0.0108</td>
</tr>
<tr>
<td>next $500M</td>
<td>0.95%</td>
<td>0.0095</td>
</tr>
<tr>
<td>over $1B</td>
<td>0.89%</td>
<td>0.0089</td>
</tr>
</tbody>
</table>

† The tiered calculation is illustrated in the Longevity Risk section of the risk-based capital instructions.
‡ Include only the portion of reserves for products in scope per the instructions.

=MAX(ROUND(IF(D10<250000000,D10*0.0171,IF(D10<500000000,250000000*0.0171+(D10-500000000)*0.0108,IF(D10<1000000000,250000000*0.0171+250000000*0.108+(D10-1000000000)*0.0095,250000000*0.0171+250000000*0.108+500000000*0.0095+(D10-1000000000)*0.0089))),0),0)
CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Column(s)</th>
<th>Calculation</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>133</td>
<td>Disability Income Premium</td>
<td>LR019 Column(2)</td>
<td>$0 X 0.2100 = $0</td>
<td>$0</td>
</tr>
<tr>
<td>134</td>
<td>Long-Term Care</td>
<td>LR019 Column(2) + LR023</td>
<td>$0 X 0.2100 = $0</td>
<td>$0</td>
</tr>
<tr>
<td>135</td>
<td>Life Insurance C-2 Risk</td>
<td>LR025 Column(2)</td>
<td>$0 X 0.2100 = $0</td>
<td>$0</td>
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<tr>
<td>136</td>
<td>Group Insurance C-2 Risk</td>
<td>LR025 Column(2)</td>
<td>$0 X 0.2100 = $0</td>
<td>$0</td>
</tr>
<tr>
<td>136b</td>
<td>Longevity C-2 Risk</td>
<td>LR025 Column(2)</td>
<td>$0 X 0.2100 = $0</td>
<td>$0</td>
</tr>
<tr>
<td>137</td>
<td>Disability and Long-Term Care Health Claim Reserves</td>
<td>LR024 Column(4)</td>
<td>$0 X 0.2100 = $0</td>
<td>$0</td>
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<tr>
<td>138</td>
<td>Premium Stabilization Credit</td>
<td>LR026 Column(2)</td>
<td>$0 X 0.0000 = $0</td>
<td>$0</td>
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<tr>
<td>139</td>
<td>Total C-2 Risk</td>
<td>LR135 + LR136 + LR137 + LR138 + Greatest of [Guardrail Factor * (LR135 + LR136), Guardrail Factor * LR136b, Square Root of (LR135^2 + LR136^2 + 2 * (TBD Correlation Factor) * LR135 * LR136b)]</td>
<td>$0</td>
<td>$0</td>
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</tbody>
</table>

Guardrail Factor: 0.0
Correlation Factor: -0.25
CALCULATION OF AUTHORIZED CONTROL LEVEL RISK-BASED CAPITAL

Insurance Risk (C-2)

(43) Individual and Industrial Life Insurance
LR025 Life Insurance Column (2) Line (8) 0

(44) Group and Credit Life Insurance and FEGFSGLI
LR025 Life Insurance Column (2) Lines (20) and (21) 0

(44b) Longevity Risk
LR025-A Longevity Risk Column (2) Line (5) 0

(45) Total Health Insurance
LR024 Health Claim Reserves Column (4) Line (18) 0

(46) Premium Stabilization Reserve Credit
LR026 Premium Stabilization Reserves Column (2) Line (10) 0

(47) Total (C-2) - Pre-Tax
1.45 + 1.46 + Greatest of \( \text{Guardrail Factor} \times (L(43)+L(44)), \text{Guardrail Factor} \times L(44b) \), Square Root of \( [(L(43)+L(44))^2+L(44b)^2+2 \times (TBD Correlation Factor) \times (L(43)+L(44)) \times L(44b)] \) 0

(48) (C-2) Tax Effect
LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (139) 0

(49) Net (C-2) - Post-Tax
Line (47) - Line (48) 0

\[-D7+D8+MAX(H9*(D4+D5),H9*D6,SQRT((D4+D5)^2+D6^2+2*H10*(D4+D5)*D6))\]
**Capital Adequacy (E) Task Force**

**RBC Proposal Form**

[ ] Capital Adequacy (E) Task Force
[ ] Health RBC (E) Working Group
[ ] Life RBC (E) Working Group
[ ] Catastrophe Risk (E) Subgroup
[ ] Investment RBC (E) Working Group
[ ] Operational Risk (E) Subgroup
[ ] C3 Phase II/ AG43 (E/A) Subgroup
[ ] P/C RBC (E) Working Group
[ ] Longevity Risk (A/E) Subgroup

**DATE:** 2/28/21

**CONTACT PERSON:** Eva Yeung

**TELEPHONE:** 816-783-8407

**EMAIL ADDRESS:** eyeung@naic.org

**ON BEHALF OF:** P/C RBC (E) Working Group

**NAME:** Tom Botsko

**TITLE:** Chair

**AFFILIATION:** Ohio Department of Insurance

**ADDRESS:** 50 West Town Street, Suite 300

_________Columbus, OH 43215_________

---

**FOR NAIC USE ONLY**

Agenda Item # 2021-03-P

**Year** 2021

**DISPOSITION**

[ ] ADOPTED

6/30/21

[ ] REJECTED

[ ] DEFERRED TO

[ ] REFERRED TO OTHER NAIC GROUP

[ ] EXPOSED

3/15/21

[ ] OTHER (SPECIFY)

---

**IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED**

[ ] Health RBC Blanks

[ ] Property/Casualty RBC Blanks

[ ] Life and Fraternal RBC Instructions

[ ] Health RBC Instructions

[ ] Property/Casualty RBC Instructions

[ ] Life and Fraternal RBC Instructions

[ ] OTHER ____________________________

---

**DESCRIPTION OF CHANGE(S)**

Adding examples as a guide to portray the intent of the R3 ratings instructions.

---

**REASON OR JUSTIFICATION FOR CHANGE **

The proposed instruction changes would provide examples to clarify how the reporting companies should select the designation in the Annual Statement Part 3, Reinsurer Designation Equivalent Rating column if the reporting entities subscribe to one or multiple rating agencies.

---

**Additional Staff Comments:**

3/15/21 – The PCRBC WG exposed this proposal for a thirty-day public comment period ending Apr. 14.

4/27/21 – The PCRBC WG adopted this proposal with no received comments.


6/30/21 (jdb) Instructions adopted by the Task Force.

**This section must be completed on all forms.**

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The calculation of the credit risk charge for reinsurance recoverables is detailed in Schedule F Part 3 Columns 28 through 36 of the Property/Casualty Annual Statement. This calculation is performed at the transaction level and those results are then summed to determine the charge. Reinsurance balances receivable on reinsurance ceded to non-affiliated companies (excluding certain pools) and to alien affiliates are subject to the credit risk-based capital charge. The following types of cessions are exempt from this charge:

- Cessions to State Mandated Involuntary Pools and Associations or to Federal Insurance Programs.
- Cessions to U.S. Parents, Subsidiaries and Affiliates.
- Cessions to U.S. Parents, Subsidiaries and Affiliates.

The categories above are automatically excluded from the data that is calculated in Schedule F Part 3 of the Annual Statement.

Since the Annual Statement requires the collectability of reinsurance balances be considered via the reinsurance penalty, the appropriate balances must be offset by any liability that has been established for this purpose. The amount from Page 3, Line 16 should be allocated to the appropriate reinsurers listed on Schedule F. The total amount recoverable from reinsurers less any applicable reinsurance penalty is multiplied by 120% to stress the recoverable balance. The total of reinsurance payable and/or funds held amounts (not in excess of the stressed recoverable) are applied as offsets to arrive at the stressed net recoverable.

Since there are different reinsurance credit risk factors for collateralized and uncollateralized reinsurance recoverables, the stressed net recoverable should be offset by any available collateral, such as letters of credit, multiple beneficiary trusts, and single beneficiary trusts and other allowable offsets (not in excess of the stressed net recoverable). The collateralized amounts are derived from Schedule F Part 3 Column 32 and the uncollateralized amounts are derived from Column 33.

The risk-based capital for the various credits (including collateral offsets where applicable) taken for reinsurance may not be less than zero even if the amount reported or the amount net of offsets is negative.

The factor for reinsurance recoverables (paid and unpaid less any applicable reinsurance penalty) due from a particular reinsurer is determined based on that reinsurer’s financial strength rating assigned on a legal entity basis.

For the purpose of the credit risk-based capital charge, the equivalent rating category assigned will correspond to current financial strength rating received from one of the approved rating agencies as outlined in the table below. Ratings shall be based on interactive communication between the rating agency and the reinsurer and shall not be based solely on publicly available information. If the reinsurer does not have at least one financial strength rating, it should be assigned the “Vulnerable 6 or Unrated” equivalent rating. Amounts recoverable from unrated voluntary pools should be assigned the “Secure 3” equivalent rating.

For authorized associations including incorporated and individual unincorporated underwriters or a member thereof (e.g. individual authorized syndicates of Lloyds’ of London that are backed by the Central Fund) utilize the lowest financial strength group rating received from an approved rating agency.

For authorized associations, including incorporated and individual unincorporated underwriters or a member thereof (e.g. individual authorized syndicates of Lloyds’ of London that are backed by the Central Fund), may utilize the lowest financial strength group rating received from an approved rating agency.

The table below shows the R3 reinsurer equivalent rating categories and corresponding factors for A.M. Best, Standard and Poor’s, Moody’s and Fitch ratings.
Reinsurer Designation Equivalent Rating Category and Corresponding Factors—For RBC R3 Credit Risk Charge

<table>
<thead>
<tr>
<th>Description</th>
<th>Secure 1</th>
<th>Secure 2</th>
<th>Secure 3</th>
<th>Secure 4</th>
<th>Secure 5</th>
<th>Vulnerable 6 or Unrated</th>
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</thead>
<tbody>
<tr>
<td>A.M. Best</td>
<td>A++</td>
<td>A+</td>
<td>A</td>
<td>A-</td>
<td>B++, B+</td>
<td>B, B-, C++, C+, C-, D, E, F</td>
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<tr>
<td>Moody’s</td>
<td>Aaa</td>
<td>Aa1, Aa2, Aa3</td>
<td>A1, A2</td>
<td>A3</td>
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<td>4.1%</td>
<td>4.8%</td>
<td>5.0%</td>
<td>5.0%</td>
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<td>Uncollateralized Amounts Factors</td>
<td>3.6%</td>
<td>4.1%</td>
<td>4.8%</td>
<td>5.3%</td>
<td>7.1%</td>
<td>14.0%</td>
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</tbody>
</table>

Each reporting company should record in Schedule F Part 3, Column 34, the reinsurer designation equivalent financial strength ratings assigned to the (re)insurers listed, where there are balances receivable on reinsurance ceded for the Schedule F categories subject to the credit risk charge on reinsurance recoverables. The resulting credit risk charge for reinsurance recoverables is determined by applying the corresponding factor by reinsurer designation equivalent to the collateralized and uncollateralized balances respectively. These respective charges are derived from Schedule F Part 3, Columns 35 and 36 and Line 9999999 totals are reported on PR012 Lines 1 and 2. See examples below.

Miscellaneous Recoverables

There is risk associated with recoverability of amounts from creditors other than reinsurers. In addition to the default risk, there is the risk that the amounts are not accurately estimated. The factor to measure this risk is estimated at 5 percent for Amounts Receivable Relating to Uninsured Accident and Health Plans; Receivables from Parent, Subsidiaries and Affiliates; and Aggregate Write-ins for Other Than Invested Assets. For Interest, Dividends and Real Estate Income Due and Accrued, which for the most part represents interest income due and accrued from bond holdings, the charge is 1 percent, which is equivalent to the charge applicable to unaffiliated NAIC 02 bonds.

Examples: The following examples are here as a guide to portray the intent of these instructions.

These examples assume that all financial strength ratings are from one of the rating agencies listed in the table above and there is interactive communication between the rating agency and the reinsurer unless stated otherwise.

Example 1—Reinsurer has only one rating: Assume the Reinsurer XYZ has a financial strength rating of A from A.M. Best. This falls in the Secure 3 category and the reporting company should select this category and corresponding charge.

Example 2—Reinsurer has more than one rating: Assume the Reinsurer XYZ has a financial strength rating of “A” from A.M. Best and another rating of “AAA” from Fitch. The reporting company may use either of the ratings provided by A.M. Best or Fitch.

Example 3—Reinsurer only has a Public Information Rating: Ratings that include the symbol of “pi” (e.g. Api), which indicates a public information rating, are not allowed to be used. If a reinsurer has only been assigned Public Information ratings, meaning no other financial strength ratings have been assigned to it; then the reporting company must list the reinsurer’s rating as Vulnerable 6 or Unrated.
Capital Adequacy (E) Task Force

RBC Proposal Form

[ ] Capital Adequacy (E) Task Force [ ] Health RBC (E) Working Group [ ] Life RBC (E) Working Group

[ ] Catastrophe Risk (E) Subgroup [ ] Investment RBC (E) Working Group [ ] Operational Risk (E) Subgroup

[ ] C3 Phase II/AG43 (E/A) Subgroup [ ] P/C RBC (E) Working Group [ ] Longevity Risk (A/E) Subgroup

DATE: 4/27/21

CONTACT PERSON: Eva Yeung

TELEPHONE: 816-783-8407

EMAIL ADDRESS: eyeung@naic.org

ON BEHALF OF: P/C RBC (E) Working Group

NAME: Tom Botsko

TITLE: Chair

AFFILIATION: Ohio Department of Insurance

ADDRESS: 50 West Town Street, Suite 300
Columbus, OH 43215

FOR NAIC USE ONLY

Agenda Item # 2021-05-P

YEAR 2021

DISPOSITION

[ X ] ADOPTED 6/30/21

[ ] REJECTED

[ ] DEFERRED TO

[ ] REFERRED TO OTHER NAIC GROUP

[ ] EXPOSED

[ ] OTHER (SPECIFY)

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

[ ] Health RBC Blanks [ x ] Property/Casualty RBC Blanks [ ] Life and Fraternal RBC Instructions

[ ] Health RBC Instructions [ ] Property/Casualty RBC Instructions [ ] Life and Fraternal RBC Blanks

[ ] OTHER ____________________________

DESCRIPTION OF CHANGE(S)

The proposed change would update the Line 1 Factors for PR017 and PR018.

REASON OR JUSTIFICATION FOR CHANGE **

The proposed change would provide routine annual update of the industry underwriting factors (premium and reserve) in the PCRBC formula.

Additional Staff Comments:
The P/C RBC WG exposed this proposal for a 30-day comment period ended by 5/26/21.
The P/C RBC WG adopted this proposal on 6/9/21.
6/30/21- (jdb) Factors were adopted by the Task Force.

** This section must be completed on all forms.

Revised 2-2019
## PR017 Line 1 Reserves

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<th>2020 PR017 Line 1</th>
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<th>2018 PR017 Line 1</th>
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<th>2011 PR017 Line 1</th>
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© 2021 National Association of Insurance Commissioners
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<th>IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED</th>
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<td>1) Incorporate 20 NAIC Designation Category Bond Factors; 2) Modify Bond Size Factor formula and 3) Reclassification of Hybrid Securities in PR006, PR011 and PR015. Modify the instructions to incorporate references for the bonds.</td>
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<th>REASON OR JUSTIFICATION FOR CHANGE **</th>
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<td>This expansion will provide more robust and accurate results, primarily as it increases the granularity of the formula and reduces the cliffs between the different factors for the different categories.</td>
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<table>
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<th>Additional Staff Comments:</th>
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PR006 - Bonds and Bond Size Factor Adjustment

Basis of General Bond Factors

The bond risk factors for investment grade bonds (NAIC Designation Category 1.A – 2.C) are based on cash flow modeling. Each bond of a portfolio was annually tested for default (based on a “roll of the dice”) where the default probability varies by NAIC Designation category and that year’s economic environment. The default probabilities were based on historical data intended to reflect a complete cycle of favorable and unfavorable credit environment. The risk of default was measured over a 5-year time horizon, selected considering the duration of property/casualty assets and liabilities.

The factors for NAIC Designation Category 3.A to 6 recognize that these non-investment grade bonds are reported at the lower of amortized cost or fair value. These bond risk factors are based on the market value fluctuation for each of the NAIC designation category compared to the market value fluctuation of stocks during the 2008-2009 financial crisis.

The bond risk factors are selected with consideration of the effect of the bond size factor.

Bond Size Factor

The bond factors assume a portfolio of 802 issuers. The size factor reflects that the risk increases as the number of bond issuers decreases. The bond size factor adjusts the computed RBC for those bonds that are subject to this size factor to more accurately reflect the risk.

The bond size factor is to be multiplied by the risk-based capital of the bonds subject to the size factor. This calculation produces the additional RBC required for a portfolio that has 801 or less bonds in it. Portfolio with 803 or more issuers will receive a discount. The bond size factor was developed as a step factor (as in a tax table) so that the overall factor decreases as the portfolio size increases.

Bonds should be aggregated by issuer (the first six digits of the CUSIP number should be used for aggregation). In determining the total number of issuers, do not count:

- U.S. government bonds that are direct and guaranteed and backed by the full faith and credit of the U.S. government (other U.S. Government Obligations / Full Faith and Credit)
- FNMA and FHLMC collateralized mortgage obligations.
- Other obligations backed by the U.S. government.

The calculation shown below will not appear in the software but will be calculated automatically. However, you must enter the total number of issuers in the appropriate field on the RBC filing software. If you leave this field blank, the program will assume that there are less than 10 issuers and will default to the maximum bond size factor adjustment. The calculation to derive the bond size factor is:

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<th>Source</th>
<th>No of Issuers</th>
<th>Weighted Issuers</th>
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</thead>
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<tr>
<td>First 10</td>
<td>Co Records</td>
<td>X 2.6 = X 0.75</td>
</tr>
<tr>
<td>Next 50</td>
<td>Co Records</td>
<td>X 3.0 = X 0.75</td>
</tr>
<tr>
<td>Next 100</td>
<td>Co Records</td>
<td>X 0.5 = X 0.75</td>
</tr>
<tr>
<td>Over 300</td>
<td>Co Records</td>
<td>X 0.9 = X 0.75</td>
</tr>
<tr>
<td>Total</td>
<td>Co Records</td>
<td>X 0.75</td>
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</table>
Size Factor = Total Weighted Issuers/Total No of Issuers less 1

PR007 - Unaffiliated Preferred and Common Stock

Unaffiliated Preferred Stock
Detailed information on unaffiliated preferred stocks is found in Schedule D Part 2 Section 1 of the annual statement. The preferred stocks must be broken out by NAIC Designation (NAIC 01 through NAIC 06) and these individual groups are to be entered in the appropriate lines of the RBC software. The total amount of unaffiliated preferred stock reported should equal annual statement P2 L2.1 C3 less any affiliated preferred stock in Schedule D-Summary by Country C1 L18.

Unaffiliated Common Stock
The factor for other unaffiliated common stock is based on studies that indicate a 10 percent to 12 percent factor is needed to provide capital to cover approximately 95 percent of the greatest losses in common stock value over a one-year future period. The higher factor of 15 percent contained in the formula reflects the increased risk when testing a period in excess of one year. This factor assumes capital losses are unrealized and not subject to favorable tax treatment at the time loss in fair value occurs.

The total of all unaffiliated common stock reported should be equal to the total value of common stock in Schedule D-Summary by Country C1 L25 less the sum of Schedule D-Summary by Country C1 L24 and PR007, Column 1, Line 18.

PR009 - Miscellaneous Assets
Collateral loans and write-ins for invested assets are generally a small proportion of total portfolio value. A factor of 5 percent is consistent with other risk-based capital formulas studied by the working group.

The factor for cash is 0.3%. It is recognized that there is a small risk related to possible insolvency of the bank where cash deposits are held. This factor was based on the original unaffiliated NAIC 01 bond risk factor prior to the increased granularity of the NAIC Designation Categories in 2021, and reflects the short-term nature of this risk. The required risk-based capital for cash will not be less than zero, even if the company’s cash position is negative.

If the book/adjusted carrying value of Aggregate Write-ins for Invested Assets (Page 2, Line 11, Column 3 of the annual statement) is less than zero, the RBC amount will be zero.

PR011 - Asset Concentration
The purpose of the concentration factor is to reflect the additional risk of high concentrations in single exposures (represented by an issuer of a security or a mortgage borrower, etc.). The concentration factor basically doubles the risk-based capital factor (up to a maximum of 25 percent) of the 10 largest asset exposures excluding various low-risk categories or categories which already have a 25 percent factor. Since the risk-based capital of the assets included in the concentration factor has already been counted once in the basic formula, this factor itself only serves to add an additional risk-based capital requirement on these assets.

Concentrated investments in certain types of assets are not expected to represent an additional risk over and above the general risk of the asset itself. Therefore, prior to determining the 10 largest issuers, you should exclude those assets that are exempt from the asset concentration factor. Asset types that are excluded from the calculation include: NAIC 06 bonds and preferred stock, affiliated common stock, affiliated preferred stock, property and equipment, U.S. government guaranteed bonds, NAIC Designation Category A to L. Triangles, bonds and hybrid securities are also excluded from this calculation.
unaffiliated preferred stock, and investment companies (mutual funds) and common trust funds that are diversified within the meaning of the Investment Company Act of 1940 [Section 5(b) (1)]. The pro rata share of individual securities within an investment company (mutual fund) or common trust fund are to be included in the determination of concentrated investments, subject to the exclusions identified.

With respect to investment companies (mutual funds) and common trust funds, the reporting company is responsible for maintaining the appropriate documentation as evidence that such is diversified within the meaning of the Investment Company Act and provide this information upon request of the commissioner, director or superintendent of the department of insurance. The reporting company is also responsible for maintaining a listing of the individual securities and corresponding book/adjusted carrying values making up its investment companies (mutual funds) and common trust funds portfolio, in order to determine whether a concentration charge is necessary. This information should be provided to the commissioner, director or superintendent upon request.

The assets that ARE INCLUDED in the calculation are divided into two categories – Fixed Income Assets and Equity Assets. The following asset types should be aggregated to determine the 10 largest issuers:

**FIXED INCOME ASSETS**
- Bonds – NAIC Designation Category 2.A
- Bonds – NAIC Designation Category 2.B
- Bonds – NAIC Designation Category 2.C
- Bonds – NAIC Designation Category 3.A
- Bonds – NAIC Designation Category 3.B
- Bonds – NAIC Designation Category 3.C
- Bonds – NAIC Designation Category 3.D
- Bonds – NAIC Designation Category 3.E
- Bonds – NAIC Designation Category 4.A
- Bonds – NAIC Designation Category 4.B
- Bonds – NAIC Designation Category 4.C
- Bonds – NAIC Designation Category 4.D
- Bonds – NAIC Designation Category 5.A
- Bonds – NAIC Designation Category 5.B
- Bonds – NAIC Designation Category 5.C
- Collateral Loans
- Mortgage Loans
- Working Capital Finance Investments – NAIC 02
- Federal Guaranteed Low Income Housing Tax Credits
- Federal Non-Guaranteed Low Income Housing Tax Credits
- State Guaranteed Low Income Housing Tax Credits
- State Non-Guaranteed Low Income Housing Tax Credits
- All Other Low Income Housing Tax Credits

**EQUITY ASSETS**
- Unaffiliated Preferred Stock – NAIC 02
- Unaffiliated Preferred Stock – NAIC 03
- Unaffiliated Preferred Stock – NAIC 04
- Unaffiliated Preferred Stock – NAIC 05
- Unaffiliated Common Stock
- Investment Real Estate
- Encumbrances on Inv. Real Estate
- Schedule BA Assets (excluding Collateral Loans)
- Receivable for Securities
- Aggr. Write-ins for Invested Assets
- Derivatives

The name of each of the largest 10 issuers is entered at the top of the table and the appropriate statement amounts are entered in C(2) Ls (01) through (20) for fixed income assets and C(2) Ls (22) through (32) for equity assets. Aggregate all similar asset types before entering the amount in C(2). For instance, if you own five separate $1,000,000 NAIC 2.A bonds from Issuer #1, enter $5,000,000 in C(2) L (04) – NAIC 2.A Unaffiliated Bonds.
Security lending programs are required to maintain collateral. Some entities post the collateral supporting security lending programs on their financial statements and incur the related risk charges on those assets. Other entities have collateral that is not recorded on their financial statements. While not recorded on the financial statements of the company, such collateral has risks that are not otherwise captured in the RBC formula.
The collateral in these accounts is maintained by a third party (typically a bank or other agent). The collateral agent maintains on behalf of the company detail asset listings of the collateral assets, and this data is the source for preparation of this schedule. The company should maintain such asset listings, at a minimum CUSIP, market value, book/carrying value, and maturity date.

The asset risk charges are derived from existing RBC factors for bonds, preferred and common stocks, other invested assets, and invested assets not otherwise classified (aggregate write-ins).

Specific Instructions for Application of the Formula


Lines (1) through (26) – Bonds
Bond factors described on PR006 – Bonds and Bond Size Factor Adjustment

Lines (28) through (33) – Preferred Stocks
Preferred stock factors described on PR007 – Unaffiliated Preferred and Common Stock

Lines (35) – Common Stock
Common stock factors described on PR007 – Unaffiliated Preferred and Common Stock

Lines (36) – Real Estate and Schedule BA – Other Invested Assets
Real Estate and other invested asset factors described on PR008 – Other Long-Term Assets

Lines (37) – Other Invested Assets
Other invested assets factors described on PR009 – Miscellaneous Assets

Lines (39) – Cash, Cash Equivalents, and Short-Term Investments
Cash, Cash Equivalents, and Short-Term Investments factors described on PR007 – Unaffiliated Preferred, Common Stock and Hybrid Securities and PR009 – Miscellaneous Assets
| (1) | NAIC Designation Category 1.A | Footnote Amt 1 L1,000,000A - L(1) | 0 | 0 | 0 | 0 | 0.002 | 0 |
| (2) | NAIC Designation Category 1.B | Footnote Amt 2 L1,000,000B | 0 | 0 | 0 | 0 | 0.004 | 0 |
| (3) | NAIC Designation Category 1.C | Footnote Amt 3 L1,000,000C | 0 | 0 | 0 | 0 | 0.006 | 0 |
| (4) | NAIC Designation Category 1.D | Footnote Amt 4 L1,000,000D | 0 | 0 | 0 | 0 | 0.008 | 0 |
| (5) | NAIC Designation Category 1.E | Footnote Amt 5 L1,000,000E | 0 | 0 | 0 | 0 | 0.010 | 0 |
| (6) | NAIC Designation Category 1.F | Footnote Amt 6 L1,000,000F | 0 | 0 | 0 | 0 | 0.013 | 0 |
| (7) | NAIC Designation Category 1.G | Footnote Amt 7 L1,000,000G | 0 | 0 | 0 | 0 | 0.015 | 0 |
| (8) | Total NAIC 01 Bonds | Sum of Ls(1) through (8) | 0 | 0 | 0 | 0 | 0 | 0 |
| (9) | NAIC Designation Category 2.A | Footnote Amt 1 L1,000,001A | 0 | 0 | 0 | 0 | 0.018 | 0 |
| (10) | NAIC Designation Category 2.B | Footnote Amt 2 L1,000,001B | 0 | 0 | 0 | 0 | 0.021 | 0 |
| (11) | NAIC Designation Category 2.C | Footnote Amt 3 L1,000,001C | 0 | 0 | 0 | 0 | 0.025 | 0 |
| (12) | Total NAIC 02 Bonds | Sum of Ls(10) through (12) | 0 | 0 | 0 | 0 | 0 | 0 |
| (13) | NAIC Designation Category 3.A | Footnote Amt 1 L1,000,001C | 0 | 0 | 0 | 0 | 0.055 | 0 |
| (14) | NAIC Designation Category 3.B | Footnote Amt 2 L1,000,001C | 0 | 0 | 0 | 0 | 0.060 | 0 |
| (15) | NAIC Designation Category 3.C | Footnote Amt 3 L1,000,001C | 0 | 0 | 0 | 0 | 0.066 | 0 |
| (16) | Total NAIC 03 Bonds | Sum of Ls(16) through (18) | 0 | 0 | 0 | 0 | 0 | 0 |
| (17) | NAIC Designation Category 4.A | Footnote Amt 1 L1,000,001D | 0 | 0 | 0 | 0 | 0.087 | 0 |
| (18) | NAIC Designation Category 4.B | Footnote Amt 2 L1,000,001D | 0 | 0 | 0 | 0 | 0.090 | 0 |
| (19) | NAIC Designation Category 4.C | Footnote Amt 3 L1,000,001D | 0 | 0 | 0 | 0 | 0.097 | 0 |
| (20) | Total NAIC 04 Bonds | Sum of Ls(20) through (20) | 0 | 0 | 0 | 0 | 0 | 0 |
| (21) | NAIC Designation Category 5.A | Footnote Amt 1 L1,000,001E | 0 | 0 | 0 | 0 | 0.109 | 0 |
| (22) | NAIC Designation Category 5.B | Footnote Amt 2 L1,000,001E | 0 | 0 | 0 | 0 | 0.120 | 0 |
| (23) | NAIC Designation Category 5.C | Footnote Amt 3 L1,000,001E | 0 | 0 | 0 | 0 | 0.120 | 0 |
| (24) | Total NAIC 05 Bonds | Sum of Ls(22) through (24) | 0 | 0 | 0 | 0 | 0 | 0 |
| (25) | Total NAIC 06 Bonds | Footnote Amt 1 L1,000,001F | 0 | 0 | 0 | 0 | 0.300 | 0 |
| (26) | Subtotal - Bonds Subject to Bond Size Factor | L(27) x L(28) + L(29) | 0 | 0 | 0 | 0 | 0 | 0 |
| (27) | Number of Issuers | 0 | 0 | 0 | 0 | 0 | 0 |
| (28) | Bond Size Factor | 0 | 0 | 0 | 0 | 6.800 | 0 |
| (29) | Bond Size Factor RBC | C(5) x 6.800 | 0 | 0 | 0 | 0 | 0 | 0 |
| (30) | Total Bonds RBC | L(27) + L(28) | 0 | 0 | 0 | 0 | 0 | 0 |

Denotes items that must be vendor linked.
Denotes items that must be manually entered on the filing software.
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**UNAFFILIATED PREFERRED AND COMMON STOCK AND HYBRID SECURITIES**

**UNAFFILIATED PREFERRED STOCK**

<table>
<thead>
<tr>
<th>Book/Adjusted Carrying Value</th>
<th>Factor</th>
<th>RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sch D.Pt.2 Sn.1</td>
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<td>0.003</td>
</tr>
<tr>
<td>Sch D.Pt.2 Sn.1</td>
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<tr>
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<tr>
<td>Sch D-Pt.2 Sn.1</td>
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</tr>
</tbody>
</table>

**TOTAL UNAFFILIATED PREFERRED STOCK**

- Should equal P2.L21.C3 less Sch D-Sum C1.L18
## MISCELLANEOUS ASSETS  PR009

| (1) | Receivable for Securities | P2C3L9 | 0 | 0.025 | 0 |
| (2) | Aggregate W/I for Invest Assets | P2C3L11 | 0 | 0.050 | 0 |
| (3) | Cash | P2 L5, inside amnt 1 | 0 | 0.003 | 0 |
| (4) | Cash Equivalents | P2 L5, inside amnt 2 | 0 | 0 |
| (5) | Less: Cash Equivalents, Total Bonds | Sch E Pt 2 C7 L8399999 | 0 | 0 |
| (6) | Less: Exempt Money Market Mutual Funds as Identified by SVO | Sch E Pt 2 C7 L8599999 | 0 | 0 |
| (7) | Net Cash Equivalents | L(4)+L(5)+L(6) | 0 | 0.003 | 0 |
| (8) | Short-Term Investments | P2 L5, inside amnt 3 | 0 | 0 |
| (9) | Short-Term Bonds | Sch DA Pt1 C7 L8599999 | 0 | 0 |
| (10) | Total Other Short-Term Investments | L(8)+L(9) | 0 | 0.003 | 0 |
| (11) | Collateral Loans | Sch BA Pt1 C12 L2999999+3099999 | 0 | 0 |
| (12) | Less: Non-Admitted Collateral Loans | P2 L8 C2 in part | 0 | 0.050 | 0 |
| (13) | Net Admitted Collateral Loans | L(11) - L(12) | 0 | 0.050 | 0 |
| (14) | Derivatives | P2C3L7 | 0 | 0 |
| (15) | Total Miscellaneous Assets | L(1)+L(2)+L(3)+L(7)+L(10)+L(13)+L(14) | 0 | 0 |

Denotes items that must be manually entered on the filing software.
| (1) | NAIC Designation Category 2.A Bonds | 0 | 0.0180 | 0 |
| (2) | NAIC Designation Category 2.B Bonds | 0 | 0.0210 | 0 |
| (3) | NAIC Designation Category 2.C Bonds | 0 | 0.0250 | 0 |
| (4) | NAIC Designation Category 3.A Bonds | 0 | 0.0550 | 0 |
| (5) | NAIC Designation Category 3.B Bonds | 0 | 0.0600 | 0 |
| (6) | NAIC Designation Category 3.C Bonds | 0 | 0.0660 | 0 |
| (7) | NAIC Designation Category 4.A Bonds | 0 | 0.0710 | 0 |
| (8) | NAIC Designation Category 4.B Bonds | 0 | 0.0770 | 0 |
| (9) | NAIC Designation Category 4.C Bonds | 0 | 0.0870 | 0 |
| (10) | NAIC Designation Category 5.A Bonds | 0 | 0.0980 | 0 |
| (11) | NAIC Designation Category 5.B Bonds | 0 | 0.1090 | 0 |
| (12) | NAIC Designation Category 5.C Bonds | 0 | 0.1200 | 0 |
| (13) | Collateral Loans | 0 | 0.0500 | 0 |
| (14) | Mortgage Loans | 0 | 0.0500 | 0 |
| (15) | NAIC 02 Working Capital Finance Investments | 0 | 0.0125 | 0 |
| (16) | Federal Guaranteed Low Income Housing Tax Credits | 0 | 0.0014 | 0 |
| (17) | Federal Non-Guaranteed Low Income Housing Tax Credits | 0 | 0.0260 | 0 |
| (18) | State Guaranteed Low Income Housing Tax Credits | 0 | 0.0014 | 0 |
| (19) | State Non-Guaranteed Low Income Housing Tax Credits | 0 | 0.0260 | 0 |
| (20) | All Other Low Income Housing Tax Credits | 0 | 0.1500 | 0 |
| (21) | SUBTOTAL - FIXED INCOME | 0 | 0 | 0 |
| (22) | NAIC 02 Unaffiliated Preferred Stock | 0 | 0.0100 | 0 |
| (23) | NAIC 03 Unaffiliated Preferred Stock | 0 | 0.0200 | 0 |
| (24) | NAIC 04 Unaffiliated Preferred Stock | 0 | 0.0450 | 0 |
| (25) | NAIC 05 Unaffiliated Preferred Stock | 0 | 0.1000 | 0 |
| (26) | Property Held For Production of Income or For Sale Excluding Home Office | 0 | 0.0000 | 0 |
| (27) | Property Held For Production of Income or For Sale Encumbrances Excluding Home Office | 0 | 0.0000 | 0 |
| (28) | Schedule BA Assets | 0 | 0.1000 | 0 |
| (29) | Receivable for Securities | 0 | 0.0250 | 0 |
| (30) | Aggregate Write-Ins for Invested Assets | 0 | 0.0500 | 0 |
| (31) | Derivatives | 0 | 0.0500 | 0 |
| (32) | Unaffiliated Common Stock | 0 | 0.1500 | 0 |
| (33) | SUBTOTAL - EQUITY | 0 | 0 | 0 |
| (34) | TOTAL - ISSUER #1 (L21+L33) | 0 | 0 | 0 |

Denotes items that must be manually entered on the filing software.
<table>
<thead>
<tr>
<th>Asset Category</th>
<th>Annual Statement Source</th>
<th>Schedule DL, Part I</th>
<th>Book/Adjusted Carrying Value</th>
<th>Equity Assets</th>
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<td>Bonds</td>
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<td></td>
<td>Subtotal</td>
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<td>(1) NAC 1A - U.S. Government Full Faith and Credit, Other U.S. Government Obligations, and NAC E.U. Government Money Market Fund List (Refer to AS Instructions)</td>
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<td>(6) NAC Designation Category 1E</td>
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<td>(7) NAC Designation Category 1F</td>
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<td>(8) NAC Designation Category 1G</td>
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<td>(9) Total NAC 01 Bonds</td>
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<td>(11) NAC Designation Category 2B</td>
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<td>(16) NAC Designation Category 3C</td>
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<td>(28) NAC 01 Unaffiliated Preferred Stock</td>
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<td>(29) NAC 02 Unaffiliated Preferred Stock</td>
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<td>(30) NAC 03 Unaffiliated Preferred Stock</td>
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<td>(31) NAC 04 Unaffiliated Preferred Stock</td>
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<tr>
<td>(32) NAC 05 Unaffiliated Preferred Stock</td>
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<tr>
<td>(33) NAC 06 Unaffiliated Preferred Stock</td>
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<tr>
<td>(34) Total Unaffiliated Preferred Stock</td>
<td>Sum of Ls (28 through 33)</td>
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<tr>
<td>Real Estate and Schedule BA - Other Invested Assets</td>
<td>Company Records</td>
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<tr>
<td>(35) Mortgage Loans on Real Estate</td>
<td>Company Records</td>
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</tr>
<tr>
<td>(36) Other Invested Assets</td>
<td>Company Records</td>
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<tr>
<td>(37) Cash, Cash Equivalents and Short-Term Investments</td>
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<td>(38) Total</td>
<td>Sum of Ls (27) through (37)</td>
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Denotes items that must be manually entered on the filing software.
## Calculation of Total Risk-Based Capital After Covariance

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<tr>
<th>Description</th>
<th>PR030 Reference</th>
<th>RBC Amount</th>
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<tbody>
<tr>
<td><strong>R0 - Subsidiary Insurance Companies and Misc. Other Amounts</strong></td>
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<td></td>
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<tr>
<td>1. Affiliated US P&amp;C Insurers - Directly Owned</td>
<td>PR004 L(1)C(4)</td>
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</tr>
<tr>
<td>2. Affiliated US P&amp;C Insurers - Indirectly Owned</td>
<td>PR004 L(4)C(4)</td>
<td>0</td>
</tr>
<tr>
<td>3. Affiliated US Life Insurers - Directly Owned</td>
<td>PR004 L(3)C4(4)</td>
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</tr>
<tr>
<td>4. Affiliated US Life Insurers - Indirectly Owned</td>
<td>PR004 L(5)C(4)</td>
<td>0</td>
</tr>
<tr>
<td>5. Affiliated US Health Insurer - Directly Owned</td>
<td>PR004 L(6)C(4)</td>
<td>0</td>
</tr>
<tr>
<td>6. Affiliated US Health Insurer - Indirectly Owned</td>
<td>PR004 L(7)C(4)</td>
<td>0</td>
</tr>
<tr>
<td>7. Affiliated Alien Insurers - Directly Owned</td>
<td>PR004 L(8)C(4)</td>
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<tr>
<td>8. Affiliated Alien Insurers - Indirectly Owned</td>
<td>PR004 L(9)C(4)</td>
<td>0</td>
</tr>
<tr>
<td>9. Misc Off-Balance Sheet - Non-Controlled Assets</td>
<td>PR004 L(15)C(3)</td>
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<tr>
<td>10. Misc Off-Balance Sheet - Guarantees for Affiliates</td>
<td>PR004 L(16)C(3)</td>
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<tr>
<td>11. Misc Off-Balance Sheet - Contingent Liabilities</td>
<td>PR004 L(17)C(3)</td>
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<tr>
<td>12. Misc Off-Balance Sheet - Total Bonds</td>
<td>PR004 L(19)C(3)</td>
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<tr>
<td>13. Misc Off-Balance Sheet - Total Bonds</td>
<td>PR004 L(20)C(3)</td>
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<tr>
<td>14. Total R0</td>
<td>PR004 L(1)+L(2)+L(3)+L(4)+L(5)+L(6)+L(7)+L(8)+L(9)+L(10)+L(11)+L(12)+L(13)</td>
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</tbody>
</table>

| Description                                                                 | PR006 L(27)C(5) | 0          |
| 15. Bonds Subject to Size Factor                                           | PR006 L(27)C(5) | 0          |
| 16. Bond Size Factor RBC                                                    | PR006 L(27)C(5) | 0          |

| Description                                                                 | PR001 L(1)+L(4)+L(5)+L(6)+L(7)+L(8)+L(9)+L(10)+L(12)+L(13)+L(15) | 0      |
| 17. Off-Balance Sheet - Total Bonds                                        | PR001 L(1)+L(4)+L(5)+L(6)+L(7)+L(8)+L(9)+L(10)+L(12)+L(13)+L(15) | 0      |
| 18. Off-Balance Sheet - Cash Equivalents                                   | PR001 L(1)+L(4)+L(5)+L(6)+L(7)+L(8)+L(9)+L(10)+L(12)+L(13)+L(15) | 0      |
| 19. Misc Assets - Other Short-Term Investments                             | PR009 L(1)+L(4)+L(5)+L(6)+L(7)+L(8)+L(9)+L(10)+L(12)+L(13)+L(15) | 0      |
| 20. Replication - Synthetic Asset: One Half                                | PR001 L(1)+L(4)+L(5)+L(6)+L(7)+L(8)+L(9)+L(10)+L(12)+L(13)+L(15) | 0      |
| 21. Total R1                                                               | PR001 L(1)+L(4)+L(5)+L(6)+L(7)+L(8)+L(9)+L(10)+L(12)+L(13)+L(15) | 0      |

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### CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE  
**PR031 R2-R3**

<table>
<thead>
<tr>
<th>R2 - Asset Risk - Equity</th>
<th>PRBC O&amp;I Reference</th>
<th>RBC Amount</th>
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<tbody>
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<td>(27) Common - Affiliate Investment Subs.</td>
<td>PR004 L(7)C(2)</td>
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<tr>
<td>(28) Common - Affiliate Hold. Company, in excess of Ins. Subs.</td>
<td>PR004 L(10)C(2)</td>
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<tr>
<td>(29) Common - Investment in Parent</td>
<td>PR004 L(11)C(2)</td>
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</tr>
<tr>
<td>(30) Common - Aff'd US P&amp;C Not Subj to RBC</td>
<td>PR004 L(12)C(2)</td>
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</tr>
<tr>
<td>(31) Common - Affil US Life Not Subj to RBC</td>
<td>PR004 L(13)C(2)</td>
<td>0</td>
</tr>
<tr>
<td>(32) Common - Affil US Health Insurer Not Subj to RBC</td>
<td>PR004 L(14)C(2)</td>
<td>0</td>
</tr>
<tr>
<td>(33) Common - Aff'd Non-insurer</td>
<td>PR004 L(15)C(2)</td>
<td>0</td>
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<tr>
<td>(34) Preferred - Aff'd Invest Sub</td>
<td>PR004 L(7)C(3)</td>
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<td>(35) Preferred - Aff'd Hold. Co. in excess of Ins. Subs.</td>
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<tr>
<td>(36) Preferred - Investment in Parent</td>
<td>PR004 L(11)C(3)</td>
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<tr>
<td>(37) Preferred - Affil US P&amp;C Not Subj to RBC</td>
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<tr>
<td>(38) Preferred - Affil US Life Not Subj to RBC</td>
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<td>(39) Preferred - Affil US Health Insurer Not Subj to RBC</td>
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<td>(40) Preferred - Affil Non-insurer</td>
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<tr>
<td>(41) Unaffiliated Preferred Stock</td>
<td>PR007 L(7)C(2)+PR015 L(34)C(4)</td>
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<td>(42) Unaffiliated Common Stock</td>
<td>PR007 L(21)C(2)+PR015 L(35)C(4)</td>
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<td>(43) Other Long-Term Assets - Real Estate</td>
<td>PR008 L(7)C(2)</td>
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<td>(44) Other Long-Term Assets - Schedule BA Assets</td>
<td>PR008 L(19)C(2)+PR015 L(36)+L(37)C(4)</td>
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<td>(45) Misc Assets - Receivable for Securities</td>
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<tr>
<td>(46) Misc Assets - Aggregate Write-ins for Invested Assets</td>
<td>PR009 L(2)C(2)</td>
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<tr>
<td>(47) Misc Assets - Derivatives</td>
<td>PR009 L(14)C(2)</td>
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<tr>
<td>(48) Replication - Synthetic Asset: One Half</td>
<td>PR010 L(99999999)C(2)</td>
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<td>(49) Asset Concentration RBC - Equity</td>
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Total R2: \[ L(27)+L(28)+L(29)+L(30)+L(31)+L(32)+L(33)+L(34)+L(35)+L(36)+L(37)+L(38)+L(39)+L(40)+L(41)+L(42)+L(43)+L(44)+L(45)+L(46)+L(47)+L(48)+L(49) \] 0

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<th>R3 - Asset Risk - Credit</th>
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<tbody>
<tr>
<td>(51) Other Credit RBC</td>
<td>PR012 L(5)C(2)-L(1)-L(2)C(2)</td>
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<tr>
<td>(52) One half of Rein Recoverables</td>
<td>0.5 x (PR012 L(1)+L(2)C(2))</td>
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<tr>
<td>(53) Other half of Rein Recoverables</td>
<td>If R4 L(57)&gt;R3 L(51)+R3 L(52), 0, otherwise, R3 L(52)</td>
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<td>(54) Health Credit Risk</td>
<td>PR013 L(12)C(2)</td>
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Total R3: \[ L(51)+L(52)+L(53)+L(54) \] 0
### CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE

**R4 - Underwriting Risk - Reserves**

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<th>RBC Amount</th>
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<td>(56)</td>
<td>One half of Reinsurance RBC</td>
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<td>(57)</td>
<td>Total Adjusted Unpaid Loss/Expense Reserve RBC</td>
<td>PR016</td>
<td>0</td>
</tr>
<tr>
<td>(58)</td>
<td>Excessive Premium Growth - Loss/Expense Reserve</td>
<td>PR024</td>
<td>0</td>
</tr>
<tr>
<td>(59)</td>
<td>A&amp;H Claims Reserves Adjusted for LCF</td>
<td>PR025</td>
<td>0</td>
</tr>
<tr>
<td>(60)</td>
<td>Total R4</td>
<td>L(56)+L(57)+L(58)+L(59)</td>
<td>0</td>
</tr>
</tbody>
</table>

**R5 - Underwriting Risk - Net Written Premium**

<table>
<thead>
<tr>
<th>Formula</th>
<th>Description</th>
<th>Reference</th>
<th>RBC Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(61)</td>
<td>Total Adjusted NWP RBC</td>
<td>PR018</td>
<td>0</td>
</tr>
<tr>
<td>(62)</td>
<td>Excessive Premium Growth - Written Premiums Charge</td>
<td>PR016</td>
<td>0</td>
</tr>
<tr>
<td>(63)</td>
<td>Total Net Health Premium RBC</td>
<td>PR022</td>
<td>0</td>
</tr>
<tr>
<td>(64)</td>
<td>Health Stabilization Reserves</td>
<td>PR025</td>
<td>0</td>
</tr>
<tr>
<td>(65)</td>
<td>Total R5</td>
<td>L(61)+L(62)+L(63)+L(64)</td>
<td>0</td>
</tr>
</tbody>
</table>

**Rcat - Catastrophe Risk**

<table>
<thead>
<tr>
<th>Formula</th>
<th>Description</th>
<th>Reference</th>
<th>RBC Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(66)</td>
<td>Total Rcat</td>
<td>PR027</td>
<td>0</td>
</tr>
<tr>
<td>(67)</td>
<td>Total RBC After Covariance Before Basic Operational Risk</td>
<td>R0+SQRT(R1^2+R2^2+R3^2+R4^2+R5^2+Rcat^2)</td>
<td>0</td>
</tr>
<tr>
<td>(68)</td>
<td>Basic Operational Risk = 0.030 x L(67)</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>(69)</td>
<td>C-4a of U.S. Life Insurance Subsidiaries (from Company records)</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>(70)</td>
<td>Net Basic Operational Risk = Line (68) - Line (69) (Not less than zero)</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>(71)</td>
<td>Total RBC After Covariance including Basic Operational Risk = L(67) + L(70)</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Formula</th>
<th>Description</th>
<th>Reference</th>
<th>RBC Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(72)</td>
<td>Authorized Control Level RBC including Basic Operational Risk = .5 x L(71)</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>NAC Designation Category</td>
<td>1A</td>
<td>1B</td>
<td>1C</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Current (2020)</td>
<td>0.3%</td>
<td>0.3%</td>
<td>0.3%</td>
</tr>
<tr>
<td>AAA Proposed</td>
<td>0.2%</td>
<td>0.4%</td>
<td>0.6%</td>
</tr>
<tr>
<td>%Change</td>
<td>-33.3%</td>
<td>33.3%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bond size factor proposed by Academy</th>
<th>Current Bond size factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size band</td>
<td>Issuers Factor</td>
</tr>
<tr>
<td>Up To</td>
<td>10</td>
</tr>
<tr>
<td>Next</td>
<td>90</td>
</tr>
<tr>
<td>Next</td>
<td>100</td>
</tr>
<tr>
<td>Next</td>
<td>300</td>
</tr>
<tr>
<td>Over</td>
<td>500</td>
</tr>
</tbody>
</table>
### 2020 RBC Charges by Company Size - Current verse Proposed (Academy) Bond RBC Charges (with Reclassification of Hybrid Securities)

<table>
<thead>
<tr>
<th>TAC Size</th>
<th>0 - $5M</th>
<th>$5M - $25M</th>
<th>$25M - $75M</th>
<th>$75M - $250M</th>
<th>$250M - $1B</th>
<th>Over $1B</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Adjusted Capital</td>
<td>684,515</td>
<td>9,592,253</td>
<td>26,021,963</td>
<td>57,842,654</td>
<td>127,266,401</td>
<td>900,864,013</td>
<td>1,122,221,799</td>
</tr>
<tr>
<td>R0 - Current</td>
<td>46,667</td>
<td>31,306</td>
<td>312,264</td>
<td>1,542,151</td>
<td>4,720,714</td>
<td>6,071,235</td>
<td>9,693,713</td>
</tr>
<tr>
<td>R1 - Proposed</td>
<td>6,561</td>
<td>84,410</td>
<td>270,047</td>
<td>1,350,514</td>
<td>7,019,341</td>
<td>9,925,498</td>
<td>12,820,041</td>
</tr>
<tr>
<td>R1 % Change</td>
<td>148.2%</td>
<td>108.7%</td>
<td>166.9%</td>
<td>162.1%</td>
<td>113.8%</td>
<td>48.2%</td>
<td>95.9%</td>
</tr>
<tr>
<td>R2 - Current (2020)</td>
<td>75,955</td>
<td>306,980</td>
<td>1,059,597</td>
<td>2,401,913</td>
<td>9,558,431</td>
<td>15,984,903</td>
<td>19,041,006</td>
</tr>
<tr>
<td>R2 - Proposed</td>
<td>95,955</td>
<td>329,980</td>
<td>1,079,597</td>
<td>2,401,913</td>
<td>9,558,431</td>
<td>15,984,903</td>
<td>19,041,006</td>
</tr>
<tr>
<td>R2 % Change</td>
<td>125.5%</td>
<td>105.3%</td>
<td>168.0%</td>
<td>145.9%</td>
<td>115.8%</td>
<td>82.5%</td>
<td>93.1%</td>
</tr>
<tr>
<td>R3 - Current</td>
<td>65,167</td>
<td>258,025</td>
<td>914,497</td>
<td>1,443,880</td>
<td>1,900,922</td>
<td>5,759,927</td>
<td>10,248,440</td>
</tr>
<tr>
<td>R4 - Current</td>
<td>383,941</td>
<td>740,177</td>
<td>2,343,271</td>
<td>7,423,651</td>
<td>19,030,888</td>
<td>98,396,748</td>
<td>128,318,675</td>
</tr>
<tr>
<td>R5 - Current</td>
<td>82,454</td>
<td>870,870</td>
<td>2,008,636</td>
<td>6,130,150</td>
<td>12,540,378</td>
<td>55,447,500</td>
<td>77,079,987</td>
</tr>
<tr>
<td>Rcat</td>
<td>4,268</td>
<td>293,618</td>
<td>1,035,798</td>
<td>2,373,169</td>
<td>5,750,623</td>
<td>45,165,271</td>
<td>54,622,745</td>
</tr>
<tr>
<td>ACL RBC - Current</td>
<td>266,814</td>
<td>898,288</td>
<td>2,561,218</td>
<td>7,037,246</td>
<td>18,039,209</td>
<td>155,532,161</td>
<td>184,334,936</td>
</tr>
<tr>
<td>ACL RBC - Proposed</td>
<td>268,107</td>
<td>931,600</td>
<td>2,634,848</td>
<td>7,152,488</td>
<td>18,155,000</td>
<td>155,815,086</td>
<td>184,957,128</td>
</tr>
<tr>
<td>ACL RBC % Change</td>
<td>0.5%</td>
<td>3.7%</td>
<td>2.5%</td>
<td>1.6%</td>
<td>0.6%</td>
<td>0.2%</td>
<td>0.3%</td>
</tr>
<tr>
<td># of Companies</td>
<td>238</td>
<td>750</td>
<td>566</td>
<td>422</td>
<td>260</td>
<td>145</td>
<td>2,381</td>
</tr>
</tbody>
</table>

### Distributions of Change in R1 Charges by Company Size under Proposed (Academy) Bond RBC Charges (with Reclassification of Hybrid Securities)

<table>
<thead>
<tr>
<th>% Change of R1</th>
<th>0 to 10%</th>
<th>10% to 20%</th>
<th>20% to 50%</th>
<th>Greater than 50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>2,381</td>
<td>1,035,798</td>
<td>2,373,169</td>
<td>5,750,623</td>
</tr>
</tbody>
</table>

### Notes
- Excluding Companies with Negative TAC
- RBC Charges (with Reclassification of Hybrid Securities)
- R1 (Proposed base factor only)
- Change from Current R1
- % Change from Current R1
- Additional change
- % Change from Current R1
- Distributions of Change in R1 Charges by Company Size under Proposed (Academy) Bond RBC Charges (with Reclassification of Hybrid Securities)

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### Distributions of Changes in ACL RBC by Company Size under Proposed (Academy) Bond RBC Charges (with Reclassification of Hybrid Securities)

(Excluding Companies with Negative TAC)

<table>
<thead>
<tr>
<th>ACL RBC % Change/LC</th>
<th>$0 - $5M</th>
<th>$5M - $25M</th>
<th>$25M - $75M</th>
<th>$75M - $250M</th>
<th>$250M - $1B</th>
<th>Over $1B</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than -50%</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>-50% to -25%</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>-25% to -15%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>-15% to -5%</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>-5% to 5%</td>
<td>2</td>
<td>22</td>
<td>16</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>56</td>
</tr>
<tr>
<td>5% to 15%</td>
<td>203</td>
<td>478</td>
<td>160</td>
<td>299</td>
<td>232</td>
<td>142</td>
<td>1,758</td>
</tr>
<tr>
<td>15% to 25%</td>
<td>7</td>
<td>67</td>
<td>32</td>
<td>20</td>
<td>10</td>
<td>1</td>
<td>117</td>
</tr>
<tr>
<td>25% to 50%</td>
<td>2</td>
<td>26</td>
<td>14</td>
<td>17</td>
<td>3</td>
<td>0</td>
<td>62</td>
</tr>
<tr>
<td>Greater than 50%</td>
<td>19</td>
<td>175</td>
<td>119</td>
<td>54</td>
<td>11</td>
<td>2</td>
<td>380</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>238</td>
<td>750</td>
<td>566</td>
<td>423</td>
<td>260</td>
<td>145</td>
<td>2,381</td>
</tr>
</tbody>
</table>

### Distributions of Changes in RBC Ratios by Company Size under Proposed (Academy) Bond RBC Charges (with Reclassification of Hybrid Securities)

(Excluding Companies with Negative TAC)

<table>
<thead>
<tr>
<th>RBC Ratio % Change/LC</th>
<th>$0 - $5M</th>
<th>$5M - $25M</th>
<th>$25M - $75M</th>
<th>$75M - $250M</th>
<th>$250M - $1B</th>
<th>Over $1B</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than -50%</td>
<td>16</td>
<td>136</td>
<td>82</td>
<td>28</td>
<td>7</td>
<td>2</td>
<td>271</td>
</tr>
<tr>
<td>-50% to -25%</td>
<td>5</td>
<td>55</td>
<td>46</td>
<td>36</td>
<td>6</td>
<td>0</td>
<td>146</td>
</tr>
<tr>
<td>-25% to -15%</td>
<td>2</td>
<td>23</td>
<td>18</td>
<td>12</td>
<td>4</td>
<td>0</td>
<td>54</td>
</tr>
<tr>
<td>-15% to -5%</td>
<td>8</td>
<td>55</td>
<td>31</td>
<td>25</td>
<td>9</td>
<td>1</td>
<td>129</td>
</tr>
<tr>
<td>-5% to 5%</td>
<td>203</td>
<td>480</td>
<td>387</td>
<td>321</td>
<td>254</td>
<td>142</td>
<td>1,767</td>
</tr>
<tr>
<td>5% to 15%</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>15% to 25%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Greater than 25%</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>238</td>
<td>750</td>
<td>566</td>
<td>423</td>
<td>260</td>
<td>145</td>
<td>2,381</td>
</tr>
</tbody>
</table>

### 2020 P&C RBC - Comparison of Action Levels by Company Size Between Current and Proposed (Academy) Bond RBC Charges (with Reclassification of Hybrid Securities)

(Excluding Companies with Negative TAC)

<table>
<thead>
<tr>
<th>MGL</th>
<th>AGU</th>
<th>AAL</th>
<th>CAL</th>
<th>Total</th>
<th>No Action</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>3</td>
<td>4</td>
<td>14</td>
<td>0</td>
<td>2</td>
<td>18</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Category</th>
<th>Book Value</th>
<th>Percentage</th>
<th>Current Risk Factor</th>
<th>Proposed Risk Factor</th>
<th>% Change in Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A</td>
<td>255,703,383,562</td>
<td>27.1%</td>
<td>0.003</td>
<td>0.002</td>
<td>-33.3%</td>
</tr>
<tr>
<td>1B</td>
<td>63,666,739,646</td>
<td>6.7%</td>
<td>0.003</td>
<td>0.004</td>
<td>33.3%</td>
</tr>
<tr>
<td>1C</td>
<td>81,152,983,206</td>
<td>8.6%</td>
<td>0.003</td>
<td>0.006</td>
<td>100.0%</td>
</tr>
<tr>
<td>1D</td>
<td>83,707,799,486</td>
<td>8.9%</td>
<td>0.003</td>
<td>0.008</td>
<td>166.7%</td>
</tr>
<tr>
<td>1E</td>
<td>53,762,688,175</td>
<td>5.7%</td>
<td>0.003</td>
<td>0.010</td>
<td>233.3%</td>
</tr>
<tr>
<td>1F</td>
<td>88,813,399,627</td>
<td>9.4%</td>
<td>0.003</td>
<td>0.013</td>
<td>333.3%</td>
</tr>
<tr>
<td>1G</td>
<td>64,846,819,508</td>
<td>6.9%</td>
<td>0.003</td>
<td>0.015</td>
<td>400.0%</td>
</tr>
<tr>
<td>2A</td>
<td>76,354,389,147</td>
<td>8.1%</td>
<td>0.010</td>
<td>0.018</td>
<td>80.0%</td>
</tr>
<tr>
<td>2B</td>
<td>72,711,346,719</td>
<td>7.7%</td>
<td>0.010</td>
<td>0.021</td>
<td>110.0%</td>
</tr>
<tr>
<td>2C</td>
<td>46,811,089,487</td>
<td>5.0%</td>
<td>0.010</td>
<td>0.025</td>
<td>150.0%</td>
</tr>
<tr>
<td>3A</td>
<td>9,568,228,547</td>
<td>1.0%</td>
<td>0.020</td>
<td>0.055</td>
<td>175.0%</td>
</tr>
<tr>
<td>3B</td>
<td>9,318,628,752</td>
<td>1.0%</td>
<td>0.020</td>
<td>0.060</td>
<td>200.0%</td>
</tr>
<tr>
<td>3C</td>
<td>10,726,858,935</td>
<td>1.1%</td>
<td>0.020</td>
<td>0.066</td>
<td>230.0%</td>
</tr>
<tr>
<td>4A</td>
<td>5,433,699,582</td>
<td>0.6%</td>
<td>0.045</td>
<td>0.071</td>
<td>57.8%</td>
</tr>
<tr>
<td>4B</td>
<td>11,598,731,578</td>
<td>1.2%</td>
<td>0.045</td>
<td>0.077</td>
<td>71.1%</td>
</tr>
<tr>
<td>4C</td>
<td>5,367,195,481</td>
<td>0.6%</td>
<td>0.045</td>
<td>0.087</td>
<td>93.3%</td>
</tr>
<tr>
<td>5A</td>
<td>1,567,651,355</td>
<td>0.2%</td>
<td>0.100</td>
<td>0.098</td>
<td>-2.0%</td>
</tr>
<tr>
<td>5B</td>
<td>3,018,927,015</td>
<td>0.3%</td>
<td>0.100</td>
<td>0.109</td>
<td>9.0%</td>
</tr>
<tr>
<td>5C</td>
<td>332,366,273</td>
<td>0.0%</td>
<td>0.100</td>
<td>0.120</td>
<td>20.0%</td>
</tr>
<tr>
<td>6</td>
<td>575,169,235</td>
<td>0.1%</td>
<td>0.300</td>
<td>0.300</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Total 945,038,095,316 100.0%
Capital Adequacy (E) Task Force
Virtual Meeting
April 29, 2021

The Capital Adequacy (E) Task Force met April 29, 2021. The following Task Force members participated: Judith L. French, Chair, represented by Tom Botsko (OH); Doug Slape, Vice Chair, represented by Rachel Hemphill (TX); Lori K. Wing-Heier represented by Wally Thomas (AK); Jim L. Ridling represented by Richard Ford (AL); Ricardo Lara represented by Thomas Reedy (CA); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by Philip Barlow (DC); David Altmaier represented by Carolyn Morgan (FL); Doug Ommen represented by Carrie Mears (IA); Dana Popish Severinghaus represented by Kevin Fry (IL); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Jeff Gaither (KY); Chlora Lindley-Myers represented by John Rehagen (MO); Mike Causey represented by Jackie Obusek (NC); Eric Dunning represented Lindsay Crawford (NE); Marlene Caride represented by Diana Sherman (NJ); Glen Mulready represented by Diane Carter (OK); Mike Kreidler represented by Steve Drutz (WA); and Mark Afable represented by Randy Milquet (WI).

1. Exposed Proposal 2021-07-CA

Mr. Botsko said the Task Force agreed to conduct a weighted average every three years for the receivables for securities factor. The analysis and proposed factor will be exposed for a 30-day public comment period ending May 28.

2. Exposed Proposal 2021-04-CA Investment Income in Health Underwriting Factors

Mr. Drutz said the purpose of Proposal 2021-04-CA is to incorporate investment income into the underwriting risk factors for Columns 1–4 on the Experience Fluctuation Risk page. The proposal was previously exposed at the Working Group level for a 30-day public comment period. The Life Risk-Based Capital (E) Working Group received two comment letters and discussed those on its April 23 call. The Working Group agreed to move forward with the 0.5% investment yield return. The Working Group asked that the Task Force re-expose the proposal for health—that incorporates the changes for the life and property/casualty (P/C) formulas—for a 23-day public comment period ending May 21, with comments to come back to the Working Group.

3. Adopted Proposal 2021-01-L (Real Estate Structure)

Mr. Barlow said proposal 2021-01-L was exposed and adopted by the Life Risk-Based Capital (E) Working Group on its April 6 call. The purpose of this proposed is to update the experience and analysis since it was first developed.

Mr. Barlow made a motion, seconded by Mr. Chou, to adopt proposal 2021-01-L (Real Estate Structure) (Attachment Two-A). The motion passed unanimously.

Nancy Bennett (American Academy of Actuaries—Academy) clarified that the verbiage shown in the proposal for Schedule BA real estate “use same factor” is not part of the current exposure for the real estate language. Mr. Barlow concurred.

4. Adopted Proposal 2021-02-CA (Managed Care Credit Incentives)

Mr. Drutz said proposal 2021-02-CA provides clarifying language for the inclusion of incentives in the Managed Care Credit instructions and blank. The proposal was exposed by the Task Force, and no comments were received.

Mr. Drutz made a motion, seconded by Mr. Barlow, to adopt proposal 2021-02-CA (Attachment Two-B). The motion passed unanimously.

5. Adopted Proposal 2021-03-P (Credit Risk Instruction Modification)

Mr. Botsko said the purpose of proposal 2021-03-P is to provide examples to clarify how the reporting companies should select the designation in the Annual Statement Schedule F, Part 3, Reinsurer Designation Equivalent Rating column if the reporting entities subscribe to one or multiple rating agencies. He also stated that the Life Risk-Based Capital (E) Working Group received no comments during the exposure period.

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Mr. Chou made a motion, seconded by Mr. Milquet, to adopt proposal 2021-03-P (Attachment Two-C). The motion passed unanimously.

6. Adopted its Working Agenda

Mr. Drutz summarized the changes to the 2021 health risk-based capital (RBC) working agenda, which included the substantial change to add an item to work with the Academy to perform a comprehensive review of the H2 – Underwriting Risk Component, along with the Managed Care Credit.

Mr. Barlow summarized the change to the Life Risk-Based Capital (E) Working Group’s 2021 working agenda, which was to remove items that have been addressed by the Working Group.

Mr. Botsko added that the Task Force continues to address the items on its working agenda as they are prioritized and reflect the completion of items that were referred to the Working Group.

Mr. Chou made a motion, seconded by Mr. Drutz, to adopt the Task Force’s working agenda (Attachment Two-D). The motion passed unanimously.

Having no further business, the Capital Adequacy (E) Task Force adjourned.
Capital Adequacy (E) Task Force
RBC Proposal Form

DATE: January 21, 2021

CONTACT PERSON: Steve Clayburn
TELEPHONE: (202) 624-2197
EMAIL ADDRESS: steveclayburn@acli.com
ON BEHALF OF: American Council of Life Insurers (ACLI)
NAME: Steve Clayburn
TITLE: Senior Actuary, Health Insurance & Reinsurance
AFFILIATION: ACLI
ADDRESS:

FOR NAIC USE ONLY
Agenda Item # 2021-01-L
Year 2021

DISPOSITION
[ x ] ADOPTED 4-29-21 - CADTF
[ ] REJECTED
[ ] DEFERRED TO
[ ] REFERRED TO OTHER NAIC GROUP
[ ] EXPOSED
[ ] OTHER (SPECIFY)

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED
[ ] Health RBC Blanks [ ] Property/Casualty RBC Blanks [X] Life and Fraternal RBC Instructions
[ ] Health RBC Instructions [ ] Property/Casualty RBC Instructions [X] Life and Fraternal RBC Blanks
[ ] OTHER

DESCRIPTION OF CHANGE(S)
To update the RBC calculation for Real Estate to reflect updated experience and analysis since RBC was first developed. The factors and instructions included are not final, with the exception of the structure which is included and presented in Figure 7, and will be addressed with a separate proposal.

REASON OR JUSTIFICATION FOR CHANGE **
When RBC was developed, there was limited experience on the default and loss for commercial real estate. Since then data sources have been compiled and tracked in the industry, and can now be accessed to provide more meaningful analysis and information for development of capital standards.

Additional Staff Comments:

** This section must be completed on all forms.
1. REAL ESTATE

Basis of Factors

Companies that have developed their own risk-based capital factors for real estate have used a range of factors from 5 percent to 20 percent. One study indicated real estate volatility is about 60 percent of common stock, suggesting a factor in the range of 18 percent. Assuming a full tax effect for losses, a pre-tax factor of 15 percent was chosen. Foreclosed real estate would carry a somewhat higher risk at 23 percent pre-tax. Schedule BA real estate also has a 23 percent factor pre-tax because of the additional risks inherent in owning real estate through a partnership. The pre-tax factors were developed by dividing the post-tax factor by 0.65 (0.65 is calculated by taking 1.0 less 0.35). The pre-tax factors are not changing for 2018 due to tax reform. The base factor for equity real estate of [10%] was developed by adding a margin for conservatism to the results of an analysis of real estate performance over the period of 1978 – 2012. The analysis was conducted by a group of life insurance company real estate investment professionals coordinated by the ACLI. The data used was a national database of real property owned by investment fiduciaries and supplemented by data on real estate backing mortgage securities. The analysis is documented in a report to the NAIC dated April 9, 2017. In addition to modifying the factor for company owned and investment real estate, this updated factor will also be used for real estate acquired in satisfaction of debt (Foreclosed real estate) and for assets with the characteristics of real held estate (partnership or other structure) reported on Schedule BA. Foreclosed real estate is recognized in the statutory statements as having acquisition cost equal to market value at time of foreclosure. Schedule BA real estate was originally given a higher factor under a presumption that it was more highly levered. Analysis has shown these assets to have experience very similar to directly held and will therefore use the same factor.

While the experience analysis was done based on analysis of fair value impacts, Real Estate is reported at depreciated cost in the Statutory statements. Therefore, beginning in 2021 an adjustment is made to the factor to partially account for the difference between fair value and statutory carrying value on a property by property basis. The adjustment is defined as

\[
\text{Adj Factor} = \text{RE Factor} \times (1 - \text{factor} \times \frac{\text{MV-BVg}}{\text{BVg}})
\]

factor is [2/3]

The resulting adjusted RBC factor is subject to a minimum of zero. In the RBC calculation, see Figure 7, fair value is taken from Schedule A Column 10 plus encumbrances, or from Schedule BA column 11 plus encumbrances, respectively, while BVg is the net Book Adjusted Carrying Value plus the encumbrance.

Encumbrances have been included in the real estate base since the value of the property is held net of the encumbrance, but the entire value is subject to loss would include encumbrances. Encumbrances receive a base real estate factor of [10%] reduced by the average factor for commercial mortgages of 1.752 percent pre-tax, In the past this was computed as a base factor applied to the net real estate value plus a separate factor applied to the amount of the encumbrance. Beginning in 2021, the equivalent result will be obtained by applying a base factor to the gross statutory value of the property, and a credit provided for the amount of the encumbrance for real estate encumbrances not in foreclosure and 20 percent pre-tax for real estate encumbrances in foreclosure and encumbrances on Schedule BA real estate.

The final RBC amount is subject to a minimum of the Baa bond factor (1.30%) applied to the BACV, and a maximum of 45% of the BACV.

All references to involuntary reserves as it relates to real estate were removed to comply with the codification of statutory accounting principles.

Specific Instructions for Application of the Formula

Column (1)

Calculations are done on an individual property or joint venture basis in the worksheets and then the summary amounts are entered in this column for each class of real estate investment. Refer to the real estate calculation worksheet (Figure 7) for how the individual property or joint venture calculations are completed.
Low income housing tax credit investments are reported in Column (1) in accordance with SSAP No. 93—Low Income Housing Tax Credit Property Investments.

Column (2)
The average factor column is calculated as Column (3) divided by Column (1).

Column (3)
Summary amounts are entered for Column (3) based on calculations done on an individual property or joint venture basis. Refer to Column (8) of the real estate calculation worksheet (Figure 7).

Line (17)
Guaranteed federal low-income housing tax credit (LIHTC) investments are to be included in Line (17). There must be an all-inclusive guarantee from an ARO-rated entity that guarantees the yield on the investment.

Line (18)
Non-guaranteed federal LIHTC investments with the following risk mitigation factors are to be included in Line (18):
   a) A level of leverage below 50 percent. For a LIHTC Fund, the level of leverage is measured at the fund level.
   b) There is a tax credit guarantee agreement from general partner or managing member. This agreement requires the general partner or managing member to reimburse investors for any shortfalls in tax credits due to errors of compliance, for the life of the partnership. For an LIHTC fund, a tax credit guarantee is required from the developers of the lower-tier LIHTC properties to the upper-tier partnership.

Line (19)
State LIHTC investments that at a minimum meet the federal requirements for guaranteed LIHTC investments.

Line (20)
State LIHTC investments that at a minimum meet the federal requirements for non-guaranteed LIHTC investments.

Line (21)
State and federal LIHTC investments that do not meet the requirements of lines (17) through (20) would be reported on Line (21).
<table>
<thead>
<tr>
<th>Description</th>
<th>RBC Requirement</th>
<th>Encumbrances</th>
<th>Fair Value</th>
<th>RBC Factor</th>
<th>Adjusted RBC Factor</th>
<th>Gross RBC Factor</th>
<th>Fair Value Requirement</th>
<th>Credit Requirement</th>
<th>RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company Occupied Real Estate</td>
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<td>All Properties Without Encumbrances</td>
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<td>Investment Real Estate</td>
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</tbody>
</table>
Schedule BA Assets with characteristics of Real Estate
XXX 0.10230 XXX

Note that column (2) is the book/adjusted carrying value net of any encumbrances, while column (4) is the fair value of the property not reduced for any encumbrances. 
† For each category, each property Line (1) should also exclude properties or joint ventures that have a negative book/adjusted carrying value. These should be listed individually, including those for which there is no encumbrance.
‡ Column (7) is Column (5) times (1-factor) * (Column (4) – (Column (2) + Column (3))) / (Column (2) + Column (3)), but not less than zero.
§ Column (97) is calculated as Column (3) multiplied by Column (65).
* Column (108) is calculated as the sum of Column (96) minus Column (95), but not less than zero or more than Column (2) * 1.3% nor more than 4.5% of column (2), and not less than zero.
# Capital Adequacy (E) Task Force

## RBC Proposal Form

| [ ] | Catastrophe Risk (E) Subgroup | [ ] | Investment RBC (E) Working Group | [ ] | Longevity Risk (A/E) Subgroup |
| [ ] | C3 Phase II/ AG43 (E/A) Subgroup | [ ] | P/C RBC (E) Working Group |

**DATE:** 1-28-21  
**CONTACT PERSON:** Crystal Brown  
**TELEPHONE:** 816-783-8146  
**EMAIL ADDRESS:** cbrown@naic.org  
**ON BEHALF OF:** Health RBC (E) Working Group  
**NAME:** Steve Drutz  
**TITLE:** Chief Financial Analyst/Chair  
**AFFILIATION:** WA Office of Insurance Commissioner  
**ADDRESS:** PO Box 40255  
  Olympia, WA 98504-0255

**FOR NAIC USE ONLY**  
**Agenda Item # 2021-02-CA**  
**Year:** 2021  
**DISPOSITION**  
[ x ] ADOPTED 4-29-21 - CADTF  
[ ] REJECTED  
[ ] DEFERRED TO  
[ ] REFERRED TO OTHER NAIC GROUP  
[ ] EXPOSED  
[ ] OTHER (SPECIFY)

### IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

| [x] | Health RBC Blanks | [x] | Property/Casualty RBC Blanks | [x] | Life and Fraternal RBC Instructions |
| [x] | Health RBC Instructions | [x] | Property/Casualty RBC Instructions | [x] | Life and Fraternal RBC Blanks |
| [ ] | OTHER __________________________ |

### DESCRIPTION OF CHANGE(S)

Incorporate references for “Incentives” under the managed care instructions and blank as “Bonuses/Incentives.”

### REASON OR JUSTIFICATION FOR CHANGE **

Currently the managed care instructions and blank only reference the bonuses, this change would clarify that both incentives and bonuses are to be included.

### Additional Staff Comments:

02-10-21 cbg The Proposal was exposed to the Health Risk-Based Capital (E) Working Group for a 30-day comment period that ends on Mar. 12, 2021.  
03-17-21 cbg No comments were received during the comment period. The Working Group referred the proposal to the Capital Adequacy (E) Task Force for a 30-day comment period for all lines of business, with any comments to come back to the Working Group.  
03-23-21 cbg The Capital Adequacy (E) Task Force exposed the proposal for a 30-day comment period ending on 4/22/21.  
4/23/21 cbg No comments were received during the exposure period.  

** This section must be completed on all forms.  
Revised 2-2019

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1
The effect of managed care arrangements on the variability of underwriting results is the fundamental difference between health entities and pure indemnity carriers. The managed care credit is used to reduce the RBC requirement for experience fluctuations. It is important to understand that the managed care credit is based on the reduction in uncertainty about future claims payments, not on any reduction in the actual level of cost. Those managed care arrangements that have the greatest reduction in the uncertainty of claim payments receive the greatest credit, while those that have less effect on the predictability of claims payments engender less of a discount.

There are currently five levels of managed care that are used in the formula, other than for Medicare Part D Coverage, although in the future as new managed care arrangements evolve, the number of categories may increase, or new arrangements may be added to the existing categories. The managed care categories are:

- Category 0 – Arrangements not Included in Other Categories
- Category 1 – Contractual Fee Payments
- Category 2 – Bonus and/or Incentives / Withhold Arrangements
- Category 3 – Capitation
- Category 4 – Non-Contingent Expenses and Aggregate Cost Arrangements and Certain PSO Capitated Arrangements

For Medicare Part D Coverage, the reduction in uncertainty comes from two federal supports. The reinsurance coverage is optional in that a plan sponsor may elect to participate in the Part D Payment Demonstration. The risk corridor protection is expected to have less impact after the first few years. To allow flexibility within the RBC formula, Lines (10) through (13) will be used to give credit for the programs in which the plan sponsor participates. While all PDPs will have formularies and may utilize other methods to reduce uncertainty, for the near future, no other managed care credits are allowed for this coverage.

The managed care credit is based on the percentage of paid claims that fall into each of these categories. Total claims payments are allocated among these managed care “buckets” to determine the weighted average discount, which is then used to reduce the Underwriting Risk-Experience Fluctuation RBC. Paid claims are used instead of incurred claims due to the variability of reserves (unpaid claims) in incurred claim amounts and the difficulty in allocating reserves (unpaid claims) by managed care category.

In some instances, claim payments may fit into more than one category. If that occurs, enter the claim payments into the highest applicable category. CLAIM PAYMENTS CAN ONLY BE ENTERED INTO ONE OF THESE CATEGORIES! The total of the claim payments reported in the Managed Care Credit Calculation page should equal the total year’s paid claims.

Line (1) – Category 0 – Arrangements not Included in Other Categories. There is a zero managed care credit for claim payments in this category, which includes:

- Fee for service (charges)
- Discounted FFS (based upon charges)
- Usual Customary and Reasonable (UCR) Schedules
- Relative Value Scales (RVS) where neither payment base nor RV factor is fixed by contract or where they are fixed by contract for one year or less
- Stop-loss payments by a health entity to its providers that are capitated or subject to withhold incentive programs
- Retroactive payments to capitated providers or intermediaries whether by capitation or other payment method (excluding retroactive withholds later released to the provider and retroactive payments made solely because of a correction to the number of members within the capitated agreement)
- Capitation paid to providers or intermediaries that have received retroactive payments for previous years (including bonus arrangements on capitation programs)
This amount should equal Exhibit 7, Part 1, Column 1, Line 5 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (2) - Category 1 – Payments Made According to Contractual Arrangements. There is a 15 percent managed care credit for payments included in this category:

- Hospital per diems, DRGs or other hospital case rates.
- Non-adjustable professional case and global rates.
- Provider fee schedules.
- RVS where the payment base and RV factor are fixed by contract for more than one year.
- Ambulatory payment classifications (APCs).

This amount should equal Exhibit 7, Part 1, Column 1, Line 6 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (3) - Category 2a - Payments Made Subject to Withholds or Bonuses/Incentives With No Other Managed Care Arrangements. This category may include business that would have otherwise fit into Category 0. That is, there may be a bonus/incentive withhold arrangement with a provider who is reimbursed based on a UCR schedule (Category 0).

The maximum Category 2a managed care credit is 25 percent. The credit is based upon a calculation that determines the ratio of withhold and bonuses and/or incentives paid to providers during the prior year to total withholds and bonuses and incentives available to the providers during that year. That ratio is then multiplied by the average provider withhold ratio for the prior year to determine the current year’s Category 2a managed care credit factor. Bonus and/or incentive payments that are not related to financial results are not included (e.g., patient satisfaction). Therefore, the credit factor is equal to the result of the following calculation:

EXAMPLE – 2019 Reporting Year

<table>
<thead>
<tr>
<th>2018 withhold / bonus/incentive payments</th>
<th>750,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018 withholds / bonuses/incentives available</td>
<td>1,000,000</td>
</tr>
<tr>
<td>A. MCC Factor Multiplier</td>
<td>75% – Eligible for credit</td>
</tr>
<tr>
<td>2018 withhold / bonuses/incentives available</td>
<td>1,000,000</td>
</tr>
<tr>
<td>2018 claims subject to withhold - gross*</td>
<td>5,000,000</td>
</tr>
<tr>
<td>B. Average Withhold Rate</td>
<td>20%</td>
</tr>
<tr>
<td>Category 2 Managed Care Credit Factor (A x B)</td>
<td>15%</td>
</tr>
</tbody>
</table>

The resulting factor is multiplied by claim payments subject to withhold - net** in the current year.

** These are amounts due before deducting withhold or paying bonuses, and/or incentives.
** These are actual payments made after deducting withhold or paying bonuses, and/or incentives.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives, but otherwise had no managed care arrangements. This amount should equal Exhibit 7, Part 1, Column 7 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).
Line (4) – Category 2b – Payments Made Subject to Withholds or Bonuses/Incentives That Are Otherwise Managed Care Category 1. Category 2b may include business that would have otherwise fit into Category 1. That is, there may be a bonus/incentives withhold arrangement with a provider who is reimbursed based on a provider fee schedule (Category 1). The Category 2 discount for claim payments that would otherwise qualify for Category 1 is the greater of the Category 1 factor or the calculated Category 2 factor.

The maximum Category 2b managed care credit is 25 percent. The minimum of Category 2b managed care credit is 15 percent (Category 1 credit factor). The credit calculation is the same as found in the previous example for Category 2a.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives AND where the payments were made according to one of the contractual arrangements listed for Category 1. This amount should equal Exhibit 7, Part 1, Column 1, Line 8 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (5) – Category 3a – Capitated Payments Directly to Providers. There is a managed care credit of 60 percent for claims payments in this category, which includes:

- All capitation or percent of premium payments directly to licensed providers.

Enter the amount of claim payments paid DIRECTLY to licensed providers on a capitated basis. This amount should equal Exhibit 7, Part 1, Column 1, Line 1 + Line 3 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (6) – Category 3b – Capitated Payments to Regulated Intermediaries. There is a managed care credit of 60 percent for claim payments in this category, which includes:

- All capitation or percent of premium payments to intermediaries that in turn pay licensed providers.

Enter the amount of medical expense capitations paid to regulated intermediaries. An intermediary is a person, corporation or other business entity (not licensed as a medical provider) that arranges, by contracts with physicians and other licensed medical providers, to deliver health services for a health entity and its enrollees via a separate contract between the intermediary and the health entity. This includes affiliates of a health entity that are not subject to RBC, except in those cases where the health entity qualifies for a higher managed care credit because the capitated affiliate employs providers and pays them non-contingent salaries, and where the affiliated intermediary has a contract only with the affiliated health entity. A Regulated Intermediary is an intermediary (affiliated or not) subject to state regulation and files the Health RBC formula with the state.

Line (7) – Category 3c – Capitated Payments to Non-Regulated Intermediaries. There is a managed care credit of 60 percent for claim payments in this category, which includes:

- All capitation or percent of premium payments to intermediaries that in turn pay licensed providers. (Subject to a 5 percent limitation on payments to providers or other corporations that have no contractual relationship with such intermediary. Amounts greater than the 5 percent limitation should be reported in Category 0.)

Enter the amount of medical expense capitations paid to non-regulated intermediaries.

IN ORDER TO QUALIFY FOR ANY OF THE CAPITATION CATEGORIES, SUCH CAPITATION MUST BE FIXED (AS A PERCENTAGE OF PREMIUM OR FIXED DOLLAR AMOUNT PER MEMBER) FOR A PERIOD OF AT LEAST 12 MONTHS. Where an arrangement contains a provision for prospective revision within a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under category 1 for a provider, and for an intermediary at the greater of category 1 or a credit calculated using the underlying payment method(s) to the providers of care. Where an arrangement contains a provision for retroactive revisions...
either within or beyond a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under category 0 for both providers and intermediaries.

**Line (8) – Category 4 – Medical & Hospital Expense Paid as Salary to Providers:** There is a managed care credit of 75 percent for claim payments in this category. Once claim payments under this managed care category are totaled, any fee for service revenue from uninsured plans (i.e., ASO or ASC) that was included on line 7 in the Underwriting Risk section should be deducted before applying the managed care credit factor. This category includes:

- Non-contingent salaries to persons directly providing care.
- The portion of payments to affiliated entities, which is passed on as non-contingent salaries to persons directly providing care where the entity has a contract only with its affiliated health entity.
- All facilities related medical expenses and other non-provider medical costs generated within a health facility that is owned and operated by the health entity.
- Aggregate cost payments.

Salaries paid to doctors and nurses whose sole corporate purpose is utilization review are also included in this category if such payments are classified as "medical expense" payments (paid claims) rather than administrative expenses. The "aggregate cost" method of reimbursement means where a health plan has a reimbursement plan with a corporate entity that directly provides care, where (1) the health plan is contractually required to pay the total operating costs of the corporate entity, less any income to the entity from other users of services, and (2) there are mutual unlimited guarantees of solvency between the entity and the health plan, which put their respective capital and surplus at risk in guaranteeing each other.

This amount should equal Exhibit 7, Part 1, Column 1, Line 9 + Line 10 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

**Line (9) – Sub-Total Paid Claims:** The total of paid claims for Comprehensive Medical, Medicare Supplement and Dental should equal the total paid claims for the year as reported in Exhibit 7, Part 1, Column 1, Line 13 less Line 11 of the annual statement and the sum of Lines (8.3), (12) and (13) on page XR017 – Underwriting Risk – Managed Care Credit.

**Line (10) – Category 0 – No Federal Reinsurance or Risk Corridor Protection:** Category 0 for Medicare Part D Coverage would be all claims during a period where neither the reinsurance coverage or risk corridor protection is provided.

**Line (11) – Category 1 – Federal Reinsurance but no Risk Corridor Protection:** Category 1 for Medicare Part D Coverage would be all claims during a period when only the reinsurance coverage is provided. This is designed for some future time period and is not to be interpreted as including employer-based Part D coverage that is not subject to risk corridor protection.

**Line (12) – Category 2a – No Federal Reinsurance but Risk Corridor Protection:** Category 2a for Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

**Line (13) – Category 3a – Federal Reinsurance and Risk Corridor Protection:** Category 3a for Medicare Part D Coverage would be for all claims during a period when both reinsurance coverage and risk corridor protection are provided.

**Line (14) – Sub-Total Paid Claims:** The total paid claims for Medicare Part D Coverage, excluding supplemental benefits.

**Line (16) – Weighted Average Managed Care Discount:** These amounts are calculated by dividing the total weighted claims by the comparable sub-total claim payments. For Column (3), this is Column (3), Line (9) divided by Column (2), Line (9). For Column (4), this is Column (4) Line (14) divided by Column (2), Line (14).
Line (17) - Weighted Average Managed Care Risk Adjustment Factor. These are the credit factors that are carried back to the underwriting risk calculation. They are one minus the Weighted Average Managed Care Discount values in Line (16).

Lines (18) through (24) are the calculation of the weighted average factor for the Category 2 claims payments subject to withholds and bonuses/incentives. This table requires data from the PRIOR YEAR to compute the current year’s discount factor. These do not apply to Medicare Part D coverage.

Line (18) - Withhold & Bonus Incentive Payments, prior year. Enter the prior year’s actual withhold and bonus/incentive payments.

Line (19) - Withhold & Bonuses Incentives Available, prior year. Enter the prior year's withholds and bonuses/incentives that were available for payment in the prior year.

Line (20) - MCC Multiplier - Average Withhold Returned. Divides Line (18) by Line (19) to determine the portion of withholds and bonuses/incentives that were actually returned in the prior year.

Line (21) - Withholds & Bonuses Incentives Available, prior year. Equal to Line (19) and is automatically pulled forward.

Line (22) - Claims Payments Subject to Withhold, prior year. Claim payments that were subject to withholds and bonuses/incentives in the prior year. Equal to Line (3) + Line (4) of the managed care credit claims payment table FOR THE PRIOR YEAR.

Line (23) - Average Withhold Rate, prior year. Divides Line (21) by Line (22) to determine the average withhold rate for the prior year.

Line (24) - MCC Discount Factor, Category 2. Multiplies Line (20) by Line (23) to determine the discount factor for Category 2 claims payments in the current year, based on the performance of the health entity’s withhold/bonus/incentive program in the prior year.
LIFE

UNDERWRITING RISK - MANAGED CARE CREDIT
LR022

This worksheet LR022 Underwriting Risk – Managed Care Credit is optional. It may be completed for only part of the comprehensive medical dental business, Stand-Alone Medicare Part D Coverage or all of them. Line (1) will be filled in as the balancing item if any of Lines (2) through (8) are entered (and then Line (9) will be required).

The effect of managed care arrangements on the variability of underwriting results is the fundamental difference between coverages subject to the managed care credit and pure indemnity insurance. The managed care credit is used to reduce the RBC requirement for experience fluctuations. It is important to understand that the managed care credit is based on the reduction in uncertainty about future claims payments, not on any reduction in the actual level of cost. Those managed care arrangements that have the greatest reduction in the uncertainty of claims payments receive the greatest credit, while those that have less effect on the predictability of claims payments engender less of a discount.

There are five levels of managed care that are used in the RBC formulas other than for Stand-Alone Medicare Part D Coverage, although in the future as new managed care arrangements evolve, the number of categories may increase or new arrangements may be added to the existing categories. The managed care categories are:

- Category 0 - Arrangements not Included in Other Categories
- Category 1 - Contractual Fee Payments
- Category 2 - Bonus and/or incentives / Withhold Arrangements
- Category 3 - Capitation
- Category 4 - Non-contingent Expenses and Aggregate Cost Arrangements and Certain PSO Capitated Arrangements

For Stand-Alone Medicare Part D Coverage, the reduction in uncertainty comes from two federal supports. The reinsurance coverage is optional in that a plan sponsor may elect to participate in the Part D Payment Demonstration. The risk corridor protection is expected to have less impact after the first few years. To allow flexibility within the RBC formula, Lines (10) through (13) will be used to give credit for the programs in which the plan sponsor participates. While all PDPs will have formularies and may utilize other methods to reduce uncertainty, for the near future no other managed care credits are allowed for this coverage.

The managed care credit is based on the percentage of paid claims that fall into each of these categories. Total claims payments are allocated among these managed care “buckets” to determine the weighted average discount, which is then used to reduce the Underwriting Risk-Experience Fluctuation RBC. Paid claims are used instead of incurred claims due to the variability of reserves (unpaid claims) in incurred claim amounts and the difficulty in allocating reserves (unpaid claims) by managed care category.

In some instances, claims payments may fit into more than one category. If that occurs, enter the claims payments into the highest applicable category. CLAIMS PAYMENTS CAN ONLY BE ENTERED INTO ONE OF THESE CATEGORIES! The total of the claims payments reported in the managed care worksheet should equal the total year’s paid claims. Category 2a, Category 2b and Category 3c are not allowed to include non-regulated intermediaries who are affiliated with the reporting company in order to insure that true risk transfer is accomplished.

Line (1)
Category 0 - Arrangements not Included in Other Categories. There is a zero managed care credit for claim payments in this category, which includes:
- Fee for service (charges).
- Discounted fee for service (based upon charges).
Usual customary and reasonable (UCR) schedules.
Relative value scale (RVS), where neither payment base nor RV factor is fixed by contract or where they are fixed by contract for one year or less.
Retroactive payments to capitated providers or intermediaries whether by capitation or other payment method (excluding retroactive withholds later released to the provider and retroactive payments made solely because of a correction to the number of members within the capitated agreement).
Capitation paid to providers or intermediaries that have received retroactive payments for previous years (including bonus arrangements on capitation programs).
Claim payments not included in other categories.

Line (2)
Category 1 - Payments Made According to Contractual Arrangements. There is a 15 percent managed care credit for payments included in this category:
- Hospital per diems, diagnostic related groups (DRGs) or other hospital case rates.
- Non-adjustable professional case and global rates.
- Provider fee schedules.
- Relative value scale (RVS), where the payment base and RV factor are fixed by contract for more than one year.

Line (3)
Category 2a - Payments Made Subject to Withholds or Bonuses with No Other Managed Care Arrangements. This category may include business that would have otherwise fit into Category 0. That is, there may be a bonus/incentive withhold arrangement with a provider who is reimbursed based on a UCR schedule (Category 0).

The maximum Category 2a managed care credit is 25 percent. The credit is based upon a calculation that determines the ratio of withheld returned and bonuses and/or incentives paid to providers during the prior year to total withholds and bonuses and incentives available to the providers during that year. That ratio is then multiplied by the average provider withhold ratio for the prior year to determine the current year’s Category 2a managed care credit factor. Bonus and/or incentive payments that are not related to financial results are not included (e.g., patient satisfaction). Therefore, the credit factor is equal to the result of the following calculation:

\[
\text{Category 2 Managed Care Credit Factor (A x B)} = \frac{\text{1997 withhold / bonus/incentive payments}}{\text{1997 withhold / bonus/incentive available}} \times \frac{\text{1997 claims subject to withhold - gross}}{\text{average Withhold Rate}}
\]

The resulting factor is multiplied by claims payments subject to withhold - net in the current year.

† These are amounts due before deducting withhold or paying bonuses and/or incentives.
‡ These are actual payments made after deducting withhold or paying bonuses and/or incentives.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses, but otherwise had no managed care arrangements.

Line (4)
Category 2b - Payments Made Subject to Withholds or Bonuses/Incentives That Are Otherwise Managed Care Category 1. Category 2b may include business that would have otherwise fit into Category 1. That is, there may be a bonus/incentive withhold arrangement with a provider who is reimbursed based on a provider fee schedule (Category 1). The Category 2 discount for claims payments that would otherwise qualify for Category 1 is the greater of the Category 1 factor or the calculated Category 2 factor.

The maximum Category 2b managed care credit is 25 percent. The minimum of Category 2b managed care credit is 15 percent (Category 1 credit factor). The credit calculation is the same as found in the previous example for Category 2a.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives AND where the payments were made according to one of the contractual arrangements listed for Category 1.

Line (5)
Category 3a - Capitated Payments Directly to Providers. There is a managed care credit of 60 percent for claims payments in this category, which includes:

• All capitation or percent of premium payments directly to licensed providers.

Enter the amount of claims payments paid DIRECTLY to licensed providers on a capitated basis.

Line (6)
Category 3b - Capitated Payments to Regulated Intermediaries. There is a managed care credit of 60 percent for claims payments in this category, which includes:

• All capitation or percent of premium payments to regulated intermediaries that, in turn, pay licensed providers.

Enter the amount of medical expense capitations paid to regulated intermediaries (see Appendix 2 for definition). In those cases where the capitated regulated intermediary employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

Line (7)
Category 3c - Capitated Payments to Non-Regulated Intermediaries. There is a managed care credit of 60 percent for claims payments in this category, which includes:

• All capitated or percent of premium payments to non-affiliated intermediaries that, in turn, pay licensed providers (subject to a 5 percent limitation on payments to providers or other corporations that have no contractual relationship with such intermediary. Amounts greater than the 5 percent limitation should be reported in Category 0).

Enter the amount of medical expense capitations paid to non-regulated intermediaries not affiliated with the reporting company. Do not include the amount of medical expense capitations paid to non-regulated intermediaries affiliated with the reporting company. These amounts should be reported in Category 0. Non-regulated intermediaries are those organizations that meet the definition in Appendix 2 for Intermediary but not regulated intermediary. In those cases where the capitated non-regulated intermediary (even if affiliated) employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

IN ORDER TO QUALIFY FOR ANY OF THE CAPITATION CATEGORIES, SUCH CAPITATION MUST BE FIXED (AS A PERCENTAGE OF PREMIUM OR FIXED DOLLAR AMOUNT PER MEMBER) FOR A PERIOD OF AT LEAST 12 MONTHS. Where an arrangement contains a provision for prospective revision within a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under Category 1 for a provider, and for an intermediary at the greater
of Category 4 for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

Category 2a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

Category 3a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when both reinsurance coverage and risk corridor protection are provided.

Line (16) Weighted Average Managed Care Discount – The amounts in Column (3) and Column (4) are calculated by dividing the total weighted claims in Column (3) by the total paid claims in Column (2) for Lines (9) and (14) respectively.

attachment Two-B 
Capital Adequacy (E) Task Force 
7/28/21
Weighted Average Managed Care Risk Adjustment Factor – These are the credit factors that are carried back to the underwriting risk calculation. They are one minus the Weighted Average Managed Care Discount (Line (16)).

Lines (18) through (24) are the calculation of the weighted average factor for the Category 2 claims payments subject to withhold and bonuses/incentives. This table requires data from the PRIOR YEAR to compute the current year’s discount factor.

Line (18)
Enter the prior year’s actual withhold and bonus/incentive payments.

Line (19)
Enter the prior year’s withhold and bonuses/incentives that were available for payment in the prior year.

Line (20)
Divides Line (18) by Line (19) to determine the portion of withhold and bonuses/incentives that were actually returned in the prior year.

Line (21)
Equal to Line (19) and is automatically pulled forward.

Line (22)
Claims payments that were subject to withhold and bonuses/incentives in the prior year. Equal to Line (3) + Line (4) of LR022 Underwriting Risk – Managed Care Credit FOR THE PRIOR YEAR.

Line (23)
Divides Line (21) by Line (22) to determine the average withhold rate for the prior year.

Line (24)
Multiplies Line (20) by Line (23) to determine the discount factor for Category 2 claims payments in the current year, based on the performance of the insurer’s withhold/bonus/incentive program in the prior year.
This worksheet PR021 Underwriting Risk – Managed Care Credit is optional. It may be completed for only part of the Comprehensive Medical, Stand-Alone Medicare Part D Coverage, Dental business or all of them. Line (1) will be filled in as the balancing item if any of Lines (2) through (8) are entered (and then Line (9) will be required).

The effect of managed care arrangements on the variability of underwriting results is the fundamental difference between coverages subject to the managed care credit and pure indemnity insurance. The managed care credit is used to reduce the RBC requirement for experience fluctuations. It is important to understand that the managed care credit is based on the reduction in uncertainty about future claims payments, not on any reduction in the actual level of cost. Those managed care arrangements that have the greatest reduction in the uncertainty of claims payments receive the greatest credit, while those that have less effect on the predictability of claims payments engender less of a discount.

There are currently five levels of managed care that are used in the RBC formulas other than for Stand-Alone Medicare Part D Coverage, although in the future as new managed care arrangements evolve, the number of categories may increase or new arrangements may be added to the existing categories. The managed care categories are:

- Category 0 - Arrangements not Included in Other Categories
- Category 1 - Contractual Fee Payments
- Category 2 - Bonus and/or Incentives / Withhold Arrangements
- Category 3 - Capitation
- Category 4 - Non-contingent Expenses and Aggregate Cost Arrangements and Certain PSO Capitated Arrangements

For Stand-Alone Medicare Part D Coverage, the reduction in uncertainty comes from two federal supports. The reinsurance coverage is optional in that a plan sponsor may elect to participate in the Part D Payment Demonstration. The risk corridor protection is expected to have less impact after the first few years. To allow flexibility within the RBC formula, Lines (10.1) through (10.4) will be used to give credit for the programs in which the plan sponsor participates. While all PDPs will have formulas and may utilize other methods to reduce uncertainty, for the near future no other managed care credits are allowed for this coverage.

The managed care credit is based on the percentage of paid claims that fall into each of these categories. Total claims payments are allocated among the managed care “buckets” to determine the weighted average discount, which is then used to reduce the Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental RBC. Paid claims are used instead of incurred claims due to the variability of reserves (unpaid claims) in incurred claim amounts and the difficulty in allocating reserves (unpaid claims) by managed care category.

In some instances, claims payments may fit into more than one category. If that occurs, enter the claims payments into the highest applicable category. CLAIMS PAYMENTS CAN ONLY BE ENTERED INTO ONE OF THESE CATEGORIES! The total of the claims payments reported in the managed care worksheet should equal the total year’s paid claims. Category 2a, Category 2b and Category 3c are not allowed to include non-regulated intermediaries who are affiliated with the reporting company in order to ensure that true risk transfer is accomplished.

**Line (1)**

Category 0 - Arrangements not Included in Other Categories. There is a zero managed care credit for claim payments in this category, which includes:

- Fee for service (charges).
- Discounted fee for service (based upon charges).
- Usual customary and reasonable (UCR) schedules.
- Relative value scale (RVS) where neither payment base nor RV factor is fixed by contract or where they are fixed by contract for one year or less.
* Retroactive payments to capitated providers or intermediaries whether by capitation or other payment method (excluding retroactive withholds later released to the provider and retroactive payments made solely because of a correction to the number of members within the capitated agreement).
* Capitation paid to providers or intermediaries that have received retroactive payments for previous years (including bonus arrangements on capitation programs).
* Claim payments not included in other categories.

Line (2)
Category 1 - Payments Made According to Contractual Arrangements. There is a 15 percent managed care credit for payments included in this category:
* Hospital per diems, diagnostic related groups (DRGs) or other hospital case rates.
* Non-adjustable professional case and global rates.
* Provider fee schedules.
* Relative value scale (RVS) where the payment base and RV factor are fixed by contract for more than one year.

Line (3)
Category 2a - Payments Made Subject to Withholds or Bonuses/Incentives with No Other Managed Care Arrangements. This category may include business that would have otherwise fit into Category 0. That is, there may be a bonus/incentive withhold arrangement with a provider who is reimbursed based on a UCR schedule (Category 0).

The maximum Category 2a managed care credit is 25 percent. The credit is based upon a calculation that determines the ratio of withholds returned and bonuses and/or incentives paid to providers during the prior year to total withholds and bonuses and/or incentives available to the providers during that year. That ratio is then multiplied by the average provider withhold ratio for the prior year to determine the current year’s Category 2a managed care credit factor. Bonus and/or incentive payments that are not related to financial results are not included (e.g., patient satisfaction). Therefore, the credit factor is equal to the result of the following calculation:

**EXAMPLE - 1998 Reporting Year**

| 1997 withhold / bonus payments | $750,000 |
| 1997 withholds / bonuses available | $1,000,000 |
| A. MCC Factor Multiplier | 75% - Eligible for credit |
| 1997 withholds / bonuses available | $1,000,000 |
| 1997 claims subject to withhold - gross† | $5,000,000 |
| B. Average Withhold Rate | 20% |
| Category 2 Managed Care Credit Factor (A x B) | 15% |

The resulting factor is multiplied by claims payments subject to withhold - net‡ in the current year.

† These are amounts due before deducting withhold or paying bonuses and/or incentives.
‡ These are actual payments made after deducting withhold or paying bonuses and/or incentives.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses, but otherwise had no managed care arrangements.

Line (4)
Category 2b - Payments Made Subject to Withholds or Bonuses/Incentives That Are Otherwise Managed Care Category 1. Category 2b may include business that would have otherwise fit into Category 1. That is, there may be a bonus/incentive withhold arrangement with a provider who is reimbursed based on a provider fee schedule.
The Category 2 discount for claims payments that would otherwise qualify for Category 1 is the greater of the Category 1 factor or the calculated Category 2 factor.

The maximum Category 2b managed care credit is 25 percent. The minimum Category 2b managed care credit is 15 percent (Category 1 credit factor). The credit calculation is the same as found in the previous example for Category 2a.

Enter the paid claims for the current year where payments to providers were subject to withhold and bonuses AND where the payments were made according to one of the contractual arrangements listed for Category 1.

Line (5) Category 3a - Capitated Payments Directly to Providers. There is a managed care credit of 60 percent for claims payments in this category, which includes:

* All capitation or percent of premium payments made directly to licensed providers.

Enter the amount of claims payments paid DIRECTLY to licensed providers on a capitated basis.

Line (6) Category 3b - Capitated Payments to Regulated Intermediaries. There is a managed care credit of 60 percent for claims payments in this category, which includes:

* All capitation or percent of premium payments to regulated intermediaries that in turn pay licensed providers.

Enter the amount of medical expense capitations paid to regulated intermediaries (see Appendix 1 for definition). In those cases where the capitated regulated intermediary employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

Line (7) Category 3c - Capitated Payments to Non-Regulated Intermediaries. There is a managed care credit of 60 percent for claims payments in this category, which includes:

* All capitated or percent of premium payments to non-affiliated intermediaries that in turn pay licensed providers. (Subject to a 5 percent limitation on payments to providers or other corporations that have no contractual relationship with such intermediary. Amounts greater than the 5 percent limitation should be reported in Category 0).

Enter the amount of medical expense capitations paid to non-regulated intermediaries not affiliated with the reporting company. Do not include the amount of medical expense capitations paid to non-regulated intermediaries that are affiliated with the reporting company. These amounts should be reported in Category 0. Non-regulated intermediaries are those organizations which meet the definition of Intermediary but not regulated intermediary in Appendix 1. In cases where the capitated non-regulated intermediary (even if affiliated) employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

IN ORDER TO QUALIFY FOR ANY OF THE CAPITATION CATEGORIES, SUCH CAPITATION MUST BE FIXED (AS A PERCENTAGE OF PREMIUM OR FIXED DOLLAR AMOUNT PER MEMBER) FOR A PERIOD OF AT LEAST 12 MONTHS. Where an arrangement contains a provision for prospective revision within a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under Category 1 for a provider, and for an intermediary at the greater of Category 1 or a credit calculated using the underlying payment method(s) to the providers of care. Where an arrangement contains a provision for retroactive
revisions either within or beyond a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under Category 0 for providers and intermediaries.

Line (8)
Category 4 - Medical & Hospital Expense Paid as Salary to Providers. There is a managed care credit of 75 percent for claims payments in this category. Once claims payments under this managed care category are totaled, any fee for service revenue from uninsured plans (i.e., ASO or ASC) that was included on Line (7) in the underwriting risk section should be deducted before applying the managed care credit factor.

* Non-contingent salaries to persons directly providing care.
* The portion of payments to affiliated entities which is passed on as non-contingent salaries to persons directly providing care where the entity has a contract only with the company.
* All facilities related medical expenses and other non-provider medical costs generated within health facility that is owned and operated by the insurer.
* Aggregate cost payments.

Salaries paid to doctors and nurses whose sole corporate purpose is utilization review are also included in this category if such payments are classified as “medical expense” payments (paid claims) rather than administrative expenses. The Aggregate Cost method of reimbursement means where a health plan has a reimbursement plan with a corporate entity that directly provides care, where (1) the health plan is contractually required to pay the total operating costs of the corporate entity, less any income to the entity from other uses of services; and (2) there are mutual unlimited guarantees of solvency between the entity and the health plan, that put their respective capital and surplus at risk in guaranteeing each other.

Line (10.1)
Category 0 for Stand-Alone Medicare Part D Coverage would be all claims during a period where neither the reinsurance coverage or risk corridor protection is provided.

Line (10.2)
Category 1 for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the reinsurance coverage is provided. This is designed for some future time period and is not to be interpreted as including employer-based Part D coverage that is not subject to risk corridor protection.

Line (10.3)
Category 2a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

Line (10.4)
Category 3a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when both reinsurance coverage and risk corridor protection are provided.

Line (10.6)
Total Paid Claims – The total of Column (1) paid claims should equal the total claims paid for the year as reported in Schedule H, Part 5, Columns 1 and 2, Line D16 of the annual statement.

Line (11)
Weighted Average Managed Care Discount – This amount is calculated by dividing the total weighted claims (Line (9) Column (2)) by the total claim payments (Line (9) Column (1)).

Line (12)
Weighted Average Managed Care Risk Adjustment Factor - This is the credit factor that is carried back to the underwriting risk calculation. They are one minus the Weighted Average Managed Care Discount (Line (11)).

Lines (13) through (19) are the calculation of the weighted average factor for the Category 2 claims payments subject to withhold and bonuses/incentives. This table requires data from the PRIOR YEAR to compute the current year’s discount factor.

Line (13)
Enter the prior year’s actual withhold and bonus/incentive payments.

Line (14)
Enter the prior year’s withhold and bonuses/incentives that were available for payment in the prior year.

Line (15)
Divides Line (13) by Line (14) to determine the portion of withholds and bonuses/incentives that were actually returned in the prior year.

Line (16)
Equal to Line (14) and is automatically pulled forward.

Line (17)
Claims payments that were subject to withhold and bonuses/incentives in the prior year. Equal to Line (3) + Line (4) of Underwriting Risk–Managed Care Credit FOR THE PRIOR YEAR.

Line (18)
Divides Line (16) by Line (17) to determine the average withhold rate for the prior year.

Line (19)
Multiplies Line (15) by Line (18) to determine the discount factor for Category 2 claims payments in the current year, based on the performance of the insurer’s withhold/bonus/incentive program in the prior year.
HEALTH, LIFE AND PROPERTY AND CASUALTY

APPENDIX 1 – COMMONLY USED TERMS

The Definitions of Commonly Used Terms are frequently duplicates from the main body of the text. If there are any inconsistencies between the definitions in this section and the definitions in the main body of the instructions, the main body definition should be used.

Incentives, Withhold and Bonus Amounts—Are amounts to be paid to providers by the Health entity as an incentive to achieve goals such as effective management of care. An incentive arrangement may involve paying an agreed-on amount for each claim (e.g., provider agrees to practice in an underserved area). While a bonus arrangement may be paid at the end of a contract period after specific goals have been met. Withhold arrangements can involve a set amount to be withheld from each claim, and then paying a portion (which could be none or all) of the withheld amount at the end of the contract period.

Incentive pool, withhold, and bonus amounts are defined as: amounts to be paid to providers by the Health entity as an incentive to achieve goals such as effective management of care. Some arrangements involve paying an agreed-on amount for each claim, and then paying a bonus at the end of the contract period. Other arrangements involve a set amount to be withheld from each claim, and then paying a portion (which could be none or all) of the withheld amount at the end of the contract period.

Commented [BC1]: This could also be worded as “e.g., provider is paid on a per-claim basis for practicing in an underserved area.”

Commented [BC2]: This is directly from the A/S instructions. It was used as a basis for the definition drafted above.
### UNDERWRITING RISK - Managed Care Credit Calculation

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<th>Managed Care Claim Payments</th>
<th>Annual Statement Source</th>
<th>Factor</th>
<th>Paid Claims</th>
<th>Weighted Claims</th>
<th>Part D Weighted Claims</th>
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<tr>
<td>(7) <strong>Category 3c</strong> - Capitated Payments to Non-Regulated Intermediaries</td>
<td>Included in Exhibit 7, Part 1, Column 1, Line 2 §</td>
<td>0.600</td>
<td>$0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(8) Category 4 - Medical &amp; Hospital Expense Paid as Salary to Providers</td>
<td></td>
<td>0.750</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(8.1) Non-Contingent Salaries - Category 4</td>
<td>Exhibit 7, Part 1, Column 1, Line 9, in part §</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(8.2) Aggregate Cost Arrangements - Category 4</td>
<td>Exhibit 7, Part 1, Column 1, Line 10, in part §</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(8.3) Less Fee For Service Revenue from ASC or ASO Company Records</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(9) <strong>Sub-Total Paid Claims</strong></td>
<td>Exhibit 7, Part 1, Column 1, Lines 13 - 11 - (8.3) - (12) - (13)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Stand-Alone Medicare Part D Coverage Claim Payments**

<table>
<thead>
<tr>
<th>Managed Care Claim Payments</th>
<th>Annual Statement Source</th>
<th>Factor</th>
<th>Paid Claims</th>
<th>Weighted Claims</th>
<th>Part D Weighted Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>(10) <strong>Category 0</strong> - No Federal Reinsurance or Risk Corridor Protection</td>
<td>Company Records</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>(11) <strong>Category 1</strong> - Federal Reinsurance but no Risk Corridor Protection</td>
<td>Company Records</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>(12) <strong>Category 2a</strong> - No Federal Reinsurance but Risk Corridor Protection</td>
<td>Company Records</td>
<td>0.667</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(13) <strong>Category 3a</strong> - Federal Reinsurance and Risk Corridor Protection Apply</td>
<td>Company Records</td>
<td>0.767</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(14) <strong>Sub-Total Paid Claims</strong></td>
<td>Sum of Lines (10) through (13)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(15) <strong>Total Paid Claims</strong></td>
<td>Sum of Lines (9) and (14)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(16) Weighted Average Managed Care Discount
(17) Weighted Average Managed Care Risk Adjustment Factor

† This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental/Vision Managed Care Discount factor.
‡ This column is for the Medicare Part D Managed Care Discount factor.
§ Stand-Alone Medicare Part D business reported in Lines (12) and (13) would be excluded from these amounts.
* The factor is calculated on page XR018.

Denotes items that must be manually entered on filing software.
<table>
<thead>
<tr>
<th>Annual Statement Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company Records</td>
<td></td>
</tr>
<tr>
<td>Company Records</td>
<td></td>
</tr>
<tr>
<td>Company Records</td>
<td></td>
</tr>
<tr>
<td>Company Records</td>
<td></td>
</tr>
</tbody>
</table>

* Calculation of Category 2 Managed Care Factor

- (18) Withhold & Bonus/Incentive Payments, Prior Year
- (19) Withhold & Bonuses/Incentives Available, Prior Year
- (20) MCC Multiplier - Average Withhold Returned [Line (18)/(19)]
- (21) Withholds & Bonuses/Incentives Available, Prior Year
- (22) Claims Payments Subject to Withhold, Prior Year
- (23) Average Withhold Rate, Prior Year [Line (21)/(22)]
- (24) MCC Discount Factor, Category 2 Min{.25,[Lines (20) x (23)]}

* The factor is pulled into Lines (3) and (4) on page XR017.

Denotes items that must be manually entered on filing software.
## UNDERWRITING RISK – MANAGED CARE CREDIT

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Paid Claims</th>
<th>Factor</th>
<th>Weighted Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Category 0 - Arrangements not Included in Other Categories</td>
<td>Company records</td>
<td>X 0.000</td>
<td>=</td>
<td></td>
</tr>
<tr>
<td>(2) Category 1 - Payments Made According to Contractual Arrangements</td>
<td>Company records</td>
<td>X 0.150</td>
<td>=</td>
<td></td>
</tr>
<tr>
<td>(3) Category 2a - Subject to Withholds or Bonuses/Incentives – Otherwise Category 0</td>
<td>Company records</td>
<td>X †</td>
<td>=</td>
<td></td>
</tr>
<tr>
<td>(4) Category 2b - Subject to Withholds or Bonuses/Incentives – Otherwise Category 1</td>
<td>Company records</td>
<td>X ‡</td>
<td>=</td>
<td></td>
</tr>
<tr>
<td>(5) Category 3a - Capitated Payments Directly to Providers</td>
<td>Company records</td>
<td>X 0.600</td>
<td>=</td>
<td></td>
</tr>
<tr>
<td>(6) Category 3b - Capitated Payments to Regulated Intermediaries</td>
<td>Company records</td>
<td>X 0.600</td>
<td>=</td>
<td></td>
</tr>
<tr>
<td>(7) Category 3c - Capitated Payments to Non-Regulated Intermediaries</td>
<td>Company records</td>
<td>X 0.600</td>
<td>=</td>
<td></td>
</tr>
<tr>
<td>(8) Category 4 - Medical &amp; Hospital Expense Paid as Salary to Providers</td>
<td>Company records</td>
<td>X 0.750</td>
<td>=</td>
<td></td>
</tr>
<tr>
<td>(9) Subtotal Paid Claims</td>
<td>Sum of Lines (1) through (8)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stand-Alone Medicare Part D Coverage Claim Payments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(10) Category 0 - No Federal Reinsurance or Risk Corridor Protection</td>
<td>Company records</td>
<td>XXX X xxx</td>
<td>=</td>
<td>XXX</td>
</tr>
<tr>
<td>(11) Category 1 - Federal Reinsurance but no Risk Corridor Protection</td>
<td>Company records</td>
<td>XXX X xxx</td>
<td>=</td>
<td>XXX</td>
</tr>
<tr>
<td>(12) Category 2a - No Federal Reinsurance but Risk Corridor Protection</td>
<td>Company records</td>
<td>X 0.667</td>
<td>=</td>
<td></td>
</tr>
<tr>
<td>(13) Category 3a - Federal Reinsurance and Risk Corridor Protection</td>
<td>Company records</td>
<td>X 0.767</td>
<td>=</td>
<td></td>
</tr>
<tr>
<td>(14) Subtotal Stand-Alone Medicare Part D Paid Claims</td>
<td>Sum of Lines (10) through (13)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(15) Total Paid Claims</td>
<td>Line (9) + Line (14)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(16) Weighted Average Managed Care Discount</td>
<td>Column (3) = Column (3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(17) Weighted Average Managed Care Risk Adjustment Factor</td>
<td>1.0 - Line (16)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Calculation of Category 2 Managed Care Factor (Comprehensive Medical and Dental only)

<table>
<thead>
<tr>
<th>Calculation of Category 2 Managed Care Factor (Comprehensive Medical and Dental only)</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(18) Withhold &amp; bonus/incentive payments, prior year</td>
<td>Company Records</td>
</tr>
<tr>
<td>(19) Withhold &amp; bonus/incentive available, prior year</td>
<td>Company Records</td>
</tr>
<tr>
<td>(20) Managed Care Multiplier – average withhold returned</td>
<td>Line (18) / Line (19)</td>
</tr>
<tr>
<td>(21) Withholds &amp; bonuses/incentive available, prior year</td>
<td>Line (19)</td>
</tr>
<tr>
<td>(22) Claims payments subject to withhold, prior year</td>
<td>Company Records</td>
</tr>
<tr>
<td>(23) Average withhold rate, prior year</td>
<td>Line (21) / Line (22)</td>
</tr>
<tr>
<td>(24) Managed Care Discount Factor, Category 2</td>
<td>Minimum of 0.25 or Line (20) x Line (23)</td>
</tr>
</tbody>
</table>

* Category 2 Managed Care Factor calculated on Line (24).

** This column is for the Stand-Alone Medicare Part D managed care discount factor.

---

**Denotes items that must be manually entered on the filing software.**
### UNDERWRITING RISK - MANAGED CARE CREDIT  PR021

<table>
<thead>
<tr>
<th>Comprehensive Medical, Medicare Supplement and Dental &amp; Vision Claim Payments</th>
<th>Annual Statement Source</th>
<th>Paid Claims</th>
<th>Factor</th>
<th>Weighted Claim (1)</th>
<th>Weighted Claim (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Category 0 - Arrangements not Included in Other Categories</td>
<td>Company records</td>
<td>0</td>
<td>0.000</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(2) Category 1 - Payments Made According to Contractual Arrangements</td>
<td>Company records</td>
<td>0</td>
<td>0.150</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(3) Category 2a - Subject to Withholds or Bonuses/Incentives - Otherwise Category 0</td>
<td>Company records</td>
<td>0</td>
<td>*</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(4) Category 2b - Subject to Withholds or Bonuses/Incentives - Otherwise Category</td>
<td>Company records</td>
<td>0</td>
<td>**</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(5) Category 3a - Capitated Payments Directly to Providers</td>
<td>Company records</td>
<td>0</td>
<td>0.600</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(6) Category 3b - Capitated Payments to Regulated Intermediaries</td>
<td>Company records</td>
<td>0</td>
<td>0.600</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(7) Category 3c - Capitated Payments to Non-Regulated Intermediaries</td>
<td>Company records</td>
<td>0</td>
<td>0.600</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(8) Category 4 - Medical &amp; Hospital Expense Paid as Salary to Providers</td>
<td>Company records</td>
<td>0</td>
<td>0.730</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(9) Sub-Total Paid Claims</td>
<td>Sum of Lines (1) through (8)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Stand-Alone Medicare Part D Coverage Claim Payments

| Category 0 - No Federal Reinsurance or Risk Corridor Protection | Company records | XXX | XXX | XXX |
| Category 1 - Federal Reinsurance but no Risk Corridor Protection | Company records | XXX | XXX | 0 |
| Category 2a - Federal Reinsurance but Risk Corridor Protection apply | Company records | 0 | 0.767 | 0 |
| (10.5) Sub-Total Paid Claims | Sum of Lines (10.1) through (10.4) | 0 | 0 | 0 |
| (10.6) Total Paid Claims | Sum of Lines (9) and (10.5) | 0 | 0 | 0 |

#### Calculation of Category 2 Managed Care Factor

| Category 0 - Arrangements not Included in Other Categories | Company records | 0 | 0 |
| Withhold & bonus/Incentives payments, prior year | Company Records | 0 |
| Managed Care Credit Multiplier – average withhold returned | Line (13) / Line (14) | 0.000 |
| Withholds & bonuses/Incentives available, prior year | Line (14) | 0 |
| Claims payments subject to withhold, prior year | Company Records | 0 |
| Average withhold rate, prior year | Line (16) / Line (17) | 0.000 |
| Managed Care Credit Discount Factors, Category 2 | Minimum of 0.25 or | Line (15) x Line (18) | 0.000 |

* Category 2 Managed Care Factor calculated on Line (19)
* Category 2 Managed Care Factor calculated on Line (19) with a minimum factor of 15 percent.
† This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental managed care discount factor.
∥ This column is for the Stand-Alone Medicare Part D managed care discount factor.

Denotes items that must be manually entered on the filing software.
Capital Adequacy (E) Task Force

RBC Proposal Form

| [ ] Capital Adequacy (E) Task Force | [ ] Health RBC (E) Working Group | [ ] Life RBC (E) Working Group |
| [ ] Catastrophe Risk (E) Subgroup | [ ] Investment RBC (E) Working Group | [ ] Operational Risk (E) Subgroup |
| [ ] C3 Phase II/ AG43 (E/A) Subgroup | [x ] P/C RBC (E) Working Group | [ ] Longevity Risk (A/E) Subgroup |

DATE: 2/28/21

CONTACT PERSON: Eva Yeung
TELEPHONE: 816-783-8407
EMAIL ADDRESS: eyeung@naic.org
ON BEHALF OF: P/C RBC (E) Working Group
NAME: Tom Botsko
TITLE: Chair
AFFILIATION: Ohio Department of Insurance
ADDRESS: 50 West Town Street, Suite 300 Columbus, OH 43215

FOR NAIC USE ONLY
Agenda Item # 2021-03-P
Year 2021

DISPOSITION
[ ] ADOPTED 6/30/21
[ ] REJECTED
[ ] DEFERRED TO
[ ] REFERRED TO OTHER NAIC GROUP
[ x ] EXPOSED 3/15/21
[ ] OTHER (SPECIFY)

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

| [ ] Health RBC Blanks | [ ] Property/Casualty RBC Blanks | [ ] Life and Fraternal RBC Instructions |
| [ ] Health RBC Instructions | [x ] Property/Casualty RBC Instructions | [ ] Life and Fraternal RBC Instructions |
| [ ] OTHER ____________________________ |

DESCRIPTION OF CHANGE(S)

Adding examples as a guide to portray the intent of the R3 ratings instructions.

REASON OR JUSTIFICATION FOR CHANGE **

The proposed instruction changes would provide examples to clarify how the reporting companies should select the designation in the Annual Statement Part 3, Reinsurer Designation Equivalent Rating column if the reporting entities subscribe to one or multiple rating agencies.

Additional Staff Comments:
3/15/21 – The PCRBC WG exposed this proposal for a thirty-day public comment period ending Apr. 14.
4/27/21 – The PCRBC WG adopted this proposal with no received comments.
6/30/21 (jdb) Instructions adopted by the Task Force.

** This section must be completed on all forms.

Revised 2-2019
The calculation of the credit risk charge for reinsurance recoverables is detailed in Schedule F Part 3 Columns 28 through 36 of the Property/Casualty Annual Statement. This calculation is performed at the transaction level and those results are then summed to determine the charge. Reinsurance balances receivable on reinsurance ceded to non-affiliated companies (excluding certain pools) and to alien affiliates are subject to the credit risk-based capital charge. The following types of cessions are exempt from this charge:

- Cessions to State Mandated Involuntary Pools and Associations or to Federal Insurance Programs.
- This category includes all federal insurance programs [e.g., National Flood Insurance Program (NFIP), Federal Crop Insurance Corporation (FCIC), etc., all state mandated residual market mechanisms and the National Council on Compensation Insurance (NCCI).
- Cessions to U.S. Parents, Subsidiaries and Affiliates.

The categories above are automatically excluded from the data that is calculated in Schedule F Part 3 of the Annual Statement.

Since the Annual Statement requires the collectability of reinsurance balances be considered via the reinsurance penalty, the appropriate balances must be offset by any liability that has been established for this purpose. The amount from Page 3, Line 16 should be allocated to the appropriate (re)insurers listed on Schedule F. The total amount recoverable from reinsurers less any applicable reinsurance penalty is multiplied by 120% to stress the recoverable balance. The total of reinsurance payable and/or funds held amounts (not in excess of the stressed recoverable) are applied as offsets to arrive at the stressed net recoverable.

Since there are different reinsurance credit risk factors for collateralized and uncollateralized reinsurance recoverables, the stressed net recoverable should be offset by any available collateral, such as letters of credit, multiple beneficiary trusts, and single beneficiary trusts and other allowable offsets (not in excess of the stressed net recoverable). The collateralized amounts are derived from Schedule F Part 3 Column 32 and the uncollateralized amounts are derived from Column 33.

The risk-based capital for the various credits (including collateral offsets where applicable) taken for reinsurance may not be less than zero even if the amount reported or the amount net of offsets is negative.

The factor for reinsurance recoverables (paid and unpaid less any applicable reinsurance penalty) due from a particular reinsurer is determined based on that reinsurer’s financial strength rating assigned on a legal entity basis.

For the purpose of the credit risk-based capital charge, the equivalent rating category assigned will correspond to current financial strength rating received from one of the approved rating agencies as outlined in the table below. Ratings shall be based on interactive communication between the rating agency and the reinsurer and shall not be based solely on publicly available information. If the reinsurer does not have at least one financial strength rating, it should be assigned the “Vulnerable 6 or Unrated” equivalent rating. Amounts recoverable from unrated voluntary pools should be assigned the “Secure 3” equivalent rating.

For authorized associations including incorporated and individual unincorporated underwriters or a member thereof (e.g., individual authorized syndicates of Lloyds’ of London that are backed by the Central Fund) utilize the lowest financial strength group rating received from an approved rating agency.

For authorized associations, including incorporated and individual unincorporated underwriters or a member thereof (e.g., individual authorized syndicates of Lloyds’ of London that are backed by the Central Fund), may utilize the lowest financial strength group rating received from an approved rating agency.

The table below shows the R3 reinsurer equivalent rating categories and corresponding factors for A.M. Best, Standard and Poor’s, Moody’s and Fitch ratings.
Reinsurer Designation Equivalent Rating Category and Corresponding Factors—For RBC R3 Credit Risk Charge

<table>
<thead>
<tr>
<th>Description</th>
<th>Secure 1</th>
<th>Secure 2</th>
<th>Secure 3</th>
<th>Secure 4</th>
<th>Secure 5</th>
<th>Vulnerable 6 or Unrated</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.M. Best</td>
<td>A++</td>
<td>A+</td>
<td>A</td>
<td>A-</td>
<td>B++, B+</td>
<td>B, B-, C++, C+, C-, C-, D, E, F</td>
</tr>
<tr>
<td>Moody’s</td>
<td>Aaa</td>
<td>Aa1, Aa2, Aa3</td>
<td>A1, A2</td>
<td>A3</td>
<td>Baa1, Baa2, Baa3</td>
<td>Baa1, Baa2, Baa3, B1, B2, B3, Caa, Ca, C</td>
</tr>
<tr>
<td>Collateralized Amounts Factors</td>
<td>3.6%</td>
<td>4.1%</td>
<td>4.8%</td>
<td>5.0%</td>
<td>5.0%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Uncollateralized Amounts Factors</td>
<td>3.6%</td>
<td>4.1%</td>
<td>4.8%</td>
<td>5.3%</td>
<td>7.1%</td>
<td>14.0%</td>
</tr>
</tbody>
</table>

Each reporting company should record in Schedule F Part 3, Column 34, the reinsurer designation equivalent financial strength ratings assigned to the (re)insurers listed, where there are balances receivable on reinsurance ceded for the Schedule F categories subject to the credit risk charge on reinsurance recoverables. The resulting credit risk charge for reinsurance recoverables is determined by applying the corresponding factor by reinsurer designation equivalent to the collateralized and uncollateralized balances respectively. These respective charges are derived from Schedule F Part 3, Columns 35 and 36 and Line 9999999 totals are reported on PR012 Lines 1 and 2. See examples below.

Miscellaneous Recoverables

There is risk associated with recoverability of amounts from creditors other than reinsurers. In addition to the default risk, there is the risk that the amounts are not accurately estimated. The factor to measure this risk is estimated at 5 percent for Amounts Receivable Relating to Uninsured Accident and Health Plans; Receivables from Parent, Subsidiaries and Affiliates; and Aggregate Write-ins for Other Than Invested Assets. For Interest, Dividends and Real Estate Income Due and Accrued, which for the most part represents interest income due and accrued from bond holdings, the charge is 1 percent, which is equivalent to the charge applicable to unaffiliated NAIC 02 bonds.

Examples: The following examples are here as a guide to portray the intent of these instructions.

These examples assume that all financial strength ratings are from one of the rating agencies listed in the table above and there is interactive communication between the rating agency and the reinsurer unless stated otherwise.

Example 1—Reinsurer has only one rating: Assume the Reinsurer XYZ has a financial strength rating of A from A.M. Best. This falls in the Secure 3 category and the reporting company should select this category and corresponding charge.

Example 2—Reinsurer has more than one rating: Assume the Reinsurer XYZ has a financial strength rating of “A” from A.M. Best and another rating of “AAA” from Fitch. The reporting company may use either of the ratings provided by A.M. Best or Fitch.

Example 3—Reinsurer only has a Public Information Rating: Ratings that include the symbol of “pi” (e.g. Api), which indicates a public information rating, are not allowed to be used. If a reinsurer has only been assigned Public Information ratings, meaning no other financial strength ratings have been assigned to it; then the reporting company must list the reinsurer’s rating as Vulnerable 6 or Unrated.
## CAPITAL ADEQUACY (E) TASK FORCE
### WORKING AGENDA ITEMS FOR CALENDAR YEAR 2021

<table>
<thead>
<tr>
<th>#</th>
<th>Owner</th>
<th>Priority</th>
<th>Date</th>
<th>Working Agenda Item</th>
<th>Source</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Life RBC WG</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>Make technical corrections to Life RBC instructions, blank and/or methods to provide for consistent treatment among asset types and among the various components of the RBC calculations for a single asset type.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021 or later</td>
<td>1. Monitor the impact of the changes to the variable annuities reserve framework and risk-based capital (RBC) calculation and determine if additional revisions need to be made. 2. Develop and recommend appropriate changes including those to improve accuracy and clarity of variable annuity (VA) capital and reserve requirements.</td>
<td>CATF</td>
<td>Being addressed by the Variable Annuities Capital and Reserve (E/A) Subgroup</td>
</tr>
<tr>
<td>3</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021 or later</td>
<td>Provide recommendations for recognizing longevity risk in statutory reserves and/or RBC, as appropriate.</td>
<td>New Jersey</td>
<td>Being addressed by the Longevity (E/A) Subgroup</td>
</tr>
<tr>
<td>4</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021 or later</td>
<td>Update the current C-3 Phase I or C-3 Phase II methodology to include indexed annuities with consideration of contingent deferred annuities as well.</td>
<td>AAA</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021</td>
<td>Determine if any adjustment is needed to the XXX/AXXX RBC Shortfall calculation to address surplus notes issued by captives.</td>
<td>11/1/12 Referral from the Reinsurance (E) Task Force</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021</td>
<td>Determine if any adjustment is needed due to the changes made to the Life and Health Guaranty Association Model Act, Model #520.</td>
<td>9/1/2018</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021</td>
<td>Discuss and determine the need to adjust the real estate factors.</td>
<td>Referral from Investment RBC A/h/2020</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021 or later</td>
<td>Work with the Life Actuarial (A) Task Force and Conning to develop the economic scenario generator for implementation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Cat Risk SG</td>
<td>1</td>
<td>Year-end 2022 or later</td>
<td>a) Evaluate other catastrophe risks for possible inclusion in the charge - determine whether to recommend developing charges for any additional perils, which perils or perls those should be.</td>
<td>Referral from the Climate and Resiliency Task Force. March 2021</td>
<td>4/26/21 - The SG expose the referral for a 30-day exposure period.</td>
</tr>
</tbody>
</table>
## Working Agenda Items for Calendar Year 2021

<table>
<thead>
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<tbody>
<tr>
<td>10</td>
<td>P/C</td>
<td>1</td>
<td>Year-end 2020 or later</td>
<td>1/25/2018</td>
<td>Evaluate whether the current growth risk methodology adequately reflects both operational risk and underwriting risk.</td>
</tr>
<tr>
<td>11</td>
<td>P/C</td>
<td>1</td>
<td>Year-end 2021 or later</td>
<td>6/10/2019</td>
<td>Evaluate proposed changes from the Affiliated Investment Ad Hoc Group related to the P/C Affiliated Investments.</td>
</tr>
<tr>
<td>12</td>
<td>P/C</td>
<td>1</td>
<td>Year-end 2021 or later</td>
<td>6/10/2019</td>
<td>Evaluate proposed changes from the Affiliated Investment Ad Hoc Group related to the P/C Affiliated Investments.</td>
</tr>
<tr>
<td>13</td>
<td>P/C</td>
<td>1</td>
<td>Summer Meeting or later</td>
<td>7/28/2019</td>
<td>Continue working with the Academy on reinsurance risk factors.</td>
</tr>
<tr>
<td>14</td>
<td>Cat Risk</td>
<td>1</td>
<td>Year-end 2020 or later</td>
<td>5/18/2019</td>
<td>Evaluate the proposed changes from the Affiliated Investment Ad Hoc Group related to the P/C Affiliated Investments.</td>
</tr>
<tr>
<td>15</td>
<td>Cat Risk</td>
<td>1</td>
<td>2021 Spring Meeting</td>
<td>4/16/2021</td>
<td>Evaluate the proposed changes from the Affiliated Investment Ad Hoc Group related to the P/C Affiliated Investments.</td>
</tr>
<tr>
<td>16</td>
<td>Cat Risk</td>
<td>1</td>
<td>2021 Spring Meeting</td>
<td>4/16/2021</td>
<td>Evaluate the proposed changes from the Affiliated Investment Ad Hoc Group related to the P/C Affiliated Investments.</td>
</tr>
<tr>
<td>17</td>
<td>Cat Risk</td>
<td>1</td>
<td>Summer Meeting</td>
<td>7/28/2021</td>
<td>Modify instructions to PR027 Interrogatories to clarify how insurers with no gross exposure to earthquake or hurricane should complete the interrogatories.</td>
</tr>
<tr>
<td>18</td>
<td>P/C</td>
<td>1</td>
<td>Year-end 2020 or later</td>
<td>10/23/2020</td>
<td>Remove the embedded 3% operational risk component contained in the reinsurance contingent credit risk factor of Rcat.</td>
</tr>
<tr>
<td>19</td>
<td>P/C</td>
<td>1</td>
<td>Year-end 2020 or later</td>
<td>10/23/2020</td>
<td>Remove the embedded 3% operational risk component contained in the reinsurance contingent credit risk factor of Rcat.</td>
</tr>
<tr>
<td>20</td>
<td>Cat Risk</td>
<td>1</td>
<td>Summer Meeting</td>
<td>7/28/2021</td>
<td>Implement the Wildfire Peril in the Rcat component (For Informational Purposes Only).</td>
</tr>
</tbody>
</table>

**Notes:**
- Priority 1 – High priority
- Priority 2 – Medium priority
- Priority 3 – Low priority
- Year-end – December 31, 2020 or later
- Summer – June 1, 2021 or later
- Spring – March 1, 2021 or later
- Fall – October 1, 2021 or later

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# Working Agenda Items for Calendar Year 2021

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<tbody>
<tr>
<td>22</td>
<td>Health RBC WG</td>
<td>3</td>
<td>Year-end 2022 RBC or later</td>
<td>Discuss and monitor the development of federal level programs and actions and the potential impact of these changes to the HRBC formula: - Development of the state reinsurance programs; - Association Health Plans; - Cross-border sales</td>
<td></td>
<td>HRBCWG</td>
</tr>
<tr>
<td>23</td>
<td>Health RBC WG</td>
<td>3</td>
<td>Year-end 2022 RBC or later</td>
<td>Consider changes for stop-loss insurance or reinsurance</td>
<td>AAA Report at Dec. 2006 Meeting (Based on Academy report expected to be received at YE-2016)</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Health RBC WG</td>
<td>2</td>
<td>Year-end 2023 RBC or later</td>
<td>Review the individual factors for each health care receivables line within the Credit Risk H3 component of the RBC formula.</td>
<td></td>
<td>HRBC WG</td>
</tr>
<tr>
<td>25</td>
<td>Health RBC WG</td>
<td>1</td>
<td>Year-end 2022 or later</td>
<td>Establish an Ad Hoc Group to review the Health Test and annual statement changes for reporting health business in the Life and P/C Blanks</td>
<td></td>
<td>HRBCWG</td>
</tr>
<tr>
<td>26</td>
<td>Health RBC WG</td>
<td>1</td>
<td>Year-end 2022 RBC or later</td>
<td>Review the Managed Care Credit calculation in the Health RBC formula - specifically Category 2a and 2b. Review Managed Care Credit across formulas.</td>
<td></td>
<td>HRBCWG</td>
</tr>
<tr>
<td>27</td>
<td>Health RBC WG</td>
<td>1</td>
<td>Year-end 2022 or later</td>
<td>Review referral letter from the Operational Risk (E) Subgroup on the excessive growth charge and the development of an Ad Hoc group to charge.</td>
<td></td>
<td>HRBCWG</td>
</tr>
<tr>
<td>28</td>
<td>Health RBC WG</td>
<td>1</td>
<td>Year-end 2022 or later</td>
<td>Consider impact of COVID-19 and pandemic risk in the Health RBC formula.</td>
<td></td>
<td>HRBCWG</td>
</tr>
<tr>
<td>#</td>
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<tr>
<td>29</td>
<td>Health RBC WG</td>
<td>1</td>
<td>Year-End 2021 or later</td>
<td>Work with the Academy to evaluate incorporating and including investment income in the Underwriting Risk component of the Health RBC formula.</td>
<td>HRBCWG</td>
<td>Referral Letter was sent to the Academy on Sept 21.</td>
</tr>
<tr>
<td>30</td>
<td>Health RBC WG</td>
<td>1</td>
<td>2021</td>
<td>Discuss and determine the bond factors for the 20 designations.</td>
<td></td>
<td>Working Group will use two- and five-year time horizon factors in 2020 impact analysis</td>
</tr>
</tbody>
</table>

New Items – Health RBC

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<tr>
<td>31</td>
<td>Health RBC WG</td>
<td>1</td>
<td>Year-End 2022 or later</td>
<td>Work with the Academy to perform a comprehensive review of the H2 - Underwriting Risk component of the Health RBC formula including the Managed Care Credit review (Item 18 above)</td>
<td>HRBCWG</td>
<td></td>
<td>4/23/2021</td>
</tr>
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New Items – Task Force

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<thead>
<tr>
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<tbody>
<tr>
<td>32</td>
<td>CADTF</td>
<td>1</td>
<td>2022 or Later</td>
<td>Supplementary Investment Risks Interrogatories (SIRI)</td>
<td></td>
<td>Referral from Blackrock and IL DOI</td>
<td>11/19/2020</td>
</tr>
<tr>
<td>33</td>
<td>CADTF</td>
<td>1</td>
<td>2021</td>
<td>Consideration given to 20 designations for bonds in all RBC formulas so that an impact analysis can be provided on 2020 year-end data to determine the bond RBC factors. The Task Force will need to discuss and determine whether Hybrids are included with the new bond's structure. History In 2012 /13 as part of the Solvency Modernization Initiative &quot;roadmap&quot; and subsequent White Paper roadmap, the Capital Adequacy (E) Task Force identified increased granularity in the asset and investment risk charges as a priority area. It was originally targeted at the Life RBC formula and was referred to as the “C1 factor review”. The project was assigned to a newly formed Investment RBC (E) Working Group in 2013. Work was conducted by the Life C-1 Work Group of the American Academy of Actuaries (Academy) at the instructions of the working group using defined criteria for the analysis: The C1 bond factors are defined as the amount needed to pre-fund losses at the 96th percentile minus the amount assumed to be funded in statutory policy reserves. The credit loss distribution is skewed with the mean occurring at approximately the 60th percentile. The RP does not vary by economic scenario.</td>
<td>RBCWG - Dec 2019</td>
<td>An Academy report issued in 2015 and updated 2017 report recommended an increase in the number of designations. Ultimately, the WG members agreed that the number of designations should be increased to 20. In 2017/2018, the PRBC and HRBC (E) Working Groups began discussion of the change to 20 designations. In 2019 both working groups concurred with the LRBC WG position that the number of designations should be increased to 19 in their respective formulas Proposal # 2019 – 16CA Factors are Exposed for Comment and will be considered on the June 30th CADTF call.</td>
<td>11/19/2020</td>
</tr>
</tbody>
</table>

Carry-Over Items not Currently being Addressed – Task Force

<table>
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<tr>
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<tbody>
<tr>
<td>34</td>
<td>CADTF</td>
<td>2</td>
<td>2022</td>
<td>Affiliated Investment Subsidiaries Referral Ad Hoc group formed Sept. 2016</td>
<td>Ad Hoc Group</td>
<td>Ad Hoc group will provide periodic updates on their progress.</td>
<td></td>
</tr>
</tbody>
</table>
## Capital Adequacy (E) Task Force

### Working Agenda Items for Calendar Year 2021

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<tbody>
<tr>
<td>35</td>
<td>CADTF</td>
<td>3</td>
<td>2021</td>
<td>Receivable for Securities factor</td>
<td></td>
<td>Consider evaluating the factor every 3 years. (2021, 2024, 2027, etc.) Factors are exposed for comment. Comments due May 28, 2021 for consideration on June 30th.</td>
</tr>
<tr>
<td>36</td>
<td>CADTF</td>
<td>3</td>
<td>2022 or Later</td>
<td>NAIC Designation for Schedule D, Part 2 Section 2 - Common Stocks Equity investments that have an underlying bond characteristic should have a lower RBC charge? Similar to existing guidance for SVO-identified ETFs reported on Schedule D-1, are treated as bonds.</td>
<td>Referral from SAPWG 8/13/2018</td>
<td>10/8/19 - Exposed for a 30-day Comment period ending 11/8/2019 3-22-20 - Tabled discussion pending adoption of the bond structure and factors.</td>
</tr>
<tr>
<td>37</td>
<td>CADTF</td>
<td>3</td>
<td>2022 or Later</td>
<td>Structured Notes - defined as an investment that is structured to resemble a debt instrument, where the contractual amount of the instrument to be paid at maturity is at risk for other than the failure of the borrower to pay the contractual amount due. Structured notes reflect derivative instruments (i.e. put option or forward contract) that are wrapped by a debt structure.</td>
<td>Referral from SAPWG April 16, 2019</td>
<td>10/8/19 - Exposed for a 30-day Comment period ending 11/8/2019 3-22-20 - Tabled discussion pending adoption of the bond structure and factors.</td>
</tr>
<tr>
<td>38</td>
<td>CADTF</td>
<td>3</td>
<td>2022 or Later</td>
<td>Comprehensive Fund Review for investments reported on Schedule D Pt 2 Sn2</td>
<td>Referral from VOSTF 9/21/2018</td>
<td>Discussed during Spring Mtg. NAIC staff to do analysis. 10/8/19 - Exposed for a 30-day comment period ending 11/8/19 3-22-20 - Tabled discussion pending adoption of the bond structure and factors.</td>
</tr>
</tbody>
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### Carry-Over Items Currently Being Addressed – Task Force

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<tr>
<td>39</td>
<td>CADTF</td>
<td>2</td>
<td>2020 or Later</td>
<td>XXXXXXX Captive Reinsurance RBC Shortfall</td>
<td>Referral from Reinsurance Task Force</td>
<td>Referred to Life RBC WG for consideration and comment</td>
</tr>
<tr>
<td>40</td>
<td>CADTF</td>
<td>2</td>
<td>2020 or Later</td>
<td>Payout Annuities for RBC</td>
<td>Referral from Allstate and IL DOI</td>
<td>Referred to Life RBC WG for consideration and comment</td>
</tr>
<tr>
<td>41</td>
<td>CADTF</td>
<td>2</td>
<td>2020 or Later</td>
<td>Guaranty Association Assessment Risk</td>
<td>Referral from Receivership and Insolvency (E) Task Force</td>
<td>Referred to the Life-RBC WG and Health-RBC WG for consideration and comment.</td>
</tr>
</tbody>
</table>
Health Risk-Based Capital (E) Working Group
Virtual Meeting (in lieu of meeting at the 2021 Summer National Meeting)
July 12, 2021

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met July 12, 2021. The following Working Group members participated: Steve Drutz, Chair (WA); Jennifer Li (AL); Wanchin Chou (CT); Kyle Collins, (FL); Tish Becker and Brenda Johnson (KS); Rhonda Ahrens, Lindsay Crawford and Michael Muldoon (NE); Tom Dudek (NY); Kimberly Rankin (PA); and Mike Boerner, Matthew Richard, and Sean Fulton (TX).

1. **Adopted its June 8, May 25, and April 23 Minutes**

The Working Group met June 8, May 25, and April 23. During these meetings, the Working Group took the following action:
1) adopted its March 17 minutes; 2) discussed the 20 bond designation factors; 3) received comments and referred the investment income adjustment to the underwriting risk factors (2021-04-CA) proposal to the Capital Adequacy (E) Task Force; 4) discussed, exposed, and requested the American Academy of Actuaries’ (Academy’s) assistance in a comprehensive review of the H2 – Underwriting Risk component; 5) adopted revisions to the 2021 health risk-based capital (RBC) working agenda; 6) adopted proposal 2021-09-H (Bond Factors); 7) discussed developing a process and the other lines of business to be considered for investment income in the underwriting risk factors; and 8) received an update on the Health Test and Health RBC Excessive Growth Charge Ad Hoc Groups.

Mr. Chou made a motion, seconded by Mr. Boerner, to adopt the Working Group’s June 8 (Attachment Three-A), May 25 (Attachment Three-B), and April 23 (Attachment Three-C) minutes. The motion passed unanimously.

2. **Adopted its 2021 Health RBC Newsletter**

Mr. Drutz said the health RBC newsletter has been updated to include a summary of the proposals adopted for the 2021 health RBC formula, which have been incorporated into the instructions, blanks, and formula.

Ms. Rankin made a motion, seconded by Mr. Dudek, to adopt the 2021 health RBC newsletter (Attachment Three-D). The motion passed unanimously.

3. **Approved the 2020 Health RBC Statistics**

Mr. Drutz said the 2020 health statistics were run on June 30. He said there were 1,067 health RBC filings loaded onto the NAIC database, up from 1,012 in 2019. Fifteen companies triggered an action level in 2020, of which four were in a company action level, three were in a regulatory action level, two were in an authorized control level, and six were in a mandatory control level. Twelve companies triggered the trend test. He said that both the authorized control level (ACL) and total adjusted capital (TAC) increased from 2019 to 2020.

The Working Group unanimously approved the 2020 health RBC statistics (Attachment Three-E) to be posted to the Working Group’s web page.

4. **Received a Response from the Academy on H2-Underwriting Risk Component Review**

Derek Skoog (Academy) said that the Academy is happy to support the effort and review of the underwriting risk factors. (Attachment Three-F) He asked the Working Group to provide guidance on: 1) the scope and phases of work; 2) desired output/perspective requested by the NAIC from the Academy; and 3) general time frame and key dates/deadlines to assist in putting a project plan together. He said that the Academy wants to be thoughtful and upfront to make sure that the Working Group gets the information needed and in the time frame that is needed.

Mr. Drutz said that the scope and phases of work could include breaking out the work by structure, factors, or potentially by line of business and managed care credit. Mr. Skoog agreed. He said this will allow the Academy to identify where to focus its resources. He said that the Academy plans to approach this review in pieces to ensure that it is providing the Working Group with the information it is looking for, by starting with a survey and review of methodologies.
Mr. Drutz said that the Working Group may address the desired output/perspective requested by the NAIC from the Academy by asking if: 1) the current structure and formula still accurately reflect the risks associated with the types of business included under the H2 component; 2) there are other business types that should be considered; and 3) the structure and format of the H2 component still make sense. Mr. Boerner agreed with the questions outlined on addressing the desired output/perspective.

Mr. Drutz said if a year-end 2023 implementation date was used, the Working Group would need to receive a final report by year-end 2022 in order to expose and address any structural changes that would need to be implemented. He asked if this seemed to be a reasonable time frame to work towards and noted that if additional time was needed, the Working Group could work with the Academy to revise this. Mr. Skoog agreed that this seemed like a reasonable time frame. Mr. Boerner agreed with this approach.

Mr. Skoog said that given the importance and impact of the managed care credit, the Academy would tackle both the underwriting risk and managed care credit together because it is difficult to extricate the managed care credit from how the broader underwriting risk factors work today. He suggested that the Academy discuss both the underwriting risk and managed care credit together within the context of the broader underwriting risk structure.

Lou Felice (NAIC) suggested that additional study be done on “incentives” within the “withholds or bonuses/incentives” portion of the managed care credit to clarify what is still valid with regard to these types of incentive arrangements. Mr. Skoog said that this is something that could be incorporated into the project.

Mr. Skoog said that the information provided will assist the Academy in moving forward. The Academy will then come back to the Working Group to discuss the existing structure, fit for purpose and to the extent necessary suggested structure alternatives, quantification approaches, and come up with a path forward but not yet a full execution. He said that it may make the most sense for the Academy to first focus on the Underwriting Risk – Experience Fluctuation Risk page (experience fluctuation risk) and determine if those columns are the right roll up of the Analysis of Operations page. Mr. Muldoon said it would be worthwhile to understand all the pieces of the experience fluctuation risk page and if it is the correct roll up and combination of how that should be.

Mr. Drutz summarized the Academy’s approach as first reviewing the structure to ensure it would meet the purposes going forward and any changes to consider. Then the Academy will go to a more granular level and look at the different lines of business.

The Academy agreed to provide updates to the Working Group.

5. Discussed Bond Factors

Mr. Drutz said that the Working Group adopted the Academy’s proposed health bond factors with the bond portfolio adjustment for year-end 2021 reporting. He said the Academy’s life model was used as the basis in the development of the health bond factors and adjusted for health assumptions. He said the Life Risk-Based Capital (E) Working Group adopted the proposed Moody’s bond factors in June, which used differing assumptions from the Academy model.

Mr. Drutz asked if the Working Group thinks the adopted bond factors should be reevaluated given the differing models used between the life and health formulas. Mr. Chou said the Working Group should reevaluate the bond factors due to major assumption differences in the models by the Academy and Moody’s. The Academy used the economic state of the cycle, while Moody’s used a correlation model. He also noted that the original scope of the Academy’s data was from 2010.

Mr. Drutz said the Moody’s analysis used a typical life bond portfolio and not the broad spectrum of bonds available out in the market. He said consideration may need to be given on how a health portfolio may differ from life, as well as how that could drive some of the differences in analysis between the Moody’s and Academy’s models.

Mr. Drutz said the Working Group would need to gain a better understanding of the Moody’s model, as well as compare the differences between each model. He said the Working Group will need to identify the assumptions used by Moody’s and how those assumptions would align with health. Mr. Felice said that the Property and Casualty Risk-Based Capital (E) Working Group also adopted the Academy’s factors and suggested bringing this to the Capital Adequacy (E) Task Force to identify a justification for each group to look at adjusting the factors based on what the Life Risk-Based Capital (E) Working Group did. Mr. Chou said that he also brought this up to the Property and Casualty Risk-Based Capital (E) Working Group. Mr. Drutz
agreed to reach out to the Property and Casualty Risk-Based Capital (E) Working Group and the Working Group will continue
to discuss this item further on future calls.

6. Discussed Developing a Process and the Other Lines of Business to Be Considered for Investment Income in the
   Underwriting Risk Factors

Mr. Drutz said the Working Group previously adopted revised underwriting factors for comprehensive medical, Medicare
supplement, and dental and vision business to include a 0.5% investment income adjustment. He said the Working Group
agreed to develop benchmarking guidelines for updating the factors in the future for potential changes in investment yields. He
suggested the following approach based on the previous discussions: use a three- or six-month Treasury as the basis of the
benchmark and round up to the nearest 0.5% mark. For example, if the current rate was 0.4%, the investment yield would
remain at 0.5%. However, if the yield increased to 0.7%, the yield would round up to 1%. Mr. Drutz suggested using Jan. 1 for
which to base the adjustment. He said his suggestion for rounding up to the nearest half a percent was based on previous
discussions where the argument was made to base the adjustment on the investment portfolio as a whole, while other arguments
were made to the fact that the premiums that are part of the underwriting components are only held by the companies for a
short period of time, and the investment income from those premiums that are held are later paid out in claims. Therefore
the yield on those investments was little. Therefore, the rounding up to the nearest half percent was to provide a compromise
between both arguments.

Mr. Muldoon agreed with what has previously been discussed and noted that the Working Group will likely be reviewing this
again as part of the H2 review. He suggested using the six-month Treasury and rounding up to the nearest half of a percent, as
well as the Jan. 1 date to update annually based on where the Working Group is at right now.

Jim Braue (UnitedHealth Group—UHG) said that UHG thinks that using something like a six-month Treasury is excessively
conservative. If one is focusing on the run-off period of the reserves or the lag between premium receipt and pay out of claims,
that is basically looking at it from the viewpoint that 100% of the business runs off immediately. He said it was noted during a
previous meeting that while it may not be the case that one should expect 100% to run-off immediately, it could easily be the
case that 30% runs off immediately. This is true and supports UHG’s position. For example, 30% of the business runs off
immediately, and then another 30% runs off each year thereafter. Then one still has about two and a half years average maturity
of the business. In order to get down to six months, one would have something like 60% of the business running off
immediately. This means the day after RBC is calculated and the entirety of the remainder of the business running off the next
year, so it is a conservative approach and is not consistent with what is actually going on in the business. Mr. Braue said that
investment income adjustment was driven on a charge for a risk associated with the investment portfolio, and it seems
appropriate to have an offset for the benefits arising from that portfolio. He said UHG originally suggested that the adjustment
be incorporated as part of the bond factors. However, based on the Academy’s recommendation, the adjustment was made to
the underwriting risk factors. He said as a result one is really only looking at the investments associated with the claim reserves
in effect and ignoring some of the longer liabilities that may be out there, such as rate credit reserves that may not pay out until
a fair amount of time is past even after the business has run of the books. He said it also does not reflect the earnings on surplus.
Mr. Braue said from the extremely conservative viewpoint of how long the business will stay around and the extremely
conservative viewpoint of what investment should even be considered, the end result will be extremely conservative. He said
UHG understands the arguments for not going out the full five years to be consistent with the bond factors and consistent with
the modeling done for those factors, but going down to three to six-months is excessive. He said that an average maturity could
be calculated for a reasonable amount of business that is terminated each year and could come out with something in excess of
a year and maybe even two years. He asked the Working Group to give further consideration to this.

Mr. Drutz said his understanding of a run-off period is that premium is brought in on month one, and claims are generally paid
out on those premiums in months two and three. By the time one gets to month six, those claims have already been paid by
those premiums that were initially taken in. Mr. Braue said in terms of cash flow, premiums come in at the beginning of the
first month, and claims are paid out in the second month. However, in that second month, additional premiums would be
received. He said not everything would be invested in one-month instruments because one is going to be paying out claims in
the next month and there is a reasonable expectation of receiving more premium in the next month and more premium in the
month after that. The result is that with the net cash inflow over that entire period, one never has to liquidate any investments.
Therefore, it is not that one is taking those same premium dollars and paying them out a month and a half later. There is a
constant inflow of premiums and a constant outflow of claims. As long as the business is at least a break even, the entity will
generally have a net positive cash flow and would not have to liquidate any investments or use the maturity proceeds of any
investments to pay claims. Mr. Braue said the assumption cannot be made that business will remain constant or grow forever.
Therefore, a conservative short time horizon may be considered. He said typically an entity is not going to invest all of the

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money back in claim reserves in one-month instruments. He said from a cash-flow standpoint, an entity is not constantly investing money and then immediately liquidating the investment to pay claims. Instead, the entity invests based on what the net cash flow is going to be over time. Mr. Braue said that determining how quickly the business will run-off will determine how far out a company can invest.

Mr. Muldoon said that when reviewing the investment income, the Working Group should look at what carriers are telling state insurance regulators in the rate filings, such as how much investment income they are getting and how much is accounted for in their margins. He said some carriers state it is so negligible (not even one-tenth of a percent) that they do not account for it in their profit margins or contingency margins. Because the investment income on the unpaid claim liability reserves is so small and such a short-term liability, they do not make any investment income on it. He said at some point, the Working Group will need to put those pieces together, where they tell state insurance regulators that there is almost no investment income so it is not identified as part of the retention versus the argument here. Mr. Muldoon said that for the time being, the proposal that Mr. Drutz outlined seems the best approach for moving forward at this time.

Mr. Drutz said that the Working Group will continue to discuss this during future meetings.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.
The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met June 8, 2021. The following Working Group members participated: Steve Drutz, Chair (WA); Jennifer Li (AL); Wanchin Chou (CT); Kyle Collins, Lilyan Zhang and Benjamin Ben (FL); Tish Becker (KS); Rhonda Ahrens (NE); Tom Dudek (NY); Kimberly Rankin (PA); and Aaron Hodges and Sean Fulton (TX).

1. **Referred the Request Letter to the Academy to Review the Underwriting Risk – H2 Component**

Mr. Drutz said the letter to the American Academy of Actuaries (Academy) to request its assistance in reviewing the Underwriting Risk – H2 component was exposed for a short time, during which no comments were received. He suggested that the July 30 response date be modified to July 10 due to working groups meeting in advance of the Summer National Meeting scheduled for August. Derek Skoog (Academy) indicated that the Academy could provide a response by July 10.

Mr. Chou made a motion, seconded by Mr. Dudek, to refer the request letter (Attachment Three-A1) to the Academy to review the Underwriting Risk – H2 component with a modification to change the response date to July 10. The motion passed unanimously.

2. **Adopted Updates to the 2021 Health RBC Working Agenda**

Mr. Drutz said item 21 on the health risk-based capital (RBC) working agenda has been modified to include the following: 1) develop a process to review the investment income adjustment; 2) determine the frequency for updates to the adjustment; and 3) determine if other lines of business should include an investment income adjustment.

Ms. Rankin made a motion, seconded by Mr. Chou, to adopt the revised 2021 health RBC working agenda (see NAIC Proceedings – Summer 2021, Capital Adequacy (E) Task Force, Attachment Seven). The motion passed unanimously.

3. **Discussed Developing a Process and the Other Lines of Business to be Considered for Investment Income in the Underwriting Risk Factors**

Mr. Drutz said the Working Group previously agreed to begin developing a process for reviewing the investment income in the underwriting risk factors, and one way to do this would be to develop a set of benchmarks for the updates. He said one possible benchmark could be a six-month treasury, rounded up for the nearest 0.5%, and it could then be reviewed annually until the Academy’s review of the H2 component is completed. He said the suggestion to round up to the nearest 0.5% was based on interested party comments to use a higher investment yield and a longer holding assumption of five years for assets. He said based on the Working Group’s decision to use the 0.5% investment yield in the comprehensive medical, Medicare supplement, and dental and vision factors, it seems that a five-year benchmark should not be used; however, if Working Group members feel a need to revisit this possibility, they can pursue it.

Mr. Drutz said the Working Group also agreed to look at incorporating investment income into the other lines of business, and one approach may be to incorporate this into the Underwriting Risk – H2 component review; however, this may depend on the timeline for completion of that review. He said if the Working Group feels that the other lines of business need to be reviewed sooner, they can reach out to the Academy on the feasibility of this. He suggested that the Working Group revisit this once a response from the Academy has been received regarding the Underwriting Risk – H2 component review.

Mr. Drutz said the Working Group will continue to discuss this topic on future calls.

4. **Received an Update on the Health Test and Health RBC Excessive Growth Charge Ad Hoc Groups**

Mr. Drutz said the Health Test Ad Hoc Group met June 2 and discussed the current health test language, most specifically the “Passing the Test” section. He said the ad hoc group discussed whether there is a need to update the language at this time, given the recent updates to the annual statement by the Blanks (E) Working Group. He said the ad hoc group plans to perform additional analysis to see how many companies would move if the “licensed in 5 states or less...” and “writing 75% of premium
in the domiciliary state…” were removed and the 95% premium and reserve ratio were left as is. The ad hoc group also discussed whether the premium and reserve ratio should be modified. The ad hoc group is currently scheduled to meet again July 14.

Mr. Drutz said the Excessive Growth Charge Ad Hoc Group met June 2 and took the following action: 1) discussed how to continue moving the project forward, including the review of the property/casualty (P/C) excessive growth charge; and 2) continued analysis, including a case study. The ad hoc group is scheduled to meet again in July to continue its work on this project.

5. Discussed Other Matters

Mr. Drutz said the Working Group previously exposed proposal 2021-09-H – Bond Factors, with no comments received, and adopted it on its May 25 call. He noted that the bond portfolio adjustment was included within the Academy’s Bond Factor Model, as discussed and approved by the Working Group. Therefore, as a result, the portfolio adjustment is included within the health bond factors on page XR006 – Off-Balance Sheet Security Lending Collateral and Schedule DL, Part 1 Assets. Mr. Drutz said this is being brought to the Working Group’s attention because the life and property RBC formulas do not reflect a bond portfolio adjustment on the Off-Balance Sheet Security Lending Collateral and Schedule DL, Part 1 Assets page, whereas the health bond factors on page XR006 will include the bond portfolio adjustment. He said the impact analysis did include these factors, and the one company that moved to the trend test did not have any off-balance sheet collateral items. He said there are only 42 out of 952 companies that report off-balance sheet collateral items, and the overall industry change to authorized control level (ACL) RBC is approximately $5.7 million

Mr. Drutz said based on the lack of materiality on the inclusion of the bond portfolio adjustment in the off-balance sheet collateral charges, he does not see a reason to revisit the bond factor proposal previously adopted for 2021 reporting. He noted that if the Working Group feels that further consideration is needed, they can discuss this issue further to determine if a change is necessary for 2022 reporting.

Mr. Chou said the health bond factors were based on the original Academy life bond factor model and the 2017 study. He said the Life Risk-Based Capital (E) Working Group is continuing to study the life bond factors, and he suggested that the Health Risk-Based Capital (E) Working Group review the bond factors again after the Life Risk-Based Capital (E) Working Group has adopted its factors to consider any changes in methodology and updated data.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.

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MEMORANDUM

TO: Derek Skoog, Chair of the Health Solvency Subcommittee of the American Academy of Actuaries

FROM: Steve Drutz, Chair of the Health Risk-Based Capital (E) Working Group

DATE: May 25, 2021

RE: Request for Comprehensive Review of the H2 – Underwriting Risk Component and Managed Care Credit Calculation in the Health Risk-Based Capital Formula

On April 23, 2021, the Health Risk-Based Capital (E) Working Group agreed to request assistance from the Health Solvency Subcommittee of the American Academy of Actuaries (Academy) to perform a comprehensive review of the H2 – Underwriting Risk component and the managed care credit calculation in the health risk-based capital (RBC) formula. While there have been modifications to certain pieces of the H2 – Underwriting Risk component, there has not been a comprehensive review of the component and the managed care credit calculation performed since the inception of the formula in 1998.

Because of the evolving and changing health market over the last 23 years, the Working Group believes a review of the lines of business, methodology, and factors for the H2 – Underwriting Risk component is warranted at this time.

The Working Group requests the assistance of the Health Solvency Subcommittee to perform a comprehensive review of the H2 – Underwriting Risk component and the managed care credit calculation in the health RBC formula. Please notify the Working Group by July 30, 2021, if the Academy is willing to accept and work on this project.

Please send any questions or comments to Crystal Brown (NAIC) via email at cbrown@naic.org.

cc: Matthew Williams, Staff Support of the Health Solvency Subcommittee of the Academy
The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met May 25, 2021. The following Working Group members participated: Steve Drutz, Chair (WA); Blase Abreo and Jennifer Li (AL); Wanchin Chou and Andrew Greenhalgh (CT); Hui Tao and Lilyan Zhang (FL); Tish Becker (KS); Rhonda Ahrens, Lindsay Crawford and Michael Muldoon (NE); Tom Dudek (NY); Kimberly Rankin (PA); and Aaron Hodges (TX).

1. **Adopted Proposal 2021-09-H (Bond Factors)**

   Mr. Drutz said proposal 2021-09-H was exposed with the five-year time horizon bond factors for a 20-day comment period, and no comments were received. Mr. Chou suggested that the Working Group consider a future review of the factors for two reasons: 1) potential changes in the life bond factors since the health factors were based on the 2017 version and different from what life used; and 2) the relationship between life, health and property/casualty (P/C) are quite similar, and methodology changes to the life formula may need to be considered for health. He said he agrees with moving the current proposal forward and re-evaluating the factors in the future after life has made their final adoption.

   Mr. Chou made a motion, seconded by Mr. Muldoon, to adopt proposal 2021-09-H (see NAIC Proceedings – Summer 2021, Capital Adequacy (E) Task Force, Attachment One-C). The motion passed unanimously.

2. **Referred Proposal 2021-04-CA to the Capital Adequacy (E) Task Force for Consideration**

   Mr. Drutz said proposal 2021-04-CA was exposed by the Capital Adequacy (E) Task Force for all lines of business until May 21, and one comment letter was received from UnitedHealth Group (UHG).

   Jim Braue (UHG) summarized UHG’s comment letter and suggested that additional consideration be given to the appropriate investment income rate to be used in the future; however, for the present and in the interest of timeliness, UHG supports the current proposal, as it stands for year-end 2021 reporting.

   Mr. Muldoon said he is open to hearing additional discussion to determine if the Working Group should consider looking at the short-term liabilities or the five-year bond investment rate for the entire bond portfolio of a company. He said there could be a disconnect in having a large bond portfolio that is two to three times larger than the same reserve liability, and somewhere within this bond portfolio, there is not a specific set of bonds to cover the claim reserves. He said the Working Group must still have a range of short-term to long-term bonds that are used to cover much more than just the investment returns on the claim reserves. He said it does not seem as simple as just splitting it apart and going with a five-year bond portfolio rate. He said Colorado has a regulation that requires health insurers in their rate filings to account for the investment income that is being made on the unpaid claim liability reserves and the incurred but not reported (IBNR) losses and accounted for in the profit margins. He said many companies would say they had very short-term liabilities and made very little investment income, thus they would build in zero for their investment income because they did not want to have to account for it as part of their retention. He said UHG’s comment letter indicated that state insurance regulators cannot just go by if a plan terminates. He said it is not just if a plan terminates all their health business, it can affect companies writing federal Affordable Care Act (ACA) business. Because there are new companies coming in all the time and should one of those companies lose 30% of their volume in a year and then lose premium in the next year, they would still have to cover all the run out of claims in the next year. Now the company must cover those very short-term claims run outs, and by using the five-year adjustment, it would assume that all the company invested in were five-year bonds, which would be unlikely. Reviewing a company’s bond list shows a wide range of varying maturity dates. Mr. Muldoon said he does not believe that a simple argument can be made to disconnect the short-term duration of the claim reserve liabilities from the overall bond portfolio, which is much larger and covers other kinds of risk.

   Mr. Muldoon reiterated that he is open to hearing more discussion on this because the American Academy of Actuaries’ (Academy’s) recommendation reflected that the investment rate was based on these being very short-term liabilities or a one-year business, which makes sense in an ACA world where things can change significantly from year to year.

   Mr. Drutz suggested that the Working Group refer the proposal back to the Capital Adequacy (E) Task Force for consideration on its June 30 call using the 0.5% investment income return for year-end 2021 reporting. He said the Working Group will
update the working agenda to continue its work on developing a process for reviewing the assumed rate of investment return in future years and the frequency for which the adjustment should be reviewed.

Hearing no objections, proposal 2021-04-CA was referred to the Capital Adequacy (E) Task Force for consideration on all lines of business on its June 30 call.

3. Exposed the Letter to the Academy to Review the H2 – Underwriting Risk Component

Mr. Drutz said the Working Group agreed to request the Academy’s assistance in performing a comprehensive review of the H2 – Underwriting Risk component that includes a review of the lines of business, methodology and factors. He suggested that the Working Group expose the letter for a 10-day public comment period ending June 3.

Hearing no objections, the request letter was exposed for a 10-day public comment period ending June 3.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.
The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met April 23, 2021. The following Working Group members participated: Steve Drutz, Chair (WA); Steve Ostlund and Jennifer Li (AL); Wanchin Chou, (CT); Carolyn Morgan and Kyle Collins (FL); Tish Becker (KS); Michael Muldoon (NE); Tom Dudek (NY); Kimberly Rankin (PA); and Matthew Richard and Aaron Hodges (TX).

1. **Adopted its Spring National Meeting Minutes**

The Working Group met March 17, 2021, and took the following action: 1) adopted its Feb. 10, 2021; Jan. 22, 2021; and Dec. 18, 2020, minutes; 2) adopted its 2021 working agenda; 3) referred proposal 2021-02-CA to the Capital Adequacy (E) Task Force for exposure; 4) received an update from the American Academy of Actuaries (Academy) on incorporating investment income into the Underwriting Risk – H2 component and exposed proposal 2021-04-CA; and 5) received an update on the bond factor impact analysis.

Mr. Drutz said the Working Group met March 31 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to review the company specific impact analysis on the two- and five-year time horizon bond factors.

Mr. Chou made a motion, seconded by Mr. Dudek, to adopt the Working Group’s March 17 minutes (see NAIC Proceedings – Spring 2021, Capital Adequacy (E) Task Force, Attachment Two). The motion passed unanimously.

2. **Discussed 20 Bond Designation Bond Factors**

Mr. Drutz said the Working Group has continued to work with the Academy on the 20 new bond designations and factors as well as Johnson Luk (New York Department of Financial Services) and Eva Yeung (NAIC) to develop the impact analysis for the proposed health bond factors.

Mr. Drutz summarized the results of the health bond factor impact analysis (Attachment Three-C1). He said the base factors and BSF table reflects the current and proposed two- and five-year-time horizon factors, as well as the difference between the current factors and proposed factors. The two-year time horizon factors for NAIC 01 bonds are, for the most part, equal to or less than the current factors except for the NAIC 1F and 1G. The five-year factors for NAIC 01 bonds are equal to or greater than the current factors. Because the NAIC 3A–6 factors were calculated on a different basis than the NAIC 1A–2C factors, the only difference in the two- and five-year time horizon factors are for NAIC 1A–2C. The two- and five-year time horizon factors include the bond portfolio adjustment rather than having a separate charge or calculation. Currently, the health formula does not include a portfolio adjustment.

Mr. Drutz said the Results page provides a summary of the overall impact of the proposed two- and five-year time horizon factors. Table One shows the percent change in the H1 component by company size, as well as the percent change in Authorized Control Level (ACL). The change in the H1 component is relatively small, while the largest average change in the ACL for the five-year factors was 2.345%. Table Two shows the comparison of action level for the change in factors. There is no change in an action level for the two-year factors, while one company moved from no action to the trend test level with the five-year factors. The company that moved to the trend test was due to the significant amount in the company’s H1 component compared to the H2 component, and a large majority of the bonds are held in NAIC 1E–2C bonds. Table Three shows the distribution of the percent change in the H1 charges by company size. Table Four shows the percent change in ACL by company size. Most companies in both the two- and five-year time horizon factors had only a 5% change in their ACL. Mr. Drutz said four companies showed an improvement on their risk-based capital (RBC) with the five-year factors; however, given that the five-year factors are equal to or greater than the current factors, the RBC ratio should have been lower. NAIC staff have reviewed these four companies and found that the book/adjusted carrying value (BACV) of the NAIC 01 bonds in Column 1A and Column 1 was not reported consistently, and the companies were contacted to identify the reason for the inconsistencies. Table Five shows the distribution of the percent change in RBC ratios by company size, with most companies having only about a 5% change in their RBC ratio under both the two- and five-year time horizon factors.
Mr. Chou said the Life Risk-Based Capital (E) Working Group is looking at the bond factors and potential changes based on the Moody’s report. He said the NAIC 3A–3C factors in health seem significantly higher than life, and he suggested that further consideration be given to these factors. Crystal Brown (NAIC) said for health companies, NAIC 1 and 2 bonds (investment grade) are reported at amortized cost, while NAIC 3–6 (non-investment grade) are reported at amortized cost or fair value, and this is one reason for the difference in the NAIC 3–5 bond factors between life and health.

Mr. Drutz said the Academy’s original report indicated that a time horizon greater than two years could be considered, and the duration of assets for health insurers is about 5.2 years, which is longer than the duration of liabilities. He said a two-year time horizon makes it harder for regulatory framework to support an amortized cost basis rather than a market value-based valuation, whereas using a five-year time horizon would be more consistent with the property/casualty (P/C) formula and the asset duration for health is five years.

Hearing no objections, proposal 2021-09-H was exposed with the five-year time horizon factors for a 25-day public comment period ending May 21.

3. Received Comments on an Investment Income Adjustment to the Underwriting Risk Factors (Proposal 2021-04-CA)

Mr. Drutz said the Working Group worked with the Academy to incorporate investment income into the underwriting risk factors for Columns 1–4 on the Experience Fluctuation Risk page, and it previously exposed both the 0.5% and 1% adjusted factors. Two comment letters were received during the comment period (Attachments Three-C2 and Three-C3).

Jim Braue (UnitedHealth Group—UHG) said UHG supports the changes, and it is appropriate to include investment income in the health RBC formula. He said the key item of its comment letter relates to the rate of investment return, and it suggested that the Working Group establish the rationale for what rate should be used to support the change, as well as provide a path for updating the factors as necessary in the future. He said UHG believes there are four key considerations in determining the rationale for the rate to be used. The first is what the average maturity of the investments is to assume. Mr. Braue said UHG strongly believes the rate should be tied to the average maturity for the bond factors themselves, because it is all the same portfolio of bonds. He said to be consistent with the five-year bond factors that were exposed, and if those factors are adopted, UHG would recommend that a five-year maturity be considered for the rate of investment return as well. The second consideration is the average quality, because there have been concerns raised in the past about using a quality that is tied to an insurer’s actual portfolio, as it could provide inappropriate incentives to move to lower quality investments. Mr. Braue said UHG believes it would be appropriate to use something similar or like a U.S. Department of the Treasury (Treasury Department) rate, which is considered risk free or at least a very high-quality bond rate, to avoid any improper incentives. The third consideration is the historical time period, UHG believes historical rates and not projected rates should be used in order to give a firmer foundation. Mr. Braue said UHG does not believe it would be appropriate to look at current rates because that is not generally representative of what portfolios are actually earning at any given time. He suggested two possible ways to look at this: 1) as a time period that is fairly consistent with the maturity assumption; and 2) rounding. He said maturity assumption is not a perfect proxy for when investments in the portfolio would have been purchased, but it seems like a reasonable approximation for this purpose. He said if going with a five-year maturity, it may be appropriate to take a five-year average rate to pick the rate of investment return. He added that if a five-year average is used, it could potentially change significantly every two to three years and possibly update the factors more frequently. He said if the Working Group wants factors in place for a longer period and that requires less frequent updating, a longer period could be used and considered as a long-term average, which would be appropriate for long-term solvency regulation. Mr. Braue said the factors should be rounded to a sufficient degree of precision, so that significant changes are not skewed; however, they should not be rounded to a precision so that they have to be re-evaluated every time the rate changes by one basis point. UHG suggested using between a quarter and half of a percentage point; however, a quarter of a point will still make a meaningful change in the underwriting risk factors. Based on those considerations, a table of rates resulting from the various combinations was included in the comment letter. Mr. Braue noted that the high tier factors in the Academy’s letter were rounded to one-tenth of a percent, whereas the lower tiered factors were rounded to two-tenths of a percent, and he suggested that the two-tenths of a percent be used in both the high tier and low tier factors for greater precision. Steve Guzski (Academy) said the Academy would provide the Working Group with revised factors to include the rounding to two-tenths of a percent in the high tier factors.

Mr. Drutz said in the Academy letter, it discussed how the investment income tied to the underwriting risk factors would relate primarily to the run-off of claims, and the average for comprehensive medical is 1.5 months. He asked Mr. Braue if he disagreed with that concept. Mr. Braue said it is wrong to think of the 1.5 months as being the runoff of the reserves and therefore the runoff of the assets. He said the underwriting risk factors have nothing to do with the runoff of reserves. He said they look at the potential for underwriting losses over a period of time; i.e., two to three years. He said when modeling out over two years,
premiums come in regularly and claims are paid out regularly, and the investments represent the timing difference between the premium and claims. Therefore, the 1.5 month difference is not the difference between 0 and 1.5, but instead more like the difference between two years and two years and 1.5 months. The maturity of the assets that are being looked at should not be thought of as 1.5 month assets, but instead thought of as two year and 1.5 month assets or three year and 1.5 month assets. Mr. Braue said the case could be made that it should be tied back to the modeling period, but the Working Group has already made the decision with respect to the bond factors to think of it in terms of asset maturity rather than the liability maturity; therefore, to be consistent, asset maturity should be considered here. Mr. Drutz said when writing this business, more assets must be kept liquid, such that those claims payments can continue to roll over and then more premiums are received but still need to keep that liquidity.

Carl Labus (Blue Cross Blue Shield Association—BCBSA) summarized its comment letter and noted that the investment income is warranted. He said the maturity dates in its health portfolios are longer than those highlighted in the Academy’s letter for a claim payment pattern. He suggested that the Working Group consider a longer horizon because there is a claim payment pattern, where there are constant cash flows coming that support payment of claims, but non-profit health plans have to build up surplus, and the assets that support surplus have longer maturities and generate investment to support growth and capital as well as changes the health care industry is experiencing. He said that the BCSBSA supports the 1% option over the 0.5% option. He also suggested a transparent process for updating these factors in the future.

Mr. Drutz said he is leaning towards the 0.5% assumption after looking at the six-month and one-year Treasury Department yields. The six-month Treasury Department yield has ranged from a high 0.2% to 0.04% currently, and the one-year Treasury Department ranged from 0.2% to 0.07% currently. Mr. Muldoon agreed with moving forward with the 0.5%.

Hearing no objections, proposal 2021-04-CA was referred to the Capital Adequacy (E) Task Force for an exposure for all lines of business, with any comments to come back to the Working Group.

4. Discussed a Comprehensive Review of the H2 – Underwriting Risk Component and Adopted the Revised Working Agenda

Mr. Drutz said the Underwriting Risk - H2 component has not had a comprehensive review since its inception in 1998. There have been portions, such as stop loss, stand-alone Medicare Part D, and other health and non-health, that have been looked at on an individual basis. He asked the Working Group if it believes it would be beneficial to ask the Academy to do a comprehensive review of the H2 component, along with a review of the Managed Care Credit based on recent discussions related to the managed care credit and the investment income. He said he did reach out to the Academy to see if this is something it would be willing to look at, and it agreed that it would. Mr. Muldoon said Nebraska is in favor of a comprehensive review of the Underwriting Risk – H2 component. Mr. Drutz added that the working agenda was revised to include the underwriting risk review.

Hearing no objections, the Working Group agreed to move forward with the request to seek the Academy’s assistance in performing a comprehensive review of the Underwriting Risk – H2 component, and it requested that NAIC staff draft the request letter to be discussed on its next call.

Mr. Muldoon made a motion, seconded by Mr. Chou, to adopt the revised working agenda (see NAIC Proceedings – Summer 2021, Capital Adequacy (E) Task Force, Attachment Seven) to incorporate the Underwriting Risk – H2 component review. The motion passed unanimously.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.
### 2020 RBC Charges by Company Size - Current verse 2-Yr Time Horizon Bond RBC Charges

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<th>TAC Size</th>
<th>0 - $5M</th>
<th>$5M - $25M</th>
<th>$25M - $75M</th>
<th>$75M - $250M</th>
<th>$250M - $1B</th>
<th>Over $1B</th>
<th>Total</th>
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<td>2,520,351</td>
<td>7,681,874</td>
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<td>H0 - Current</td>
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<td>H0 - (2-Yr Horizon)</td>
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<td>2%</td>
<td>6%</td>
<td>4%</td>
<td>5%</td>
<td>7%</td>
<td>6%</td>
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<tr>
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<td>6,424</td>
<td>39,083</td>
<td>277,113</td>
<td>894,857</td>
<td>3,865,754</td>
<td>4,932,231</td>
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<td>19,340</td>
<td>51,487</td>
<td>182,227</td>
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<td>1,323,431</td>
<td>3,753,462</td>
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<tr>
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<tr>
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<td>9,999,052</td>
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### 2020 Health RBC - Comparison of Action Levels by Company Size Between Current and 2-Yr Time Horizon Bonds RBC Charges

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### 2020 RBC Charges by Company Size - Current verse 5-Yr Time Horizon Bond RBC Charges

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<td>39,083</td>
<td>277,113</td>
<td>894,857</td>
<td>3,865,754</td>
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<td>2,730</td>
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<td>3</td>
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## Distributions of % Change in H1 Charges by Company Size under 5-Yr Time Horizon Bond RBC Charges

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## Distributions of % Changes in ACL RBC by Company Size under 2-Yr Time Horizon Bond RBC Charges

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<th>RBC Ratio % Change</th>
<th>TAC</th>
<th>0 - $5M</th>
<th>$5M - $25M</th>
<th>$25M - $75M</th>
<th>$75M - $250M</th>
<th>$250M - $1B</th>
<th>Over $1B</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than -50%</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-50% to 25%</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>25% to 45%</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45% to 65%</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65% to 85%</td>
<td>210</td>
<td>189</td>
<td>156</td>
<td>171</td>
<td>133</td>
<td>27</td>
<td>915</td>
<td></td>
</tr>
<tr>
<td>85% to 95%</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>95% to 100%</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greater than 100%</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>259</td>
<td>204</td>
<td>165</td>
<td>181</td>
<td>115</td>
<td>29</td>
<td>953</td>
<td></td>
</tr>
</tbody>
</table>
April 16, 2021

Mr. Steven Drutz, Chair  
Health Risk-Based Capital (E) Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

Via electronic mail to Crystal Brown.

Re: Proposal 2021-04-CA.

Dear Mr. Drutz:

I am writing on behalf of UnitedHealth Group in regard to Proposal 2021-04-CA, as exposed for comment on 3/17/21, and the 2/22/21 letter from the American Academy of Actuaries (the “Academy letter”) that was exposed with the proposal. We appreciate your Working Group’s efforts to appropriately reflect investment income in the Health Risk-Based Capital (RBC) formula, and have previously expressed our support for this initiative in our comment letters of 8/31/20 and 1/6/21.

We fully support the changes that are recommended in Proposal 2021-04-CA. We concur that adjustments would be appropriate to the factors for Comprehensive Medical, Medicare Supplement, and Dental & Vision, and that consideration of other products can be deferred. We note that there is still an open issue as to the rate of investment return that should be used, and we offer some comments on that matter below. We also provide a comment on the Academy letter.

Rate of investment return.

The adjustment to the underwriting risk factors depends on an assumption regarding the rate of investment return on health entities’ investment portfolios. Proposal 2021-04-CA offers two options: a rate of 0.5% and a rate of 1.0%. We believe that, whatever rate is ultimately selected, the Working Group should clearly state the rationale for the selection. This would have two important benefits: first, the rationale would help to support the appropriateness of the recommended adjustment; and second, the rationale would guide future updates of the adjustment. Accordingly, we set forth below our thoughts as to how the rate should be selected; we then present illustrative rates based on those concepts.
We believe that the selected rate of investment return should be based on historical averages, rather than some projection of future rates, as historical data provide an objective basis for determining the rate. We recognize four key components of determining the rate of investment return:

1. The average maturity of the investments.
2. The average quality of the investments.
3. The historical time period over which rates should be averaged. (This also has implications for the frequency of future updates.)
4. The degree of rounding to employ. (This also has implications for the threshold for change that would trigger a future update.)

We address each of these components under the corresponding heading below.

**Average maturity.**

As we stated in our comment letters of 1/6/21 and 1/13/21, we feel strongly that the maturity underlying the assumed rate of investment return should be consistent with the maturity underlying the bond factors. The same investments are being considered for both purposes, so there is no clear rationale for making a distinction. We believe that the degree of investment return that is reflected in the underwriting risk factors should be consistent with the degree of risk that is reflected in the bond factors. (We have explained in our comment letter of 1/13/21 why the approximately 1.6-month discounting period used by the Academy is not relevant to the average maturity assumption for the rate of investment return.)

We understand that the Working Group is currently considering maturities of 2 years and 5 years for the bond factors. We urge that whichever maturity is chosen as the basis for the bond factors, that same maturity should be used in adjusting the underwriting risk factors. For the illustrative rates, we have assumed that either 2 years or 5 years will be the final choice.

**Average quality.**

Working Group members previously expressed concern about tying the average quality assumed for this adjustment to the average quality of the investments actually held by health entities. Because of the covariance adjustment in the Health RBC formula, the impact of the bond factors will be diminished relative to the impact of the underwriting risk adjustment; higher yields from riskier bonds would therefore be likely to have a net favorable impact on RBC requirements, providing an undesirable incentive to lower the quality of investments held.

We agree that this is a reasonable concern. The best way to address it would be to base the adjustment on a high-quality rate. The rate could be a risk-free rate, for which U.S. Treasury securities yields would usually be considered a proxy. That may be unnecessarily conservative; a high-quality corporate bond rate, perhaps with a reduction
for expected defaults, might be a better option. For the illustrative rates, we present rates for both Treasury securities and single-A-rated corporate bonds.

**Historical time period.**

It would not be appropriate to use current rates. First, relatively few bond portfolios will have been invested entirely at current rates; investments will have been purchased over a series of years. Second, basing the adjustment on current rates would imply very frequent updates in the future.

One possibility is to tie the averaging period to the maturity assumption. In reality, a 2-year average maturity does not imply that the investments were purchased over the last two years; e.g., the portfolio could include a bond with 4 years to maturity that was purchased 6 years ago as a 10-year bond. However, as a matter of convenience, we can look at a 2-year average if the 2-year rate is being used, and a 5-year average if the 5-year rate is being used.

If a 2-year average is being used, the average could change significantly every year, and it would be necessary to monitor the average annually to determine if an update to the adjustment is needed. Even if a 5-year average is used, an adjustment might be necessary every 2 to 3 years. If the Working Group would prefer less frequent updates, a longer-term average should be used.

For the illustrative rates, we present averages over three periods for the Treasury rates and two periods for the single-A corporate rates (because of limitations on our corporate rate data set). For each average maturity, we present an average over the maturity period (2 or 5 years); a 10-year average; and a 30-year average.

**Rounding.**

There are two competing considerations with regard to rounding. On the one hand, rounding should be to a sufficient degree of precision that significant changes are not obscured. On the other hand, rounding should not be to such a high degree of precision that a change is indicated every time that the rate is re-evaluated.

Based on the tables in the Academy letter that show how the underwriting risk factors would vary with the assumed rate of investment return, we suggest that rounding to the nearest quarter of a percentage point (0.25%) would be appropriate. The change in the underwriting risk factor would be meaningfully large at such a degree of rounding, whereas smaller changes probably would not be.

If, over time, the Working Group concludes that rounding to the nearest 0.25% would result in the factors being updated too frequently, the rounding precision could be increased to 0.50%. However, we suggest beginning with 0.25%, and modifying that if necessary in the future.
To illustrate a currently reasonable range of rates, below we present rates for two maturities (2 years and 5 years), two quality categories (Treasury and single-A corporate), and three averaging periods (2/5 years, 10 years, and 30 years). The 30-year averaging period is shown only for Treasury securities, as our data source did not include the earlier years for single-A corporates; however, the difference between the 10-year and 30-year averages for single-A corporates can perhaps be inferred from the corresponding difference for Treasury securities. All averages are for periods ending 12/31/20.

<table>
<thead>
<tr>
<th>Average over maturity period</th>
<th>10-year average</th>
<th>30-year average</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-year maturity:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treasury</td>
<td>1.11%</td>
<td>0.70%</td>
</tr>
<tr>
<td>A-rated corporate</td>
<td>1.55%</td>
<td>1.28%</td>
</tr>
<tr>
<td>5-year maturity:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treasury</td>
<td>1.67%</td>
<td>1.45%</td>
</tr>
<tr>
<td>A-rated corporate</td>
<td>2.29%</td>
<td>2.24%</td>
</tr>
</tbody>
</table>

As can be seen, the appropriate assumption for the rate of investment return can vary widely, depending on which combination of options is decided upon. If a rounding precision of 0.25% is applied, then the rate of investment return would fall within the range of 0.75% to 4.50%.

The Academy letter.

We have only one comment with regard to the Academy letter. In the table on page 3 of the letter titled “Investment Income Adjusted Tiered RBC Factors,” the “high tier” factors should be rounded to two decimal places, just as the “low tier” factors are. There is no obvious reason to use a different degree of precision for the two sets of factors, and two decimal places give a better representation of the impact of the adjustment. We recommend that the Academy be asked for a re-rounded set of factors.

* * * * *

We would be happy to discuss these comments with you and the Working Group.

James R. Braue
Director, Actuarial Services
UnitedHealth Group

cc: Crystal Brown, NAIC
Randi Reichel, UnitedHealth Group
May 4, 2017

Mr. Steve Drutz
Chair, Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners
1000 Walnut Street, Suite 1500
Kansas City, Missouri 64106-2197


Dear Mr. Drutz:

America’s Health Insurance Plans and Blue Cross and Blue Shield Association appreciate the opportunity to provide comments on the Health Risk-Based Capital (E) Working Group exposed proposal 2021-04-CA – Investment Income Adjustment in Underwriting Risk regarding the two options for an investment income adjustment to the H2 underwriting risk factors in the Health RBC formula.

We would also like to thank and express our appreciation to the Health Risk Based Capital Working Group (“Working Group”) and the Academy of Actuaries (“Academy”) for their work in the development of revised bond factors and incorporating an investment income adjustment into H2 Underwriting Risk calculation as we feel this was warranted.

Our comments regarding the proposed investment income adjustments in the underwriting risk are brief and our support is for Option 2 in the exposure.

The Academy in the development of the bond factors used a two-year time horizon and noted that a longer time horizon could be used based on the duration of assets held by health insurers. Additionally, the Academy developed bond factors for a five-year time horizon and the Working Group is completing a bond factor sensitivity analysis based on bond factors developed for both the two-year and five-year time horizons. On the surface one could assume similar time horizons would be used in the development of the H2 Investment Income Underwriting adjustment factor. In the Academy’s December 15, 2020 letter to the Working Group regarding proposed H2 investment income adjustment factors, based those factors on claim payment completion patterns and investment income earned on premium less claims, or what is left after the timing of claim payment completion. Claim and expense payments for health companies are generally funded through routine ongoing cash receipts of premium. Any excess of premium after paying claims and expenses is held by companies to fund future cash needs or earmarked in surplus to support longer term needs like new business growth, operations, RBC capital
AHIP and BCBSA comments on Investment Income Adjustment

requirements and future investments. Most of the underlying investments in health companies that support surplus are held in high quality fixed investments due to the conservative nature of health company investment policies. Historically, these bond investments have maturity dates longer than a claim payment cycle and have generated significant investment income over time to offset potential investment and underwriting risks that may be posed. Therefore, the longer time horizon in Option 2 is the more appropriate option of the two presented.

Additionally, we would recommend the development and use of a consistent transparent process to review and determine when factors should be adjusted to reflect changes in investment returns. We also recommend that ample lead time is given when any changes are proposed to allow health insurers the ability to adjust their capital and operating models to determine the impact from proposed changes. Extensive capital planning utilizing HRBC ratios is done to assure adequate capital is maintained as health plans price and grow their business and invest in strategic initiatives especially for the non-public health plans who have to support growth and strategic initiatives from operations.

Thank you in advance for your consideration of our comments and the continued work of the Health RBC Working Group and the Academy. If there are any questions about the comments submitted, please let us know. We look forward to further discussions related to this topic.

Ray Nelson
Consultant to AHIP

Carl Labus
Managing Director
Blue Cross/Blue Shield Association

c/c: Crystal Brown, NAIC Staff
Lou Felice, NAIC Staff
What RBC Pages Should Be Submitted?
For the year-end 2021 health risk-based capital (RBC) filing, submit hard copies of pages XR001 through XR027 to any state that requests a hard copy in addition to the electronic filing. Beginning with year-end 2007, a hard copy of the RBC filings was not required to be submitted to the NAIC. Other pages, outside of pages XR001 through XR027, do not need to be submitted. Those pages would need to be retained by the company as documentation.

ACA Sensitivity Test
The Capital Adequacy (E) Task Force adopted proposal 2020-02-CA to delete the Affordable Care Act (ACA) Fee Sensitivity Test from the health RBC formula during its Nov. 19, 2020, meeting.

Max Function—Line 17 RBC Growth Safe Harbor

Page Split—Bonds and Miscellaneous Assets
The Capital Adequacy (E) Task Force adopted proposal 2020-07-H to break out the bonds and miscellaneous fixed assets into separate pages (XR007 and XR008) during its Nov. 19, 2020, meeting. The break out of these pages resulted in the renumbering of all subsequent pages. The instructions and blanks were revised to reflect the changes in the page numbers.

Bond Designation Structure
The Capital Adequacy (E) Task Force adopted proposal 2020-10-CA to modify: 1) bond structure for the 20 designation categories for the bonds; 2) reclassified hybrid securities; and 3) the instructions for the incorporation of bond references and hybrid securities reclassification in the health RBC formula during its March 23, 2021, meeting. The structure for the 20 bond designation categories was modified for the Off-Balance Sheet Security Lending Collateral and Schedule DL, Part 1 Assets page (XR006), Fixed Income Assets page (XR007), and Asset Concentration page (XR012).

Incentives—Managed Care Credit
As a result of the adoption of proposal 2021-02-CA by the Capital Adequacy (E) Task Force during its April 29, 2021, meeting, the term "incentives" was incorporated into the managed care instructions and blanks as “Bonuses/Incentives.”
**Receivable for Securities Factor**

As a result of the adoption of proposal 2021-07-CA by the Capital Adequacy (E) Task Force during its June 30 meeting, the factor for the Receivables for Securities (Line (38), Page XR008) was updated from 0.0250 to 0.0240.

**Investment Income Adjustment to Underwriting Risk Factors**

As a result of the adoption of proposal 2021-04-CA by the Capital Adequacy (E) Task Force during its June 30, 2021, meeting, a 0.5% investment income adjustment was incorporated into the Underwriting Risk factors for comprehensive medical, Medicare Supplement, and dental and vision. The revised factors are:

<table>
<thead>
<tr>
<th>$0–$3 Million</th>
<th>$3–$25 Million</th>
<th>Over $25 Million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Medical &amp; Hospital</td>
<td>0.1493</td>
<td>0.1493</td>
</tr>
<tr>
<td>Medicare Supplement</td>
<td>0.1043</td>
<td>0.0663</td>
</tr>
<tr>
<td>Dental &amp; Vision</td>
<td>0.1195</td>
<td>0.0755</td>
</tr>
</tbody>
</table>

**Bond Factors**

During its June 30, 2021 meeting, the Capital Adequacy (E) Task Force adopted proposal 2021-09-H that: 1) revised factors for the 20 bond designation categories with the incorporation of a bond portfolio adjustment (based on an average of 382 issuers); and 2) modified instructions for the revised bond factors. The factors for the 20 bond designation categories were incorporated on the Off-Balance Sheet Security Lending Collateral and Schedule DL, Part 1 Assets page (XR006), Fixed Income Assets page (XR007), and Asset Concentration page (XR012).

| 1.A  | 0.003 | 2.A  | 0.022 | 3.A  | 0.069 | 4.A  | 0.089 | 5.A  | 0.123 |
| 1.B  | 0.005 | 2.B  | 0.025 | 3.B  | 0.076 | 4.B  | 0.097 | 5.B  | 0.137 |
| 1.C  | 0.008 | 2.C  | 0.031 | 3.C  | 0.083 | 4.C  | 0.110 | 5.C  | 0.151 |
| 1.D  | 0.011 | 1.E  | 0.014 | 1.F  | 0.016 | 1.G  | 0.019 |

**Editorial Changes**

1. Editorial changes were made to the Health RBC Blank and Forecasting files for consistent referencing to the Annual Statement Source columns, column headings, and footnotes (e.g., Column, Line, Schedule, etc.).

2. An editorial change was made to Columns (1), (2) and (3) headings on page XR007 to change “L2 thru 26” to “L3 thru 26.”

3. An editorial change was made to the Annual Statement Source column on page XR007 to reference the following: “(1)=Footnote Amt 1 L000001A - L(1); (2)=Footnote Amt 1 L000001A - L(1); (3)=Footnote Amt 1 L000001A- SCE, Pt2, C7 L0599999.”

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RBC Forecasting and Instructions

The Health RBC forecasting spreadsheet calculates RBC using the same formula presented in the 2021 NAIC Health Risk-Based Capital Report Including Overview & Instructions for Companies, and it is available to download from the NAIC Account Manager. The 2021 NAIC Health Risk-Based Capital Report Including Overview & Instructions for Companies publication is available for purchase in an electronic format through the NAIC Publications Department. This publication is available for purchase on or about Nov. 1 each year. The User Guide is no longer included in the Forecasting & Instructions.

**WARNING:** The RBC Forecasting Spreadsheet CANNOT be used to meet the year-end RBC electronic filing requirement. RBC filing software from an annual statement software vendor should be used to create the electronic filing. If the forecasting worksheet is sent instead of an electronic filing, it will not be accepted, and the RBC will not have been filed.
### Aggregated Health Risk-Based Capital Data

**2020 Data as of 6/30/2021**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total H0 (H0 - Asset Risk - Affiliates w/RBC)</td>
<td>5,192,392,682</td>
<td>5,192,392,682</td>
<td>4,782,424,393</td>
<td>4,782,424,393</td>
<td>4,487,634,571</td>
<td>4,487,634,571</td>
<td>4,322,880,131</td>
<td>4,322,880,131</td>
<td>4,322,880,131</td>
<td>4,322,880,131</td>
</tr>
<tr>
<td>Total H1 (H1 - Asset Risk - Other)</td>
<td>11,292,103,225</td>
<td>11,292,103,225</td>
<td>9,743,938,557</td>
<td>9,743,938,557</td>
<td>8,589,245,210</td>
<td>8,589,245,210</td>
<td>8,315,790,867</td>
<td>8,315,790,867</td>
<td>7,911,882,268</td>
<td>7,911,882,268</td>
</tr>
<tr>
<td>Total H2 (H2 - Underwriting Risk)</td>
<td>45,819,164,666</td>
<td>45,819,164,666</td>
<td>44,073,638,071</td>
<td>44,073,638,071</td>
<td>40,572,604,055</td>
<td>40,572,604,055</td>
<td>38,767,031,280</td>
<td>38,767,031,280</td>
<td>37,373,980,544</td>
<td>37,373,980,544</td>
</tr>
<tr>
<td>Total Adjusted Capital</td>
<td>193,852,790,008</td>
<td>193,852,790,008</td>
<td>156,878,344,717</td>
<td>156,878,344,717</td>
<td>132,189,821,412</td>
<td>132,189,821,412</td>
<td>127,799,198,125</td>
<td>127,799,198,125</td>
<td>127,799,198,125</td>
<td>127,799,198,125</td>
</tr>
<tr>
<td>ACA Fees</td>
<td>6,758,224</td>
<td>11,039,690,995</td>
<td>3,172,155</td>
<td>9,892,443,636</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aggregate RBC %</td>
<td>672%</td>
<td>672%</td>
<td>548%</td>
<td>548%</td>
<td>526%</td>
<td>526%</td>
<td>512%</td>
<td>512%</td>
<td>506%</td>
<td>506%</td>
</tr>
<tr>
<td>Median RBC %</td>
<td>700%</td>
<td>700%</td>
<td>600%</td>
<td>600%</td>
<td>600%</td>
<td>600%</td>
<td>640%</td>
<td>640%</td>
<td>596%</td>
<td>596%</td>
</tr>
<tr>
<td># of Companies with an RBC ratio of &gt; 10,000%</td>
<td>143</td>
<td>143</td>
<td>156</td>
<td>156</td>
<td>134</td>
<td>134</td>
<td>112</td>
<td>112</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td># of Companies with an RBC ratio of &lt; 10,000% &amp; &gt; 1,000%</td>
<td>259</td>
<td>259</td>
<td>202</td>
<td>202</td>
<td>223</td>
<td>223</td>
<td>201</td>
<td>201</td>
<td>197</td>
<td>197</td>
</tr>
<tr>
<td># of Companies with an RBC ratio of &lt; 1,000% &amp; &lt; 500%</td>
<td>320</td>
<td>320</td>
<td>257</td>
<td>257</td>
<td>267</td>
<td>267</td>
<td>237</td>
<td>237</td>
<td>238</td>
<td>238</td>
</tr>
<tr>
<td># of Companies with an RBC ratio of &lt; 500% &amp; &lt; 300%</td>
<td>278</td>
<td>278</td>
<td>267</td>
<td>267</td>
<td>285</td>
<td>285</td>
<td>247</td>
<td>247</td>
<td>283</td>
<td>283</td>
</tr>
<tr>
<td># of Companies with an RBC ratio of &lt; 300% &amp; &lt; 200%</td>
<td>527</td>
<td>527</td>
<td>59</td>
<td>59</td>
<td>67</td>
<td>67</td>
<td>71</td>
<td>71</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td># of Companies with an RBC ratio of &gt; 200%</td>
<td>14</td>
<td>14</td>
<td>31</td>
<td>31</td>
<td>15</td>
<td>15</td>
<td>18</td>
<td>18</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td># of Companies with an RBC ratio of Zero</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Companies with RBC</td>
<td>1,067</td>
<td>1,067</td>
<td>1,012</td>
<td>1,012</td>
<td>995</td>
<td>995</td>
<td>937</td>
<td>937</td>
<td>925</td>
<td>925</td>
</tr>
</tbody>
</table>

* Authorized Control Level RBC amount reported in the Health RBC Excluding ACA Fees column is pulled from Line (18), page XR026, and the Authorized Control Level RBC amount reported in the Health RBC column is pulled from Line (4), page XR027.

**Source:** NAIC Financial Data Repository

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NAIC Proceedings – Summer 2021
July 8, 2021

Steve Drutz
Chair, Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners (NAIC)

Re: Request for Comprehensive Review of the H2—Underwriting Risk Component and Managed Care Credit Calculation in the Health Risk-Based Capital Formula

Dear Mr. Drutz:

On behalf of the American Academy of Actuaries Health Solvency Subcommittee, I am pleased to provide this response letter to the National Association of Insurance Commissioners (NAIC) Health Risk-Based Capital (HRBC) (E) Working Group. This letter is in response to the request from the working group to provide analysis to perform a comprehensive review of the H2—Underwriting Risk component and the managed care credit calculation in the health risk-based capital (RBC) formula.

The subcommittee is willing to agree to this request and, as such, would like to discuss and establish the following with the working group:

- Scope and phases of work
- Desired output/perspective requested by the NAIC from the Academy
- General time frame and any key dates/deadlines

Our suggested approach would be to initially survey methods of evaluating risk and in particular underwriting risk taken by other risk quantification formulas (e.g., health, life and P&C RBC formulas, credit rating agencies) and summarize their respective merit for health underwriting risk. This initial phase would be discussed with the HRBC Working Group to determine the best approach before beginning detailed analysis and factor development.

We look forward to working with the HRBC Working Group on this worthwhile endeavor.

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1 The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
If you have any questions or would like to discuss further, please contact Matthew Williams, the Academy’s senior health policy analyst, at williams@actuary.org.

Sincerely,
Derek Skoog, MAAA, FSA
Chairperson
Health Solvency Subcommittee
American Academy of Actuaries

Cc: Crystal Brown
   Senior Insurance Reporting Analyst
cbrown@naic.org
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met July 21, 2021. The following Working Group members participated: Philip Barlow, Chair (DC); Jennifer Li (AL); Thomas Reedy (CA); Wanchin Chou (CT); Sean Collins (FL); Mike Yanacheak and Carrie Mears (IA); Vincent Tsang (IL); John Robinson (MN); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Mike Boerner and Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. **Adopted its June 11, June 3 and June 4, May 27, May 20, April 29, April 22, April 15, April 6, March 30, and March 12 Minutes**

Mr. Chou made a motion, seconded by Ms. Mears, to adopt the Working Group’s June 11 (Attachment Four-A), June 3 and June 4 (Attachment Four-B), May 27 (Attachment Four-C), May 20 (Attachment Four-D), April 29 (Attachment Four-E), April 22 (Attachment Four-F), April 15 (Attachment Four-G), April 6 (Attachment Four-H), March 30 (Attachment Four-I), and March 12 (see NAIC Proceedings – Spring 2021, Capital Adequacy (E) Task Force, Attachment Three) minutes. The motion passed unanimously.

2. **Adopted the 2021 Life and Fraternal RBC Newsletter**

Mr. Leung made a motion, seconded by Mr. Boerner, to adopt the Life and Fraternal Risk-Based Capital (RBC) Newsletter (Attachment Four-J). The motion passed unanimously.

3. **Discussed the 2020 Life and Fraternal Statistics**

Mr. Barlow said the Working Group has previously discussed taking a more in-depth look at the statistics (Attachment Four-K) to determine whether the right statistics are being captured and how the Working Group can make better use of them. He said some members of the Working Group had previously volunteered to work on this. Dave Fleming (NAIC) said he could share some of the in-depth review put together with those members interested. Mr. Tsang volunteered to take the lead on this. Mr. Chou and Mr. Boerner reiterated their willingness to work on this.

4. **Adopted Revisions to its Working Agenda**

Mr. Fleming explained that the changes were to delete items that have been addressed by the Working Group and add one item for guidance on the impact of the bond factor changes and one item to address the review of the RBC statistics. Mr. Barlow said the first new item is to provide some information, mainly to the financial regulators, on the potential impact of the bond factor changes that may, for example, cause some companies that would not otherwise do so to trigger a trend test. Mr. Fleming said this is an item directed to NAIC staff to draft, but it will need to be approved by the Working Group. Mr. Chou made a motion, seconded by Mr. Leung, to adopt the Working Group’s working agenda (Attachment Four-L). The motion passed unanimously.

5. **Discussed Other Matters**

Mr. Barlow reminded the Working Group of the work being done on the new economic scenario generator (ESG). He said most of this discussion will be through the Life Actuarial (A) Task Force; and while this will affect both reserves and capital and there is a large overlap with the Working Group in both membership and interested parties, those interested in the progress on ESGs should be aware of that.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met June 11, 2021. The following Working Group members participated: Philip Barlow, Chair (DC); Jennifer Li (AL); Thomas Reedy (CA); Wanchin Chou (CT); Sean Collins (FL); Mike Yanacheak and Carrie Mears (IA); Vincent Tsang (IL); John Robinson (MN); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Mike Boerner and Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. Adopted the ACLI Bond Proposal

Mr. Barlow stated that the meeting materials contain a proposed revision to the tax factor adjustment and should be considered as part of the adoption of either proposal before the Working Group. Paul Graham (American Council of Life Insurers—ACLI) stated that in the calculation of the bond factors, all the calculations are done on an after-tax basis; then, these are converted to a before-tax number, and a separate sheet performs the tax adjustment. He said the calculation is based on a tax efficiency factor of 80%. Jerry Holman (American Academy of Actuaries—Academy) and Nancy Bennett (Academy) stated that they agree with the calculation. Mr. Tsang asked if this revision will be double counted in the calculation. Mr. Graham verified that there is no double counting.

To reduce the burden on smaller companies, Mr. Barlow said there was a proposal to change the bond size adjustment to use factors that have a break point at up to the current 50 assets, and it would revise the factor for the first 50 assets to be 2.9. Mr. Chou stated that he agrees with the 50-threshold change, but he noted that the factor depends on either the ACLI proposal or the Academy proposal. Mr. Robinson recommended an impact study before updating this factor. Mr. Barlow said no matter which proposal is selected, he believes the best approach is to use the break point at the 50-threshold. Mr. Leung asked for clarity on the proposal as it relates to the factors discussed in the last meeting. Mr. Graham clarified how the calculation changes when the breakpoint is changed from the 50-50 threshold to the 10-90 threshold. Amnon Levy (Moody’s Analytics) provided further details on the threshold in the ACLI proposal.

Mr. Barlow stated that the meeting materials contain proposal 2021-11-L (Life Bond Factors) (ACLI) and proposal 2021-10-L (RBC Proposal) (Academy). Ms. Ahrens asked for clarity on which factors were up for adoption if using the ACLI proposal. Mr. Barlow verified that the ACLI proposal uses a one-half standard deviation. Mr. Chou asked for more documentation of the calculations of the ACLI proposal.

Steven Clayburn (ACLI) noted that an earlier exposed document contained approximately 80 pages of support for the proposal. Mr. Graham noted that when the ACLI contracted Moody’s Analytics to assist with the proposal, part of the agreement was to provide all documentation and support from the process. Ms. Ahrens stated that she believes any issues with providing documentation of the ACLI proposal have been addressed by its earlier submission. Mr. Robinson stated that he is concerned with the fairness of this process of selecting bond factors. He recommended that the Working Group use the Academy’s factors with the impact study that was provided earlier in the process, and then the state insurance regulators adjust the factors as needed. Ms. Hemphill stated that she believes the process used was appropriate, and regardless of the process, the Working Group should pick the proposal that is best for the state insurance regulators. Ms. Ahrens agreed with Ms. Hemphill’s comments on the Working Group’s process. Ms. Mears noted that there are expected changes in portfolio makeup over time, and the state insurance regulators will benefit from the ACLI proposal. Mr. Chou recommended that the bond factors be reviewed more frequently going forward.

Ms. Ahrens made a motion, seconded by Ms. Hemphill, to adopt proposal 2021-11-L (see NAIC Proceedings – Summer 2021, Capital Adequacy (E) Task Force, Attachment One-E), with the tax factor adjustment and the bond adjustment factor using the first 50, next 50 as included in the Moody’s Analytics June report. The motion passed with Minnesota dissenting.

2. Discussed Other Matters

Mr. Barlow stated that with the revised bond factors, there is the possibility that companies may trigger a trend test because of this change. He recommended that NAIC staff prepare communication for state insurance regulators with guidance for these situations. Ms. Ahrens noted that with the other revisions to risk-based capital (RBC) that have been adopted this month, there

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may be some overall impact on total RBC, and she recommended reaching out to domestic insurers and doing an impact study to assist the state insurance regulators.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met June 3 and June 4, 2021. The following Working Group members participated: Philip Barlow, Chair (DC); Jennifer Li (AL); Thomas Reedy (CA); Wanchin Chou (CT); Sean Collins (FL); Mike Yanacheak and Carrie Mears (IA); John Robinson (MN); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Mike Boerner and Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. Adopted the Proposal 2021-12-L

Mr. Barlow stated that proposal 2021-12-L (Life Reinsurance) intends to address the 2019 revisions to the Credit for Reinsurance Model Law (§785) and the Credit for Reinsurance Model Regulation (§786). The proposal was exposed for a 30-day public comment period on April 29, and one comment letter (Attachment Four-B1) was received from the American Council of Life Insurers (ACLI). Steven Clayburn (ACLI) stated his agreement with the proposal.

Mr. Boerner made a motion, seconded by Mr. Leung, to adopt proposal 2021-12-L (see NAIC Proceedings – Summer 2021, Capital Adequacy (E) Task Force, Attachment One-F). The motion passed unanimously.

2. Adopted the Proposal 2021-13-L

Mr. Barlow stated that proposal 2021-13-L (Longevity Risk Factors and Instructions) and the accompanying memorandum were exposed for a 30-day public comment period, and comment letters were received from the ACLI (Attachment Four-B2), the American Academy of Actuaries (Academy) (Attachment Four-B3), and the Principal Financial Group (Principal) (Attachment Four-B4).

Paul Navratil (Academy) stated that correlation factors of negative 0.30 and negative 0.25 are reasonable and generally consistent with the negative 0.33 factor previously proposed. He noted that the impact analysis using industry totals was conservative, and the original calculation used a 5% discount rate, where 3.75% is more reasonable.

Sam Early (Principal) stated that he supports the Academy proposal and the negative 0.30 factor, and he encouraged a zero guardrail; however, if the Working Group uses a guardrail, he recommended that it be reviewed periodically. Paul S. Graham (ACLI) stated his agreement with Mr. Early.

Ms. Ahrens provided a presentation showing additional calculations that had been performed that showed the relationship between mortality and longevity. Mr. Robinson asked that the guardrail be split from the rest of the proposal for a separate vote. Mr. Carmello stated that he prefers a covariance of zero. Mr. Leung noted that he has reservations about the factors in the proposal. Ms. Eom recommended using a covariance factor between negative 0.25 and zero. Mr. Yanacheak suggested that any work regarding the reserve should be done by the Life Actuarial (A) Task Force.

Ms. Ahrens made a motion, seconded by Mr. Chou, to adopt proposal 2021-13-L (see NAIC Proceedings – Summer 2021, Capital Adequacy (E) Task Force, Attachment One-G), with tiered after-tax factors of 1.35% down to 0.70%, negative 0.25 covariance, no guardrail, and effective for year-end 2021. The motion passed with New York dissenting.

3. Discussed the Bond Proposals

Mr. Barlow said the Working Group exposed the ACLI’s proposal and the Academy’s proposal on April 27, and 16 comment letters (Attachment Four-B5) were received. He asked if any of those submitting comment letters wish to offer additional comments.

Mr. Clayburn stated that he supports the adoption of the ACLI and Moody’s Analytics proposal. He noted that the ACLI proposal factors better differentiate risk across rating grades and are not punitive to small and medium sized carriers, and he noted that the proposal would increase aggregate risk-based capital (RBC).
Jerry Holman (Academy) summarized the main points included in the Academy’s comment letter. Nancy Bennett (Academy) noted that Moody’s Analytics developed default rates that were customized for the life insurance industry, which is a different approach than has been done historically. She noted that the Academy model bond factor used a default rate calculated from the entire corporate sector and then applied that to a representative portfolio, which projected a series of cash flows over 10 years. She stated that she is unsure of how that works within the Moody’s Analytics’ model. She noted that she supports the use of the updated discount rate of 3.47%. Mr. Leung asked for more information on the calculation of the risk premium. Ms. Bennett noted that the information was included in an earlier presentation. Mr. Tsang stated that there is no literature to support a claim that the reserve is adequate at any percentile.

Pam Hutchins (Government Personnel Mutual [GPM] Life) stated that she supports the adoption of the ACLI and Moody’s Analytics proposal, and she noted that the factors are much less punitive to small and medium sized companies.

Mr. Robinson stated that any model will include elements that are determined based on expert judgment, but different experts may disagree on those judgements. He noted that the factors used are more generous to industry than the Academy’s proposal. Amnon Levy (Moody’s Analytics) noted that the factors used in the ACLI and Moody’s Analytics model are not universally higher or lower than those used by the Academy. He said when there was uncertainty in the inputs, they intended to remain conservative.

Ms. Hemphill asked for more information on the application of judgment in the proposal for the default rate. Mr. Levy noted that the proposal is based on the composition of life insurers holdings and not on the full sample of rated corporate bonds. Edward L. Toy (Risk & Regulatory Consulting LLC) noted that the mix of assets has substantially changed over the years, but the actual year-to-year changes are minimal. Mr. Chou noted that the Academy’s proposal was based on the original scope of this project from 2010, and some of their inputs are based on outdated assumptions. Ms. Ahrens asked for clarity on the assumptions used for what percentile the reserves are meant to cover. Mr. Barlow stated that he had requested updated calculations, as it was a possibility that updated assumptions would be used. Ms. Bennett stated that the risk premium is set at the mean of the loss distribution, and because loss distribution is skewed, the result is that it is approximately the 60th percentile, so the assumption is that statutory policy reserves cover credit losses up to that mean distribution of approximately the 60th percentile. Ms. Ahrens asked if the Moody’s Analytics proposal original factors are based on one standard deviation for the reserves. Mr. Levy stated that it was one-half of a standard deviation above expected loss, which was approximately the 75th percentile.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
May 27, 2021
Mr. Philip Barlow
Chair
NAIC Life Risk-Based Capital Working Group

Sent via email: dfleming@naic.org

RE: 2021-12-L Life Reinsurance

Dear Philip:

The American Council of Life Insurers (“ACLI”) appreciates the opportunity to provide comments on 2021-12-L Reinsurance, which updates and clarifies the LR016 (Reinsurance) Exhibit and instructions. ACLI supports the exposure and encourages adoption of the exposure.

Briefly, when the U.S.-EU Covered Agreement was signed, seven charges were developed and referred to appropriate NAIC task forces and working groups. The charge sent to Life RBC Working Group was to review LR016 and update accordingly to take into consideration reciprocal jurisdictions. The Statutory Accounting Principles Working Group also received a charge to update the Annual Statement blanks to accommodate the new terminology. They updated page 3 instructions of the Annual Statement to add line items for reciprocal jurisdictions. Reciprocal jurisdiction language had been added to Schedule S – Reinsurance as well.

The additional language to LR016 exhibit and the instructions provides clarification of the information that should either feed from Schedule S or to be included in the exhibit. Also, the changes add the new reciprocal jurisdiction terminology to the exhibit and the instructions.

We appreciate the opportunity to comment on this exposure and support its adoption by the Life RBC Working Group.

Sincerely,

Steven Clayburn

cc: Dave Fleming, NAIC Senior Insurance Reporting Analyst
Mr. Philip Barlow  
Chair, NAIC Life Risk-Based Capital (E) Working Group (Life RBC)  

Re: ACLI Comments on Longevity Risk Exposure

Dear Mr. Barlow:

The American Council of Life Insurers (ACLI) appreciates the opportunity to provide comments regarding the current longevity risk exposure. We applaud the hard work of Life RBC, the NAIC Longevity Risk (E/A) Subgroup, and the American Academy of Actuaries Longevity Risk Task Force (Academy) to develop, discuss, and decide on the proposed factors. Consistent with our prior comments, we are supportive of the Academy recommendation in its entirety. Regarding the current exposure, ACLI supports the correlation factor of -30% with a guardrail factor of 0%.

**Negative correlation is appropriate for diversification between mortality and longevity**

ACLI supports appropriate incentivization to diversify risks within the RBC framework. Inherently, there are offsets between mortality and longevity risks. The Academy provided analysis supporting their recommendation, and the proposed -30% is consistent with correlation estimates in other jurisdictions. A negative correlation appropriately encourages diversification of risks, providing a real risk reduction benefit. The current pandemic provides evidence of unexpected losses in mortality products being offset by unexpected gains in longevity products.

**The guardrail is unnecessary and adds undue complexity**

ACLI appreciates the concerns of regulators that the correlation would lower the current C-2 level for certain companies; however, we believe the guardrail factors adds unnecessary complexity to the calculation, making capital forecasting and dividend planning more difficult. Had a longevity charge been proposed along with the original mortality charge, regulators would likely have thought diversification of the risks to be a benefit. Further, the inclusion of the guardrail undermines the desired incentive to diversify risks. Additionally, there is a very narrow

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1 Bermuda BSCR applies a -50% correlation between longevity and mortality risks. Canada’s LICAT and Europe’s Solvency II apply a correlation factor of -25%.

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corridor in which the guardrail would apply. If Life RBC decides on a guardrail value other than 0, we would encourage active monitoring of its effectiveness and consideration of reducing the factor as you gain comfort that the lower charge is appropriate given the real offset of risks provided by diversification.

We appreciate the consideration of our comments and look forward to discussing on a future call.

Sincerely,

[Signature]

cc: Dave Fleming, NAIC
May 27, 2021

Mr. Philip Barlow
Chair, Life Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners (NAIC)

Via email: Dave Fleming (dfleming@naic.org)

Re: April 30, 2021, 2021-13-L Longevity Factors and Instructions exposure

Dear Philip,

On behalf of the C-2 Longevity Risk Work Group of the American Academy of Actuaries,¹ I am providing comments on the April 30, 2021, exposure of longevity risk-based capital (RBC) factors.

1. Correlation Factors

   The exposed correlation factors of negative 0.30 and negative 0.25 are reasonable and generally consistent with the negative 0.33 factor we previously proposed. As discussed in prior comment letters on this topic² we do not believe a positive 100 percent correlation is a reasonable representation for how longevity and mortality risks are related.

2. Industry Level Impacts

   A draft version of the industry-level impact of the proposed factors was included in the materials for the April 29, 2021, Life Risk-Based Capital Working Group meeting with the expectation they will be updated with correlation factors matching the April 30 exposure. These impacts were calculated by using the total industry-level reserve exposure subject to longevity C-2 risk then applying the capital factors to statutory reserves up to each breakpoint and correlation calculation using this total. It is important to note that this calculation results in a smaller aggregate C-2 amount than would result from summing the total C-2 amounts calculated at an individual company level to arrive at a total. This difference is driven in two areas of the calculation:

¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

i. As acknowledged during the April 29 meeting, applying the capital factor breakpoints to the total industry amount of statutory reserves will result in a smaller total longevity C-2 amount than would applying the breakpoints at an individual company level then summing the resulting longevity C-2 directly.

ii. In addition, applying the correlation adjustment to the total industry levels of mortality C-2 and longevity C-2 will result in a lower total C-2 amount than would result from applying correlation at an individual company level then summing the resulting total C-2 amounts directly.

It is not possible to accurately estimate the amount by which this simplified aggregate level calculation understates the impact at an industry level without additional insight into company level results. The impact could be material however, and the limitations of the aggregate level calculation should be understood by the Life Risk-Based Capital Working Group when interpreting this impact analysis.

3. Interest Rate Sensitivity

The capital factors included in the exposure, which we first shared with the Longevity Risk (A/E) Subgroup in February 2019, used a pre-tax discount rate of 5% as an assumption in the analysis. This assumption was set to be consistent with the rate that had been used elsewhere in the development of capital factors for other risks. Since that 2019 proposal, interest rate levels have remained low. Further work group discussion of discount rates used in capital analysis across areas of life risk-based capital has led us to conclude that consistency of methodology is preferable to consistency in a numerical discount rate.

The original 5% discount rate used in C-1 analysis had been calculated at the time as a 20-year historical average of a 10-year risk-free rate. We are using a 20-year Treasury rate tenor for longevity risk, which is measured over the future lifetime of policyholders. At the time of our original analysis in 2018, the average 20-year Treasury rate tenor was 4.3% based on the 1998-2017 period. The impact of recent low interest rates would further decrease this assumption to 3.75% if based on 2001–2020 data. This lower discount rate would increase the present value longevity capital factors by approximately 10% compared to the 2019 proposal. Rounding the result to the nearest 0.05% would result in the after-tax factors below:

<table>
<thead>
<tr>
<th></th>
<th>Original 5% Discount Rate</th>
<th>Revised 3.75% Discount Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>First $250 Million</td>
<td>1.35%</td>
<td>1.50%</td>
</tr>
<tr>
<td>Next $250 Million</td>
<td>0.85%</td>
<td>0.95%</td>
</tr>
<tr>
<td>Next $500 Million</td>
<td>0.75%</td>
<td>0.85%</td>
</tr>
<tr>
<td>Over $1,000 Million</td>
<td>0.70%</td>
<td>0.80%</td>
</tr>
</tbody>
</table>
Implementation Considerations

We have included the interest rate sensitivity above as additional information given known material changes since the time of the analysis underlying the proposed capital factors. As with other factors within RBC, we anticipate that periodic review of the longevity risk factors will be required to reflect changing market conditions or to incorporate additional information that may become available. We included in our May 21, 2019, letter to the Longevity Risk Subgroup a list of circumstances under which a review of the factors should be considered, including a material change in the long-term assumption for interest rates.

This interest rate sensitivity does not represent a holistic review of the analysis and assumptions that underly the proposed capital factors and, as such, we are not prepared to update the recommendation. While we are not aware of other material information or assumptions that would impact the analysis, we have not done a complete refresh of the analysis and it is possible that other assumptions would also change as part of a holistic review. Long-term mortality implications of the pandemic and potential insights from Society of Actuaries’ research on mortality across socioeconomic groups are examples of developments that could also be considered in a review of the analysis. Of course it is up to the Life Risk-Based Capital Working Group to consider whether to incorporate this interest rate sensitivity into the implementation of a longevity risk charge in the near term or to defer consideration to a future review.

*****

Should you have any questions or comments regarding this letter, please contact Khloe Greenwood, life policy analyst at the Academy (greenwood@actuary.org).

Sincerely,

Paul Navratil, MAAA, FSA
Chairperson, C-2 Longevity Risk Work Group
American Academy of Actuaries

May 27, 2021

Philip Barlow
Chair, NAIC Life Risk-Based Capital (E) Working Group
Associate Commissioner for Insurance
Department of Insurance, Securities and Banking
1050 First Street, NE, Suite 801
Washington, DC 20002

RE: Longevity Risk Exposure

Dear Mr. Barlow,

This letter is written on behalf of Principal Life Insurance Company (Principal) in response to the NAIC Life RBC Working Group’s exposure of proposed changes to incorporate longevity risk into the Life RBC formula. Attached is Principal’s letter from February 2020, which expressed our support for the American Academy of Actuaries (Academy) work on the longevity risk charge, including the Academy recommendations for factors and an appropriate correlation between longevity risk and mortality risk. We continue to support the Academy proposal.

Of the options presented in the current exposure, we view the -30% correlation with no guardrail as most consistent with the Academy’s proposal and the most fit for adoption. We also note that Principal’s life insurance and annuity blocks have endured an extreme mortality event during the COVID-19 pandemic, and our results were consistent with an offset between mortality and longevity. Across product lines with exposure to mortality and longevity, we experienced higher than expected mortality, and the impact of higher life insurance claims was offset in part by higher reserves released upon death within our annuity blocks.

We appreciate the opportunity to comment on this exposure and are available to discuss our comments with regulators should they find such discussion helpful.

Sincerely,

Sam Early, FSA, MAAA
Actuary
(515) 362-2882
early.sam@principal.com

Michelle Rosel, FSA, MAAA
Senior Actuary
(515) 878-6454
rosel.michelle@principal.com

Attachment

cc: Via Email (rhonda.ahrens@nebraska.gov)
Rhonda Ahrens
Chair, Longevity Risk (A/E) Subgroup

cc: Via Email (dfleming@naic.org)
Dave Fleming
National Association of Insurance Commissioners

cc: Via Email (mike.yanacheak@iid.iow.gov)
Mike Yanacheak
Iowa Insurance Division
Greetings:

The American Council of Life Insurers (“ACLI”) appreciates the opportunity to provide comments on the two C-1 bond factor proposals exposed on April 27, 2021:

1. 2021-11-L Life Bond Factors (ACLI) developed by Moody’s Analytics (hereinafter referenced as the 2021-11 proposal), and
2. 2021-10-L RBC Proposal (Academy), the American Academy of Actuaries (“Academy”) October 10, 2017 report updated in 2021 with the 21% rate from the Tax Cuts and Jobs Act of 2017 (hereinafter referenced as the 2021-10 proposal)

Executive Summary

Corporate bonds are the largest life industry asset class (over $3 trillion), and it is important for the regulatory capital requirements for this asset class to appropriately reflect the associated credit risk. The existing RBC C-1 bond framework has provided excellent protection during tumultuous times over the last 30 years. This experience shows that the existing framework and calibration is quite robust and does not support a material increase in capital requirements, even with the project to expand from six rating categories to twenty rating categories.

- ACLI supports and urges the adoption of the C-1 bond factors and portfolio adjustment factors (2021-11 proposal) as developed and presented on April 22, 2021 (with the original 4.32% discount rate), by Moody’s Analytics, one of the world’s premiere portfolio global credit modeling firms. The proposal developed by Moody’s Analytics would materially increase aggregate C-1 RBC, reaching a 96th percentile safety level. Furthermore, it better differentiates risk across rating grades and diversification than the 2021-10 proposal.

- As stated in several previous comment letters1, ACLI has identified areas of concern with the Academy’s underlying credit risk model and is not supportive of the adoption and

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1https://content.naic.org/sites/default/files/inline-files/Academy%27s%20August%202015%20Report_Comment%20Letters.pdf (p 1-7);
https://content.naic.org/sites/default/files/inline-files/Academy%27s%20June%202017%20Report_Comment%20Letters.pdf (p 5-12);
https://content.naic.org/sites/default/files/inline-files/Academy%27s%20October%202017%20Report_Comment%20Letters.pdf

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implementation of the C-1 bond factors and portfolio adjustment in the 2021-10 proposal. These concerns were confirmed by Moody’s Analytics’ work.

**Background**

We appreciate the willingness of the Financial Condition (E) Committee and the Life RBC Working Group to allow for an independent third-party review by Moody’s Analytics of the underlying model and data issues. Moody’s Analytics’ review, as presented to the Life RBC Working Group and interested parties in February 2021, noted several concerns related to the modeling and use of the data including: 1) default correlations and the resulting portfolio adjustment; 2) the actual modeling approach and the resulting slope of the proposed factors; 3) loss given default approach and the resulting factors; 4) the risk premium assumption; and 5) omission of most recent experience.

The Life RBC Working Group asked Moody’s Analytics to model a set of C-1 bond factors and portfolio adjustment factors, resulting in the 2021-11 proposal.

The Moody’s Analytics work in the 2021-11 proposal has three distinctions: (1) the model is well-documented, (2) the historical data is seriatim and not summarized, and 3) data is updated through 2020. Industry is supportive of the proposed factors resulting from this model. Significantly, the 2021-11 proposal achieves an increased capital requirement using updated data, resulting in intuitive outcomes though the industry is presumed well-capitalized under existing reserving and capital requirements.

By using current experience (data through 2020 year-end) in developing assumptions and working through the limitations of the underlying model used to calculate the Academy’s proposed factors, Moody’s Analytics developed a set of factors addressing the concerns noted above. Further, Moody’s has made explicit provision in their modeling to calibrate the resulting factors to the 96th percentile. In taking this approach, their work makes transparent the level of conservatism layered upon the underlying best estimate factors. Such transparency is lost when conservatism is added at each interim step to assumptions in the bond factor determination process.

In addition to producing more intuitive factors, the Moody’s Analytics proposed bond factors also eliminate the Academy’s disincentives for insurers to hold higher quality portfolios. The ACLI believes elimination of these disincentives is both appropriate and desirable in a regulatory capital regime. Furthermore, the resulting increase in capital is allocated across industry based on portfolio adjustment factors to reflect the actual diversification of individual insurer portfolios. Note that, unlike the 2021-10 proposal, there is no need for an arbitrary adjustment to portfolio adjustment factors under the 2021-11 proposal.

**Detailed Review**

Moody’s Analytics’ integrated model addresses the interconnectivity of the underlying components of the credit risk model; this interconnectivity is not addressed by the Academy’s compartmentalized approach. See Appendix A – Summary of MA’s Targeted Modifications to the C1 Factors.

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2. [2021 MA Updates to RBC C1 Bond Factors](#)
Review of the empirical data indicates the relative riskiness across rating grades more closely aligns with 2021-11 proposal. The 2021-11 proposal also incentivizes higher quality bond portfolios. As evidenced by history, the existing bond RBC framework has provided excellent protection during tumultuous times, specifically the following most recent 30-year crises:

- The dot-com bubble;
- The aftermath of September 11th;
- The accounting frauds of the early 2000’s;
- The Great Financial Crisis;
- The Energy/Commodity Crisis of 2015/2016; and
- The worst pandemic in 100 years.

This track record shows that the RBC C-1 framework and calibration is quite robust. This experience does not support a material increase in capital requirements. Moody’s Analytics estimates the following overall capital increases under the various proposals:

<table>
<thead>
<tr>
<th>Total Industry Post Portfolio Adjustment Factor C-1 RBC (Pre-Tax)</th>
<th>$ Billions</th>
<th>Increase to Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Framework</td>
<td>37.82</td>
<td>n/a</td>
</tr>
<tr>
<td>Moody’s Analytics (Original with Moody’s 4.32% Discount Rate supported by ACLI)*</td>
<td>40.46</td>
<td>+7%</td>
</tr>
<tr>
<td>Moody’s Analytics (Lower Discount Rate of 3.47%)</td>
<td>41.83</td>
<td>+11%</td>
</tr>
<tr>
<td>Academy’ Proposal (with 5% Discount Rate)</td>
<td>43.19</td>
<td>+14%</td>
</tr>
</tbody>
</table>

* ACLI believes the initial rate of 4.32% used by Moody’s Analytics in its modeling produces a more supportable increase in RBC capital. This rate was calculated using information from 1993-2020.

**Default Correlations and the Resulting Portfolio Adjustment**

Moody’s Analytics used a parameterized correlation model. The correlation model more accurately reflects empirically observed default correlations and issuer diversification benefits. The correlation model generated C-1 base factors that are more conservative and more differentiated across NAIC designation categories than those using the economic state model.

The Academy’s economic state model implies very low default correlations, leading to a portfolio adjustment factor that is overly punitive to portfolios with a small number of holdings and overly lenient to portfolios with a large number of holdings. A near-zero assumption of default correlations runs counter to historical observations and may tend to overstate diversification benefits. This leads to an overall flattening of high-yield C-1 base factors relative to investment grade. In addition, the portfolio adjustment factors and the number of issuers to have a factor of 1.0 have varied tremendously between the three formal re-runs of the underlying model raising concerns about the stability of the modeling approach:

- In the Academy’s December 2016 proposal, this figure was approximately 750 issuers.
- In its June 2017 proposal, a portfolio needed 5,300 unique issuers to have a factor of 1.00.
- And in the exposed Academy’s proposal the number of issuers dropped down to 810.
Modeling Approach and the Resulting Slope of Factors

Moody’s Analytics’ correlation model resulted in C-1 base factors that are more conservative and more differentiated across NAIC designation categories than those implied using the economic state model. Furthermore, the portfolio adjustment factors are less punitive to portfolios with a smaller number of issuers and less lenient to portfolios with a larger number of issuers, relative to those from the 2021-10 proposal.

The Academy’s proposed factors are based on a projection of defaults for each rating category, leading to a misstated assessment of risk for bond portfolios as a whole. This modeling choice leads to an overestimation of projected losses on investment-grade bonds relative to below-investment-grade bonds.

LGD Approach and Resulting Misestimated Factors

Moody’s Analytics used data covering the period 1987-2019 from their MA’s Default & Recovery Database (DRD), reflecting the loss experience of life insurers’ U.S. corporate holdings across sectors. This data also reflected issuer-level loss given default (“LGD”) to avoid overweighting outliers and aligned ultimate recovery with default rate.

The Academy’s approach to LGD uses issue-level data, which tends to overweight outlier data points. This approach gives undue influence to defaulted issuers that had many issues.

Risk Premium Assumption

In its modeling, Moody’s Analytics acknowledged some conservatism already built into reserves, and provided a reasoned and thoughtful rationale for their model recommendation. They have proposed that the C-1 factors assume that reserves cover 0.5 standard deviation of credit risk beyond expected losses. Given the evolution of reserves, together with many interconnected model features, this assumption recognizes variation in industry reserving standards and closer aligns with PBR and other reserving standards generally aimed to cover adverse conditions.

While the Academy’s proposal prioritizes consistency between risk premium and AVR, the allocation of surplus across AVR and unassigned surplus does not affect the RBC ratio. Thus, the alignment between AVR and risk premium is irrelevant to the RBC framework, whose purpose is to help regulators identify potentially weakly capitalized companies.

The Academy’s risk premium, which is set equal to the expected loss, is inconsistent with the statutory reserving framework. The risk premium assumption should reflect the fact that reserves make provision for more than mean expected loss. This is explicit at a CTE 70 level in Principle-Based Reserves (PBR) and is implicitly evident in pre-PBR reserves. As the Academy stated in its 2015 report on its proposal, “The general consensus in the actuarial community is that statutory policy reserves (tabular plus additional reserves due to cash flow testing) at least cover credit losses up to one standard deviation (approximately 67th percentile).”3 We note that one standard deviation above the mean is actually closer to the 83rd percentile in a Normal distribution, as all of the losses below the mean are covered (rather than just being within one standard deviation both below and above the mean).

---

3 Model Construction and Development of RBC Factors for Fixed Income Securities for the NAIC’s Life Risk-Based Capital Formula, American Academy of Actuaries C1 Work Group, August 3, 2015
Omission of recent historical data

Moody's Analytics used the most recent experience available to model its factors, data through year-end 2020.

The Academy’s proposal does not include historical default and recovery data more recent than 2012. As the Academy states in the exposed letter, "While we have not modeled any assumption changes, we are concerned that the factors in this letter may be lower than what an analysis of updated data would produce." It is important to include as much recent and relevant experience as possible. In addition, some of the Academy’s assumptions have become outdated since their last update in 2017.

Summary

The ACLI supports and urges the adoption of the 2021-11-L Life Bond Factors (ACLI) proposal (with the original 4.32% discount rate). The modeling of these proposed C-1 bond factors and portfolio adjustment factors addresses the concerns and issues outlined by industry over the years. The factors, produced via a correlation model with up-to-date experience and assumptions, have a steeper slope (true delineation between rating categories) and provide superior estimates of diversification benefits. The Moody’s Analytics model promotes a more equitable distribution of the industrywide RBC increase, reducing the onus on small to medium size carriers in the 2021-10 proposal. The 2021-11 proposal is built by one of the premier experts in credit portfolio modeling, it represents a material increase in capital, and the results are intuitive.

Since the Moody’s Analytics model is fully integrated, its assumptions and parameters should be viewed holistically; Moody’s Analytics cautions against piecemeal modifications to individual model parameters without consideration of the interconnected elements of the framework.

Finally, we also support the LR030 change that was added during the exposure period.

*A technical note: There is a typo in the 2021-11-L Life Bond Factors (ACLI) exposure – on page 9 the portfolio adjustment factor for “Next 90” should be 1.53 and not 1.54 as shown.

We appreciate the opportunity to comment.

Sincerely,

Steven Clayburn

cc: Dave Fleming, NAIC Senior Insurance Reporting Analyst
    Paul Graham, Senior Vice President, Policy Development
### Appendix A: Summary of MA’s Targeted Modifications to the C1 Factors

<table>
<thead>
<tr>
<th>Targeted Modification</th>
<th>Current</th>
<th>Academy-Proposed</th>
<th>MA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrected possible errors in the engine code^[1]</td>
<td>Limited documentation</td>
<td>Code that replicates Academy’s results suggests two possible errors: First, the four-state model used different simulation seeds for default rates and LGD economic state. Second, when removing the mean simulated portfolio loss, the model used the product of expected default rate and expected LGD, neglecting LGD and default correlation.</td>
<td>Corrected possible simulation engine errors (1) Default rates and LGD are drawn from the same economic state for Baa-Caa MIS rated issuers; and (2) Removed mean adjustment from simulated portfolio loss (Section 6.2.6 demonstrates limited concern for simulation noise).</td>
</tr>
<tr>
<td>Discount Rate &amp; Tax Rate</td>
<td>Tax rate: 35% Discount rate: 9.23% (6% after tax) Recovery of tax loss benefit: 75% Tax recovery on default: 26.25%</td>
<td>Tax rate: 21% Discount rate (2000-2020 window): 3.47% (2.74% after tax) under guidance from the Life Risk-Based Capital (E) Working Group on April 22, 2021 Recovery of tax loss benefit: 80% Tax recovery on default: 16.8% While an alternative window start date can be justified, the discount rate enters the C1 formula as a single static rate and not as impactful as some other targeted modifications, reinforced by updated tax rate offset. Potentially important term structure dynamics that interplay with credit risk are not captured within the current framework.</td>
<td></td>
</tr>
</tbody>
</table>

---

^[1] MA did not have access to the Academy’s model and stipulates these errors based on the following: we were not able to match the Academy’s proposed C1 base factors [2017] closely when relying only on the Academy’s documentation. Discussions with industry members lead us to find two errors, that when purposely introduced, allowed for matching Academy’s proposed factors within simulation noise. First, the four-state model under the matched model used different simulation seeds for default rates and LGD economic state. Second, when removing the mean simulated portfolio loss, the matched model used the product of expected default rate and expected LGD, neglecting LGD and default correlation.
| **Loss Given Default (LGD)** | Limited documentation  
Average LGD by NAIC designation  
37.25% (NAIC 1),  
52.17% (NAIC 2),  
56.67% (NAIC 3-5) | Does not align with the date of default. This deviation can result in bias with recovery rate levels, as well as their relationships with default rates.  
Average value of LGD = 53% | Use MA’s Default & Recovery Database (DRD) over 1987–2019 window, reflect the loss experience of life insurers’ U.S. corporate holdings across sectors, reflect issuer-level LGD to avoid overweighting outliers, align ultimate recovery with default date.  
Average value of LGD = 52% |
| **Risk Premium** | Set equal to expected loss | Set equal to expected loss | Set at expected loss plus 0.5 standard deviation, recognizing variation in industry reserving standards and to closer align with reserving standards generally aimed at covering moderately adverse conditions and PBR. In addition, MA outlines a potential future update to AVR allowing alignment with default rates and LGDs that parameterize the final C1 framework; although this update is not urgent given AVR does not impact the RBC ratio and solvency. A higher Risk Premium lowers the C1 base factors and mildly increases their differentiation across the NAIC designation categories. |
| **Economic State Model** | Limited documentation  
Fivé-state model; affects both default and LGD; MA did not analyze, possibly similar properties to recent Academy proposal | A combination of two and four-state model; affects both default and LGD; Model results in C1 base factors that are not sufficiently differentiated across NAIC designation categories and under certain parameterizations C1 base factors that are not monotonic, and PAFs that provide more diversification benefits than observed empirically. | Initially outside Scope, economic state model limitations are viewed to be sufficiently material to warrant replacement by a correlation model that reflects default correlations and diversification benefits observed empirically in MA C1 Factors. Resulting C1 base factors are more differentiated across NAIC designation categories, and PAFs are a more accurate reflection of diversification benefits. |
| Default Rates | Based on data from, Moody's 1991 Special Comment: Corporate Default and Recovery Rates, 1970-1990. Documentation on data treatment is limited | Smoothed corporate default rate term structures representing the historical experience of life insurers’ U.S. corporate holdings using default data grouped by MIS alphanumeric rating using MA’s DRD. MA default rates tend to have a steeper slope (more differentiated across MIS ratings) than those proposed by the Academy, with differentiation more closely aligning with benchmarks. |
| PAFs | Documentation is limited | Initially outside Scope, economic state model limitations are viewed to be sufficiently material that the economic state model is replaced by a correlation model that reflects default correlations and diversification benefits observed empirically in MA C1 Factors. Resulting C1 base factors are more differentiated across NAIC designation categories, and PAFs are a more accurate reflection of diversification benefits. |
May 24, 2021

Mr. Philip Barlow  
Chair, Life Risk-Based Capital E Working Group  
National Association of Insurance Commissioners  
Kansas City, Missouri

Re: Bond Factors and Companion Portfolio Adjustment Factors

Dear Mr. Barlow:

I am the Executive Director of the National Alliance of Life Companies (the NALC), a trade group of more than fifty life insurance companies and associates that represents the interests of small and mid-sized insurers and their policyholders.

As noted in our prior letter of April 8, 2021, a copy of which is attached, we have very significant concerns about the American Academy of Actuaries’ proposed changes in the bond factors and portfolio adjustment factors under consideration by the Working Group. This letter updates our earlier comments based upon our subsequent review of information provided in the Moody’s Analytics report, and after further discussions with representatives of small and mid-sized life insurers from across the United States.

The NALC continues to believe that the proposed bond factors presented by the American Academy of Actuaries are more appropriate for larger life insurers with larger and more diverse bond holdings, and would do significant harm to small life insurance companies with more modest bond portfolios. The Academy’s portfolio adjustment factors would push smaller insurers to purchase bonds that may not meet their long-term duration objectives to increase user count.

Our survey of small companies showed that the proposed changes would force an increase of company capital between 7% and 17%, and a negative impact on RBC between 6.6% and 11.14%. This material adverse impact would occur without any change in the risk profile of their portfolios. The NALC strongly encourages the Working Group to make necessary adjustments in its report to address these inequities to prevent disparate impact on smaller life insurance companies.

We note further that other observers share our concerns. In a Guggenheim Investments, perspective dated May 13, 2021, the commentary notes “no comprehensive study has been performed on the impact of the new RBC changes to insurers.” We believe our survey supports this conclusion, as it shows smaller companies would see a significant erosion of their capital position the moment the ink dries on these regulatory changes. Guggenheim further notes, “the U.S. industry has nearly $7 trillion in general account assets. Without a phase-in period, there is likely to be unintended repercussions on the insurance industry and the capital markets.” Again, our survey results support this observation.

In reviewing the various options, we believe that Moody’s proposal provides better building blocks for changes in RBC factors for fixed-income securities.

We would therefore urge the Working Group to extend the deadline for comment to allow additional time to work through the concerns raised in this letter, as well as other concerns raised by interested parties. With this additional time, we believe the parties can address these reasonable concerns, and create a stronger, equitable, and more complete report.

Thank you.
Sincerely,

Jim Hodges
Executive Director
NALC
April 8, 2021

Mr. Philip Barlow  
Chair, Life Risked Based Capital E Working Group  
National Association of Insurance Commissioners  
Kansas City, Missouri

Re: Bond Factors and Companion Portfolio Adjustment Formulas

Dear Mr. Barlow:

I am the Executive Director of the National Alliance of Life Companies (the NALC), a trade group of more than fifty (50) members and associates that represents the interests of small life insurance companies in the United States. We have closely followed the work of the American Academy of Actuaries regarding proposed changes in the bond factors and the portfolio adjustment factors (herein new bond factors) for investments held by life insurance companies. We have also read the preliminary report of Moody's Analytics commissioned by the American Council of Life Insurers (the ACLI) on the impact of such changes.

We felt it would be helpful for the Working Group to hear real-world examples of the impact of these proposed bond factor changes, so we surveyed a number of small life insurance companies around the country to better assess the impact. In our survey, we looked at the Required Change in Company Capital Level based on new bond factors, as well as the RBC Ratio Percentage Change using the new bond factors. The survey was done prior to the Academy update for the decrease in the corporate tax rate.

Of the twelve companies responding to the survey, all but one reported the new factors would require a change of company capital between 7% and 17%. Those same companies reported a negative impact on their RBC Ratio of between 6.6% and 11.14%. This clearly demonstrates that the proposed bond factor changes would have a significant adverse impact on the capital position of smaller life insurance companies without any change in portfolio or risk.

One other important point is worth making - it does not appear that the impact of these proposed changes on commercial transactions for life insurance companies has been adequately explored. Many commercial transactions, such as loan documents, reinsurance agreements and other agreements, contain RBC covenants which provide for defaults to be declared if RBC covenants are violated. Of course, those provisions were negotiated and agreed to under current bond factors and RBC calculations. We are very concerned that the proposed changes would force some companies into non-compliance with those covenants, triggering a material and adverse impact on these companies. We would note further that this an issue for companies of all sizes with such covenants in place.
Based upon these and other considerations, the NALC urges the Task Force to closely examine the potential adverse business consequences of the proposed changes on small life insurance companies and their policyholders. We appreciate the positive comments that have been made about regulatory discretion as a means to mitigate the adverse effects of these changes. That approach could reduce the negative impact of the changes on a company by company basis. An additional approach would be to allow a generous phase in period that would allow companies sufficient time to make the necessary adjustments to their bond portfolios.

Thank you for allowing us to comment. We are happy to provide summary details regarding our surveys if helpful.

Sincerely,

Jim Hodges
Executive Director
NALC
May 25, 2021

NAIC
Life Risk-Based Capital Working Group
444 North Capitol Street NW, Suite 700
Washington, DC 20001

Dear Life Risk-Based Capital Working Group,

The North American CRO Council (CRO Council) is a professional association of Chief Risk Officers (CROs) of leading insurers based in the United States, Bermuda and Canada. Member CROs currently represent 32 of the largest Life and Property and Casualty insurers in North America. The CRO Council seeks to develop and promote leading practices in risk management throughout the insurance industry and provide thought leadership and direction on the advancement of risk-based solvency and liquidity assessments.

The CRO Council appreciates your continued efforts to maintain a robust and modern RBC framework. We also appreciate the opportunity to comment on the ongoing work to update RBC C1 Bond Factors. We urge the members of the Life Risk Based Capital Working Group to adopt the proposal set forth by Moody’s Analytics on April 22nd. This proposal is robust, well documented, and backed by one of the most respected names in credit analytics. This is also the only proposal to include updated experience through 2020 and updated assumptions aligning with the current credit markets and reserving standards. The Working Group is considering a top-side adjustment of the Academy’s portfolio adjustment factors to make them more intuitive. Moody’s Analytics proposal would require no such adjustment.

Moody’s Analytics is one of the premier portfolio credit modeling firms in the world. For decades, their models and analytics have been used by many of the largest banks and insurers as well as many regulators. Their parent firm curates critical data sets, including the one used to derive the original C1 factors, the Academy of Actuaries proposal and the Moody’s Analytics proposal. Moody’s Analytics submitted a response to the request for proposal by the American Council of Life Insurers because they believe in the mission of protecting the insurance industry and ensuring that rational incentives drive capital markets. They also understand the importance and magnitude of a framework that will be applied to several Trillion dollars of debt.

In our experience, issues arise when regulatory requirements materially deviate from economic incentives. In capital frameworks, this typically happens with the overall level of capital and the allocation of capital across securities.

Level of Capital: The current RBC C1 framework has served the industry and policyholders well for almost 30 years. Overall capital levels have been more than sufficient to weather every credit event that has occurred. It is hard to justify a material increase in overall capital.
requirements for the industry. Moody’s Analytics proposal on April 22nd demonstrates this with a modest increase of 7% while the Academy’s proposal would increase capital by 14%. The past 30 years simply does not justify such a large increase in required capital.

**Allocation of Capital:** The current allocation of C1 charges across bond ratings is generally intuitive and has worked well for the past 30 years. While we support expanding to additional rating granularity, it is critical that relative capital (e.g., investment grade vs high yield) is appropriate. The Academy’s proposal would significantly increase investment grade charges relative to high yield. We believe this is unintuitive (confirmed by review of the February 2021 report from Moody’s Analytics) and may incentivize increased risk taking within the investment portfolio that could potentially impact the balance sheet strength for the industry.

Thank you again for your continued efforts on this critical update. This is an opportunity for the Working Group to adopt a proposal that is backed up by transparent analytics, historical experience, intuition, and a market-leading credit analytics group. We urge you to thoughtfully consider and adopt the Moody’s Analytics proposal.

Sincerely,

Jonathan Porter  
Chair of the North American CRO Council
Mr. Philip Barlow
Chair
NAIC Life Risk-Based Capital Working Group

May 25, 2021

Dear Mr. Barlow,

As a small mutual life insurer I am very concerned about the impact of the RBC bond factors being considered for implementation. While understanding the need for conservatism, I do not understand the necessity of such punitive additional capital requirements. As I am sure you are aware, mutual companies, and small mutual companies to boot, do not have ready access to capital. For that reason, small insurers like us are very conservative in our investment philosophy (we can’t afford to lose principal). We anticipate the impact to Columbian to be on the order of 50% on a CAL basis. This, in addition to the impact of Covid-19 mortality we experienced over the past year, will have a significant negative impact on our organization, an organization which has less than 1% of our assets in below investment grade bonds and is not at significant risk to credit defaults.

I do not understand the problem the NAIC is trying to correct. Over the past 15 years the industry has experienced two potentially traumatic events with potentially devastating effect to the investment portfolios of life and P&C insurers. However, in the most recent Pandemic, I am aware of no insurers that were so negatively impacted by credit concerns that they were forced into regulatory review. From the financial crisis, I am aware of only one life insurer that was forced into receivership due to investments, and that was due to defaulted FNMA and FHLMC preferred stock positions. The insurer would not have been influenced by higher capital requirements in the purchase of these securities, due to the defaulted securities being US Government Agency obligations, which enjoyed essentially the lowest capital requirements. Indeed, more stringent capital requirements on lower rated bonds could conceivably have caused more organizations to have invested in those higher rated, but defaulted securities, purely to avoid higher capital requirements.

If you have to institute additional capital requirements I ask that the ACLI proposal, developed by Moody’s analytics, be adopted. While the ACLI proposal is still quite punitive in my mind, it is less punitive and more sound than the Academy’s proposal. Please consider adopting the ACLI proposal.

Thank you for taking into consideration the concerns of small life insurers, who typically have conservative investment portfolios and limited capital raising ability.

Sincerely,

Michael C. S. Fosbury
President & CEO
May 21, 2021

Mr. Philip Barlow
Chair
NAIC Life Risk-Based Capital Working Group
(via email to Dave Fleming (NAIC Staff for the Working Group)

Dear Mr. Barlow,

On behalf of my company, Gleaner Life Insurance Society, I am writing to you concerning the two exposure drafts related to RBC factors for bonds.

As bonds are, by far, the largest asset class that we own, the choice of RBC factors is critical.

We have reviewed both the Academy proposal (2021-10-L) and the ACLI proposal (2021-11-L) and wholeheartedly support the adoption of the ACLI proposal.

The ACLI proposal was developed by Moody’s Analytics, which is a premier credit analysis company. We believe that the methodology they used in developing the factors is state-of-the-art and superior to the older methods employed by the Academy.

As a result, companies investing in highly-rated bonds are not penalized for holding those assets. Furthermore, the portfolio adjustment factor proposed by Moody’s is much less punitive than that contained in the Academy proposal for smaller companies such as ours.

As a result, we strongly urge the Working Group to adopt the ACLI proposal.

Thank you for taking our concerns about the proposed RBC factors for bonds into account as you deliberate this important matter.

Sincerely,

Kevin A. Marti
President and CEO

cc: Mr. Marco Bravo, AAM
Mr. Tim Senachelle, AAM
Mr. Todd Warner

www.gleanerlife.org • 800.992.1894 • 517.265.7745 • 5200 West U.S. Highway 223 • P.O. Box 1894 • Adrian, MI 49221
May 21, 2021

Mr. Philip Barlow  
Chair  
NAIC Life Risk-Based Capital Working Group

Dear Mr. Barlow,

I am writing on behalf of my company, Government Personnel Mutual Life Insurance Company (GPM), concerning the two exposure drafts related to RBC factors for bonds. We have reviewed both the Academy proposal (2021-10-L) and the ACLI proposal (2021-11-L) and support the adoption of the ACLI proposal. The ACLI proposal was developed by Moody’s Analytics, which is a premier credit analysis company. We believe that the methodology they used in developing the factors is state-of-the-art and superior to the older methods employed by the Academy. As a result, companies investing in highly-rated bonds are not penalized for holding those assets. The choice of RBC factors is important, since bonds are by far the largest asset class that my company owns. Furthermore, a critical item is the portfolio adjustment factor proposed by Moody’s, which is much less punitive than the that in the Academy proposal for small companies such as ours. We continue to support the work sponsored by the ACLI and, as a result, we highly recommend that the Working Group adopt the ACLI proposal.

Thank you for taking our concerns into account as you deliberate this important matter.

Sincerely,

Peter Hennessey III, CLU, FLMI  
Chairman, President and CEO

Pamela A Hutchins, FSA, MAAA  
Senior Vice President and Chief Actuary

PHIII: msg  
C: Mike Boerner  
Rachel Hemphill
May 21, 2021

Mr. Philip Barlow
Chair
NAIC Life Risk-Based Capital Working Group

Dear Mr. Barlow,

I am writing on behalf of Oxford Life Insurance Company concerning the two exposure drafts related to RBC factors for bonds. As bonds are, by far, the largest asset class that we own, the choice of RBC factors is critical. We have reviewed both the Academy proposal (2021-10-L) and the ACLI proposal (2021-11-L) and support the adoption of the ACLI proposal. The ACLI proposal was developed by Moody’s Analytics, which is a premier credit analysis company. We believe that the methodology they used in developing the factors is state-of-the-art and superior to the older methods employed by the Academy. As a result, companies investing in highly rated bonds are not penalized for holding those assets. Furthermore, the portfolio adjustment factor proposed by Moody’s is much less punitive than the that in the Academy proposal for small companies such as ours. As a result, I highly urge the Working Group to adopt the ACLI proposal.

Thank you for taking our concerns into account as you deliberate this important matter.

Sincerely,

Mark A. Haydukovich
President and CEO
May 21, 2021

Mr. Philip Barlow
Chair
NAIC Life Risk-Based Capital Working Group

Dear Mr. Barlow,

I am writing on behalf of my company, Homesteaders Life Company, concerning the two exposure drafts related to RBC factors for bonds. As bonds are, by far, the largest asset class that we own, the choice of RBC factors is critical. We have reviewed both the Academy proposal (2021-10-L) and the ACLI proposal (2021-11-L) and support the adoption of the ACLI proposal. The ACLI proposal was developed by Moody’s Analytics, which is a premier credit analysis company. We believe that the methodology they used in developing the factors is state-of-the-art and superior to the older methods employed by the Academy. As a result, companies investing in highly-rated bonds are not penalized for holding those assets. Furthermore, the portfolio adjustment factor proposed by Moody’s is much less punitive than that in the Academy proposal for small companies such as ours. As a result, I highly urge the Working Group to adopt the ACLI proposal.

Thank you for taking our concerns into account as you deliberate this important matter.

Sincerely,

[Signature]

Stephen M. Shaffer
Board Chair, President and CEO
Office: 515-440-7888
Toll Free: 800-477-3633 Ext. 7888
email: sshaffer@homesteaderslife.com
Dear Mr. Fleming,

The American Fraternal Alliance (Alliance) appreciates the opportunity to provide input to the Life Risk-Based Capital Working Group on the review of the proposal from the American Academy of Actuaries (Academy) and a newer plan supplied by ACLI and Moody’s Analytics (ACLI) related to the C-1 Bond Factor project.

The Alliance urges the NAIC to consider implementing the proposal provided the ACLI. In previous years, Alliance members participated in a survey that demonstrated that incorporating the Academy recommendations unintentionally reduced the RBC ratios of many small-to-mid size insurers, including fraternals, significantly.

This impact to solvency ratio(s) can be misinterpreted by regulators or the general public based solely on a change in the formula. A fraternal’s actual assets, liabilities and surplus will not have changed, but the change in ratio(s) calculation or trend can be very misleading.

The magnitude of the changes in the Academy proposal is severe for smaller companies when the new portfolio adjustment factor is applied. The impact of the proposed changes will be significant, especially for smaller insurers like many fraternals.

The Alliance supports consideration of the ACLI proposal which includes up-to-date data, provides more intuitive results, and is less punitive than the Academy proposal on smaller insurers like fraternals.

Thank you for giving the Alliance the opportunity to provide feedback. Please contact me with questions or comments.

Allison Koppel
CEO
American Fraternal Alliance
akoppel@fraternalalliance.org
May 27, 2021

NAIC
Attn: Mr. Dave Fleming
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: RBC

Dear Mr. Fleming,

Catholic Financial Life appreciates the opportunity to provide input to the Life Risk-Based Capital Working Group on the review of the proposal from the American Academy of Actuaries (Academy) and a newer plan supplied by ACLI and Moody’s Analytics (ACLI) related to the C-1 Bond Factor project.

Consistent with the view from the American Fraternal Alliance (AFA), the Society urges the NAIC to consider implementing the proposal provided by the ACLI. Following is the projected impact on the Society utilizing March 31, 2021 assets, assumptions and factors for both the Academy and ACLI:

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Academy Factors</th>
<th>ACLI Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC Ratio</td>
<td>1087%</td>
<td>923%</td>
<td>1000%</td>
</tr>
<tr>
<td>Difference from Actual</td>
<td>0%</td>
<td>-164%</td>
<td>-87%</td>
</tr>
</tbody>
</table>

While Catholic Financial Life remains well capitalized under both proposed factor changes, the impact to solvency ratio(s) can be misinterpreted by regulators or the general public based solely on a change in the formula. A fraternal’s actual assets, liabilities and surplus will not have changed, but the change in ratio(s) calculation, or trend, can be very misleading. Additionally, the magnitude of the changes in the Academy proposal is anticipated to be severe for smaller companies when the new portfolio adjustment factor is applied. This is reflective for Catholic Financial Life as the...
Academy factors are projected to decrease by nearly twice as much as the ACLI factors.

Catholic Financial Life supports consideration of the ACLI proposal which includes up-to-date data, provides more intuitive results, and is less punitive than the Academy proposal on insurers like Catholic Financial Life and other smaller fraternals.

Thank you for giving Catholic Financial Life the opportunity to provide feedback. Please contact us with questions or comments.

Sincerely,

William R. O’Toole
CEO
T (414) 278-6700 | (800) 927-2547
F (414) 273-2120
Bill.Otoole@catholicfinanciallife.org

John Borgen
President
T (414) 278-6608 | (800) 927-2547
F (414) 273-2120
John.Borgen@catholicfinanciallife.org

Kari Diestelhorst
Chief Financial Officer
T (414) 278-6582 | (800) 927-2547
F (414) 273-2120
Kari.Diestelhorst@catholicfinanciallife.org
Via Email

Friday, May 21, 2021

Mr. Fleming,

I am reaching out regarding the two Bond Factor proposals that the NAIC is considering. The Catholic Association of Foresters supports the ACLI proposal as it includes up to date data and provides more intuitive results. This option is also less punitive to smaller insurers.

Thank you in advance for your support.

Christine Cunningham
High Secretary – Treasurer
Catholic Association of Foresters
Via Email

Wednesday, May 26, 2021

I respectively request that the Life Risk-Based Capital (E) Working Group consider supporting the ACLI proposal as opposed to the American Academy of Actuaries (Academy). The ACLI proposal includes up-to-date data, provides more intuitive results and is less punitive than the Academy’s proposal on smaller insurers like fraternals.

Thank you for your consideration in this matter.

Theresa

Theresa A. Kluchinski  
National President  
Ladies Pennsylvania Slovak Catholic Union  
71 S. Washington Street  
Wilkes-Barre, PA 18701
Via Email

Thursday, May 20, 2021

Good afternoon Mr. Fleming,

My name is Scott Pogorelec and I am the Executive Secretary of the Slovak Catholic Sokol (#57193). Just wanted to reach out to the Life RBC Working Group in hopes you support the ACLI proposal in regard to the adjustment of bond factors. The Academy’s proposal would negatively impact fraternals like ourself in a major way.

I thank you for your time in reading this.

All the best!

Scott T. Pogorelec, F.I.C.
Supreme Secretary

Slovak Catholic Sokol
205 Madison St.
Passaic, NJ 07055
Via Email  

Monday, May 24, 2021  

Mr. Fleming,  

As the CFO of a small fraternal insurer I am contacting you to urge the NAIC to support the ACLI proposal for revised C-1 bond factors. While both the American Academy of Actuaries and ACLI proposals could suddenly lower our RBC, the ACLI model includes up-to-date data, provides more intuitive results, and is less punitive than the Academy proposal on smaller insurers like Sons of Norway. Thank you for your time and attention to this matter.  

Fraternally,  

Erica Oberg  
Chief Financial Officer  

[SONS of NORWAY logo]  

Our mailing address is  
1455 W Lake St, Minneapolis, MN, 55408
May 25, 2021

Mr. Philip Barlow
Chair
NAIC Life Risk-Based Capital Working Group

Dear Mr. Barlow,

I am writing on behalf of my society, Royal Neighbors of America, concerning the two exposure drafts related to RBC factors for bonds. As bonds are, by far, the largest asset class that we own, the choice of RBC factors is critical. We have reviewed both the Academy proposal (2021-10-L) and the ACLI proposal (2021-11-L) and support the adoption of the ACLI proposal. The ACLI proposal was developed by Moody’s Analytics, which is a premier credit analysis company. We believe that the methodology they used in developing the factors is state-of-the-art and superior to the older methods employed by the Academy. The proposed Moody’s C-1 Factors are more differentiated across the current C-1 factors and have a steeper slope than the current C-1 factors proposed by the Society of Actuaries. In addition, the method used by Moody’s Analytics better captures economic risks of insurers fixed income portfolios. As a result, companies investing in highly rated bonds are not penalized for holding those assets. Furthermore, the portfolio adjustment factor proposed by Moody’s is much less punitive than that in the Academy proposal for small companies such as ours. Given all of these factors, I highly urge the Working Group to adopt the ACLI proposal.

Thank you for taking our concerns into account as you deliberate this important matter.

Sincerely,

John A. Friederich
General Counsel & Secretary
May 27, 2021

Mr. Philip Barlow  
Chair  
Life Risk-Based Capital Working Group (LRBCWG)  
National Association of Insurance Commissioners (NAIC)

Dear Philip,

The American Academy of Actuaries\(^1\) C1 Work Group (C1WG) appreciates the opportunity to comment on the exposure drafts of factors for bonds (Exposure of American Academy of Actuaries’ and American Council of Life Insurers’ Proposed Bond Factors and Instructions, exposed by the LRBCWG on April 21, 2021). We recognize the tight timetable to adopt a set of bond factors by June 30, 2021, and as such our comments will highlight the areas of greatest importance consistent with this timeline. In particular, our letter highlights those areas that are both material to the resulting factors and represent the greatest difference with the C1WG’s updated factors.\(^2\)

The choice before the LRBCWG involves two different methodologies to forecast credit risk for the purpose of determining capital requirements. With the exception of the corporate tax rate, the C1WG’s recommendations are based on the existing C1 bond framework with updated assumptions consistent with the timeframe when the majority of our modeling was conducted (in the early 2010s). The C1WG has provided extensive analysis, documentation, and explanations for the updated factors. Our work was guided by the request of regulators and several discussions with regulators throughout our work.

Moody’s Analytics (MA) has provided the LRBCWG with an alternative approach using a different method for measuring credit risk along with different assumptions. Some of its modeling choices have been described as more sophisticated and utilize more modern techniques. Some of the methods used by MA to project credit losses not only update for recent experience, but also represent a philosophical departure from the methods that have been used in establishing capital requirements. While some of their methods may do a better job projecting credit risk, it is difficult to completely analyze the differences without full disclosure and detailed documentation of the basis and assumptions used in the MA model.

\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

\(^2\) https://www.actuary.org/sites/default/files/2021-03/C1_Bond_Factor_Tax_Update_03112021_Final.pdf.
Nevertheless, comparing the MA recommended factors to the factors recommended by the C1WG, we make the following high-level comparisons based on some rudimentary analysis:

A. MA modeled loss experience has almost no effect, on average, on the bond factors but has significant effect across ratings. Modeled loss experience is a combination of the assumptions for default rates, loss given default (1 – recovery percentage), and the use of a correlated default rate approach;

B. MA risk premium assumptions decrease the factors by approximately 18%; and

C. MA discount rate assumption increases the factors by approximately 6-7%.

In the following section, we identify our most significant questions with each of these major areas of difference.

A. Modeled Loss Experience

The C1WG estimates the MA base factors are 0.2% lower than the C1WG’s factors due to differences between the C1WG and MA assumptions for modeled loss experience where the materiality of those differences varies by rating class. Isolating only the modeled loss experience, the MA factors for Aaa-A1 ratings are lower than the C1WG bond factors on average by 11.3% while the Baa1-Caa3 factors recommended by MA are higher by 12.5% on average. Though not completely quantifiable due to undisclosed assumptions, our analysis suggests that most of the difference in modeled loss is attributable to the default rate assumption rather than the recovery assumption.

1. Default Rates

A comparison of default rates assumed by MA and the C1WG is challenging given the use of different time periods for the experience and MA’s use of a tailored life industry default series. We observe that the additional eight years of default experience reduces the default probabilities for all corporate sectors combined. If the C1WG used the additional eight years in its model, the C1 bond factors would decrease. Whether to use the additional eight years would be the subject of significant discussion; the C1WG would explore if 38 years of experience should be used, or whether it would make sense to use a set time frame (e.g., 30 or 35 years).

Further complicating the comparison of base default rates is that MA uses default rates specifically developed for the life insurance industry. MA’s decision to include or exclude certain experience results in a downward bias for Aaa-A2 issuers and an upward bias for Baa1-Ba2 issuers as compared to default experience for the entire corporate sector. These customized default rates resulted in the “steeper slope” for the 20 C1 bond factors, resulting in lower capital charges for the highest investment-grade bonds.

In the next several paragraphs, we expand on the observations above. However, the overriding consideration for regulators should be whether the capital requirements should be based solely on aggregate historical default probabilities for the entire corporate sector applied to typical life
insurance portfolios, or whether capital requirements should be based on customized default probabilities (i.e., historical experience adjusted for outliers, shifting sector allocations, and other subjective considerations). The current basis for capital requirements is historical default experience for the entire U.S. corporate holdings (financials, industrials, and utilities).

Figure 1 shows that the additional default experience of 2013–2020 decreased 10-year cumulative default rates by about 20% with all quality ratings showing lower default rates except for Aa1 (note that 1983–2020 experience is in the numerator and 1983–2012 experience is in the denominator). Ratings below B3 are not shown because they are not available for Caa1-Caa3 in the 1983–2020 Moody’s report (*Moody’s Annual Default Study*, January 28, 2021).

Figure 2 shows the ratios of the default rates assumed vs. reported by Moody’s Investor Service (MIS) for the respective experience periods evaluated by the C1WG and MA. The MA ratios show a downward bias of assumed rates for Aaa-A2 and upward bias for Baa1-Ba2 whereas the C1WG ratios tend to track more closely to 100% of the MIS default rates.
Figure 3 shows a side–by-side view of the values embedded in the ratios of Figure 2. The bias described above of the MA rates is apparent in the right-hand graph.

Figure 4 shows the 1983–2020 10-year cumulative default rates for U.S. corporates (a subset of the annually reported MIS default rates) before smoothing and adjustments on two bases: 1) MA’s tailored life insurance series (Life Index) based on life insurance industry sector weightings and, 2) the MIS U.S. corporate rates (MIS Subset) weighted by total corporate issuance of the sectors shown. Because the rate differences are difficult to illustrate using base values, they are shown as the percentage of the Life Index to the MIS Subset in the right-hand secondary axis. The bias of the MA Life Index rates above and below the MIS Subset rates suggests that at least some of the bias noted above is due to the construction of the tailored life insurance default rates. Because the MA Life Index rates are unsmoothed in this view, the bias for Aaa is not apparent.
The tailored Aaa life insurance default rate was reduced from 0.503% to 0.079%.

Figure 4

Based on the above analysis in Figures 1-4, the C1WG concludes that there is a downward bias for higher ratings of default rates assumed by MA relative to historical 1983–2020 default rates published by MIS. This is due at least in part to the tailored weightings of life insurance industry exposure of sector-specific default rates.

The MA default rates relative to the MIS rates for the same period are also affected by the selection of a subset of the MIS universe as described in the MA documentation. These filters produced the default rates shown in Tables 8 and 16 that directly inform MA’s baseline empirical default rates, as described in Appendix Section 8.2. Because the filtering process does not completely reconcile the starting point of the MIS published rates and the endpoint of the U.S. corporate issuers, the C1WG is unable to draw further conclusions about the appropriateness of these exclusions and the resulting subset of U.S. corporate-based default rates.

A few additional comments:

a. MA has separated default experience for three different sectors (utilities, financials, and industrials). Based on conversations with Moody’s Investor Services, our understanding was that differences in expected loss were captured in the assigned rating class. We are curious why different C1 bond factors are created for different sectors, given that Global Ratings Methodology assigns equivalent ratings across all sectors. The LRBC calculation relies on the assigned rating from an NRSRO (nationally recognized statistical rating organizations) and the principle of equivalent ratings by sector. Why is MA subdividing default experience by sector when MIS has stated the equivalence of ratings by sector?
b. The downward adjustment of Aaa experience based on removing the two selected events as outliers (Getty Oil and Texaco) has contributed to pulling down the MA loss curve for higher-quality ratings. This pulling down of the fitted curve at its inception point contributes to the difficulties of tracking closer to MIS experience. We are curious as to why this modification was made, given the apparent bias created. Additionally, the Aaa default probability is used as an anchor point for all other default probabilities along the credit spectrum; therefore, while life insurers have a relatively small exposure to Aaa securities, adjusting the Aaa loss assumptions downward affects all exposures.

2. Variation of Baseline Total Loss Experience

The C1WG model uses an economic state model to project different loss experience that varies with the economic state (i.e., contraction, expansion). The C1WG bond model projects loss experience over 10,000 economic scenarios, with the resulting C1 bond factors developed from equal weighting of the scenario specific results. Moody’s is recommending a different approach using a more complex model that assumes correlated loss experience between bonds. MA analysis showed that use of this correlation model increased total loss from the base case by 24-28%. The C1WG’s analysis concluded that its economic state model increased total loss from the base case by 26%. Therefore, the approach for reflecting how total loss varies due to economic conditions is approximately the same on average but the effect varies materially by rating.

The documentation provided by MA does not describe how its correlation algorithm was calibrated and validated against actual default experience. In parameterizing the economic state algorithm, the C1WG’s bond model increased losses in contractions and decreased losses in expansions. Additionally, we compared the “stressed results” to actual loss experience to ensure the model was reasonable over the entire 10-year projection period.

While there may be validity in assuming correlation within a bond portfolio, the approach used by MA is a significant departure in method. Without further study and greater disclosure of the MA model, it is difficult to provide additional comments.

3. Recovery Assumptions

The differences between MA and the C1WG on this assumption are relatively minor. The average loss given default (LGD) for MA is 52% while the average LGD used by the C1WG is 53%. Each entity uses a histogram of possible recovery percentages in developing its respective sets of C1 bond factors. The C1WG used recovery assumptions for senior unsecured debt as approximately 85% of bonds held by life insurers are senior unsecured bonds. While MA also used senior unsecured debt as the assumed lien position, it produced a weighted LGD tailored to the sector mix of life insurance industry holdings. The difference as modeled by MA between the C1WG and MA LGD assumptions was described as a “moderate decrease” in MA’s April 15, 2021, presentation to the LRBCWG. These slight differences between the recovery assumptions do not appear to be material relative to other assumptions (particularly the default rate).
B. **Risk Premium**

As we have discussed in our July 17, 2018, letter to the Investment Risk-Based Capital (IRBC) Working Group, we continue to recommend the use of the mean of the loss distribution for the risk premium (RP). The RP assumption was established when the existing NAIC solvency framework was implemented. The C-1 bond factors assume that statutory policy reserves cover moderately adverse conditions, approximated as one standard deviation. The Asset Valuation Reserve (AVR) bond component is assumed to cover risks between the mean and one standard deviation, with the C-1 bond component covering risks between one standard deviation and the 96th percentile. Capital requirements for life insurers are not intended to make up for any deficiencies in reserve requirements and do not make allowances for any excesses or deficiencies in statutory policy reserves. Finally, the C-1 bond factor is applied to all bonds, and not just those bonds backing statutory policy reserves; consequently, any offset for the C-1 factor should only apply to those assets backing policy reserves.

If the RP is changed in the C1 bond factors, then the AVR Bond Component should be reviewed as well as the requirements for reflecting credit risk in statutory policy reserves, including the Actuarial Opinion and Memorandum. Reducing capital requirements for credit risk under the guise that statutory policy reserves cover a larger portion of credit risk than when RBC was first designed should be done with the assurance that corresponding provisions have been made for statutory policy reserves.

C. **Discount Rate**

We believe the use of a discount rate updated for recent experience, consistent with other updated assumptions, is appropriate.

D. **Modeling Questions**

1. Representative Portfolio
2. Cash Flow Projections
3. Stochastic Scenario Calculation

We also have questions related to the modeling mechanics and the derivation of the specific bond factors. Our understanding of the Moody’s loss assumptions is that they were developed for a typical life insurer’s bond portfolio. MA has used default probabilities that have been customized for the life insurance industry by removing specific default events and

altering the sector weightings (e.g., reducing the weight assigned to financials, a sector with poor credit experience in the Great Recession). Those default probabilities are applied to a modeled portfolio of bonds to project credit losses. What are the characteristics of that portfolio?

The C1WG’s factors were based on sector-wide loss given default experience for all corporate bonds (public bonds, senior unsecured) and applied to a representative portfolio for life insurers. The C1WG calculated the after tax base factor capital (before the portfolio adjustment) as the after tax present value of the maximum loss over a 10-year period. Losses are defined as the total annual losses offset by annual risk premium. Losses occurring before the end of the 10-year period are reinvested at the original quality rating and subject to subsequent additional loss until the end of the original 10-year period. Losses for these preliminary base factors were calculated at the 96th percentile level.

Although an 824-issuer portfolio is referenced in the MA documentation, it is not clear how this portfolio is used in the MA projection of bond losses. Also, there is no description of the projection mechanics (e.g., scenarios, calculation of the scenario-specific factor, scenario weights, etc.).

The components for determining projected losses comprise a material assumption and are critical to gaining comfort with the recommended factors.

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We continue to encourage the LRBC to adopt the factors recommended by the C1WG. These factors were developed in response to the request of the C1WG by regulators, which was to update the C1 bond factors, consistent with the prevailing solvency framework for U.S. life insurance companies. Throughout the lengthy process in which the NAIC has been considering this proposal, the C1WG has worked with regulators and industry in evaluating the merits of different modeling choices and the impact of assumptions. Our recommended factors reflect the regulators’ decisions leading up to the request being made and during this process. These factors satisfy the regulator-stated objectives of identifying potentially weakly capitalized companies using public information reported in statutory financial statements. A key question may be whether regulators are seeking a new framework for the factors or a framework to pursue factors in line with the prior framework.

We continue to be available to answer regulators’ questions and look forward to the final disposition on this lengthy project.
Sincerely,

Nancy Bennett, MAAA, FSA, CERA
Co-Chairperson, C1WG

Jerry Holman, MAAA, FSA, CFA
Co-Chairperson, C1WG
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met May 27, 2021. The following Working Group members participated: Philip Barlow, Chair (DC); Jennifer Li (AL); Thomas Reedy (CA); Wanchin Chou (CT); Sean Collins (FL); Mike Yanacheak and Carrie Mears (IA); Vincent Tsang (IL); John Robinson (MN); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello and Michael Cebula (NY); Andrew Schallhorn (OK); Mike Boerner and Rachel Hemphill (TX); and Tomasz Serbinowski (UT). Also participating was: Dale Bruggeman (OH).

1. **Discussed Comments Received on the ACLI’s Real Estate Proposal**

Mr. Barlow stated that the meeting materials included memorandums from the Statutory Accounting Principles (E) Working Group (Attachment Four-C1) and from the Risk-Focused Surveillance (E) Working Group (Attachment Four-C2). Mr. Barlow said the Working Group had requested information related to the real estate proposal from these two groups.

Mr. Bruggeman stated that the letter from the Statutory Accounting Principles (E) Working Group included optional approaches that could be taken, such as delaying adjusting current factors until at least 2022 to ensure time for examiners to expand procedures to include an assessment of reported fair values or by establishing guidance to restrict fair values used for risk-based capital (RBC) to the “lesser of” current or prior year reported fair values, or possibly averaging reported fair values across multiple years.

Mr. Barlow suggested the Working Group move forward with the current proposal and use zero as the market value adjustment for 2021 year-end filings.

Bruce Oliver (Mortgage Banks Association—MBA) stated that the MBA had submitted a comment letter (Attachment Four-C3) supporting the American Council of Life Insurers’ (ACLI’s) proposal. He noted that capital standards based on historical experience is the correct approach. John Bruins (ACLI) stated that the ACLI comment letter (Attachment Four-C4) agrees with a one-year deferred implementation of the fair value adjustment component of the real estate equity RBC proposal and noted that a one-year delay is warranted to enable review and possible modification of the accounting requirements and audit and exam procedures.

2. **Adopted of the ACLI Real Estate Proposal**

Mr. Barlow suggested the Working Group adopt the ACLI real estate proposal, with the factor for the market value adjustment set to zero, and to work further with the Statutory Accounting Principles (E) Working Group, the Risk-Focused Surveillance (E) Working Group and the ACLI to set the market value adjustment. Mr. Cebula stated that he is concerned with moving forward with this proposal during the COVID-19 pandemic and the unknown impact on real estate and the change on Schedule BA where the factor changes from 23% to 13%.

Mr. Barlow noted that this project has been ongoing for several years and that it is the intent of the Working Group to adopt the real estate proposal at this time. Mr. Reedy stated that he agrees with Mr. Cebula and suggested that the impact on office space will be better known in three to six months. Mr. Cebula suggested that adoption for 2022 would be a better option. Ms. Mears stated that the Working Group should move forward with adoption of the real estate proposal today. Ms. Eom stated that she agrees with Mr. Cebula and Mr. Reedy. Ms. Ahrens stated that she agrees with Ms. Mears. Ms. Hemphill said she agrees with keeping the timing consistent with the bond proposal and adopting the real estate proposal today.

Mr. Robinson made a motion, seconded by Mr. Schallhorn, to adopt the real estate proposal (see NAIC Proceedings – Summer 2021, Capital Adequacy (E) Task Force, Attachment One-D) as it was submitted by the ACLI, with the factor for the market value adjustment set to zero for 2021 annual filings. The motion passed, with California, New Jersey and New York dissenting.

3. **Discussed Other Matters**

Mr. Barlow stated that several members of the Working Group have been working with members of the Life Actuarial (A) Task Force to develop the new prescribed economic scenario generator and noted that subject-matter experts (SMEs) from the
ACLI and the American Academy of Actuaries (Academy) will be included. He said this will be published at a later Life Actuarial (A) Task Force meeting.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
MEMORANDUM

TO: Philip Barlow (DC), Chair, Life Risk-Based Capital (E) Working Group
FROM: Dale Bruggeman (OH), Chair, Statutory Accounting Principles (E) Working Group
Carrie Mears (IA), Vice-Chair, Statutory Accounting Principles (E) Working Group

DATE: May 20, 2021

RE: SAPWG Response to the Life Real Estate Proposal

The Statutory Accounting Principles (E) Working Group appreciates the opportunity to provide comments to the Life Risk-Based Capital (E) Working Group on the American Council of Life Insurers (ACLI) proposal to modify the treatment of real estate in the life risk-based capital (RBC) formula. This proposal would potentially reduce the life RBC charges for real estate based on the fair value reported. The SAPWG understands the Life RBC (E) Working Group has adopted the structure for this change and is now reviewing whether the factors to be used will reduce charges. In summary, with the limited appraisal provisions of SSAP No. 40R—Real Estate and what appears to be inconsistent historical fair value data reported in Schedule A – Part 1: Real Estate Owned, the SAPWG identifies that relying on fair value amounts reported in Schedule A to influence real estate RBC could create a situation that is susceptible to RBC optimization. The following three points further highlight this conclusion for the Schedule A proposal:

1. **Fair Value Supplemental Disclosure** – The fair value reported for real estate captured on Schedule A is only a disclosure element and is not utilized in determining the reported balance sheet amount (book adjusted carrying value - BACV) or a company’s financial condition when exceeding the reported amount. This disclosed fair value is generally considered supplementary information and not subject to audit or verification procedures.

2. **Fair Value only for OTTI** – Other than supplemental information, the intent of fair value appraisals / assessment disclosure is for purposes of determining whether an other-than-temporary impairment (OTTI) assessment is required, not for the evaluation of unrealized gains. There are a number of reporting entities that have historically left the fair value field blank for some properties or reported a fair value amount that equals the reported BACV of the real estate. (These zero values / matching BACV reporting represent 29% of Schedule A properties. Detailed data can be provided to the Life RBC Working Group staff.) This reporting has been noted even when recent appraisals have been obtained. If the appraisal supported the balance sheet reported value, some entities simply reported BACV as the proxy for fair value, presumably because there was no incentive to use resources to calculate a different fair value. This proposal will require additional resources from companies to ensure comparability of RBC, potentially creating a disparate impact in RBC calculation between large and small reporting entities if such resources are not readily available.
3. **5 Year Appraisal** – The statutory accounting “every 5-year appraisal requirements for admittance” only impacts real estate that is income producing or held for sale. There is no ongoing appraisal requirement for property that is occupied by the reporting entity. Furthermore, there is no requirement for a current appraisal prior to revising the fair value reported for any of the real estate categories. From a review of the 2020 investment schedule detail, it was noted that some reporting entities made significant changes to the reported fair value, although the last appraisal (if any) occurred years prior.

In addition to the points raised for the Schedule A proposal, there are additional concerns for this proposal if it is applied to investments captured in scope of SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies and reported on Schedule BA – Other Long-Term Invested Asset as having underlying characteristics of real estate. **These Schedule BA concerns are summarized as points 4-6 as follows:**

4. **Subjectivity of Schedule BA classification and transparency of movement within** – Classification of SSAP No. 48 investments on Schedule BA as having “underlying characteristics of real estate” is subjective. The instructions indicate the investments should have “real estate development interest,” and direct that if the requisite details are not available for reporting, then the investment should be reported in the Schedule BA “Other” category. With a potential reduction of RBC based on fair value (particularly as the “Schedule BA Other” category has the highest RBC charge of all asset classes), this change may result with an increase of SSAP No. 48 investments being classified from "Other" to having underlying real estate interests. Under current RBC factors, the variation between these Schedule BA reporting lines (0.23 and 0.30 respectively) does not create a significant motivation for this reclassification. However, if this comparison were to significantly change – and perhaps result with the elimination of RBC based on fair value differentiation – there is a significant motivation for a company to reassess whether an investment could be considered to have characteristics of underlying real estate. Furthermore, movement between reporting lines on the same schedule does not trigger any regulator indicator for assessment. It is only when investments move from one schedule to another are they captured as disposals and reacquisitions and can be identified.

5. **U.S. GAAP valuation of real estate inside holding company** – SSAP No. 48 investments are required to be audited for admittance with the BACV reflecting the reporting entity’s share, calculated using the equity method, of the SSAP No. 48 investment. The equity method begins with cost and is adjusted to reflect gains and losses within the structure not distributed to the investors. Whether those gains / losses reflect fair value changes of the underlying real estate in the SSAP No. 48 structure depends on the measurement method used within the investment structure. Under U.S. GAAP, certain structures may be required to measure holdings at fair value. (If not required, fair value may be an election by the reporting entity.) This could result with significant variation on whether the proposal influences RBC:
a. SSAP No. 48 structures that account for the underlying real estate at historical cost would likely have a lower BACV and a potential higher fair value on Schedule BA. The lower BACV is already incurring a lower RBC impact, and under the proposal, the RBC impact could be further decreased based on the differential between BACV and fair value.

b. SSAP No. 48 structures that account for the underlying real estate at fair value would likely have a higher BACV and a lower differential to the fair value reported on Schedule BA. The higher BACV is already incurring a higher RBC impact and would be less likely to be reduced based on fair value under the proposal.

6. **No appraisal requirement for Schedule BA Real Estate** – There is no requirement for appraisals of the underlying real estate held within a SSAP No. 48 structure. As such, regardless of whether the underlying real estate is held at fair value in the SSAP No. 48 structure, or if the reporting entity is calculating fair value for the entire SSAP No. 48 structure for reporting on Schedule BA, there are no appraisal requirements to validate the fair value calculation of the underlying real estate property. Pursuant to *SSAP No. 100—Fair Value*, these fair value calculations can be entity-determined based on the entity’s own assumptions of what a market participant would assume in pricing the asset. Consistent with the comments for the proposal on Schedule A, the fair value column on Schedule BA is only a disclosure element and is not utilized in determining the reported balance sheet amount (BACV) or a company’s financial condition. Other than supplemental information, the intent of the fair value disclosure is for purposes of determining whether an OTTI assessment is required.

In response to these six points, it is noted that incorporating the ACLI proposal in the current year would likely result in inconsistent application in RBC as well as result with an environment that incentivizes companies to potentially inflate reported fair values to optimize their RBC results. Although the SAPWG notes concerns with the use of fair value to influence real estate RBC, if further consideration is supported, the following initial suggestions are offered:

1. Delay adjusting current factors until at least 2022 to ensure time for examiners to expand procedures to include an assessment of reported fair values on Schedule A and Schedule BA. This would also allow time for companies that have historically not determined fair value beyond the amount needed to support BACV to revise their procedures so that the proposed RBC change will uniformly impact companies. This may not be feasible if Life RBC Working Group decides real estate and bond factors should be updated to start with the same year-end.

2. Establish guidance to restrict fair values used for RBC to the “lesser of” current or prior year reported fair values, or possibly averaging reported fair values across multiple years. Such guidance would prevent reporting entities from increasing fair value in the current year to
optimize RBC results or in response to an expected RBC shortfall. This would also allow regulators time to review updated fair value amounts, particularly if there are significant increases from past reported amounts before the increased fair value is used to reduce RBC.

Summary
After review of the year-end 2020 reported Schedule A and Schedule BA information and the SSAP No. 40R appraisal requirements and SSAP No. 48 reporting requirements, the Statutory Accounting Principles (E) Working Group has concerns on the reliability and consistency of data with the ACLI proposal to allow reporting entities to reduce RBC through their reported fair value of real estate. Additional time and safeguards are needed to ensure consistent treatment across reporting entities, ensure regulators have procedures in place to assess reported fair value information and prevent situations in which reporting entities can utilize this guidance to optimize RBC results or prevent an RBC shortfall that hinders proper assessment of the entity’s financial condition.

If you have any questions on this referral response, please contact Dale Bruggeman, Chair of the Statutory Accounting Principles (E) Working Group, or Julie Gann, NAIC staff.

c: Jane Barr, Dave Fleming, Julie Gann, Robin Marcotte, Jim Pinegar, Jake Stultz, Fatima Sediqzad

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MEMORANDUM

TO: Philip Barlow (DC), Chair, Life Risk-Based Capital (E) Working Group

FROM: Justin Schrader (NE), Chair, Risk-Focused Surveillance (E) Working Group
Amy Malm (WI), Vice-Chair, Risk-Focused Surveillance (E) Working Group

DATE: May 24, 2021

RE: RFSWG Response to the Life Real Estate Referral

The Risk-Focused Surveillance (E) Working Group appreciates the opportunity to provide comments to the Life Risk-Based Capital (E) Working Group on the American Council of Life Insurers (ACLI) proposal to modify the treatment of real estate in the life risk-based capital (RBC) formula. Based on the referral received, existing guidance and common practices around the review of real estate holdings in financial analysis and examination processes were reviewed and considered.

As a result of our review, we noted that guidance in the Market Risk Repository of the NAIC’s Financial Analysis Handbook focuses on identifying concentrations in real estate exposure at an insurer and evaluating the appropriateness of the Book Adjusted Carrying Value (BACV) of any significant real estate holdings. The NAIC’s Financial Condition Examiners Handbook does not include procedures for use in reviewing real estate holdings due to the relative infrequency of significant real estate holdings at insurers. However, common examination practices focus on verifying and validating the BACV of material real estate holdings, including consideration of OTTI, as opposed to verifying or validating Fair Value (FV) disclosures and reporting.

As such, the Life Risk-Based Capital (E) Working Group would be cautioned against relying on financial analysis or exam practices to verify or validate the FV of real estate holdings for purposes of determining an RBC charge but should be able to place some reliance on solvency monitoring processes for the accuracy of BACV reporting.

If you have any questions on this referral response, please contact Justin Schrader, Chair of the Risk-Focused Surveillance (E) Working Group, or Bruce Jenson, NAIC staff.
May 21, 2021

Philip A. Barlow, FSA, MAAA
Chair, Life Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Proposed Modifications to RBC Calculations for Real Estate

Dear Mr. Barlow and Working Group Members:

The Mortgage Bankers Association\(^1\) respectfully submits this letter of support for the modified proposal to update the risk-based capital (RBC) calculation for real estate, which was proposed by the American Council of Life Insurers (ACLI) and which this Working Group exposed on April 7, 2021.

First, we want to recognize the considerable and thoughtful engagement of the Chair and the members of the Working Group. This proposal has been in the works for some time, and the Working Group has put in the time and attention necessary to bring it forward to a decision.

As for the proposal, we believe that it is a vast improvement over the current state, and is both reasonable and appropriately conservative, as we describe below.

**Schedule A: Equity investments in real estate**

The current C-1 factor for real estate investments reported on Schedule A is 15\%. Because there was little data available on the performance of real estate assets at the time of adoption in 2000, the current C-1 factor is based on a suggested relationship between common stock and real estate volatility described by Ennis and Burik (1991).\(^2\)

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\(^1\) The Mortgage Bankers Association (MBA) is the national association representing the real estate finance industry, an industry that employs more than 330,000 people in virtually every community in the country. Its membership of over 1,700 companies includes all elements of real estate finance: mortgage companies, mortgage brokers, commercial banks, credit unions, thrifts, REITs, Wall Street conduits, more than 70 life insurance companies engaged in real estate finance, and others in the mortgage lending field. For additional information, visit MBA’s website: [www.mba.org](http://www.mba.org).

In contrast, the proposal is based on analysis of historical real estate investment performance data from the NCREIF Property Index (NPI), supplemented by further data from FRC/Kelleher to extend the series through earlier years of 1961-1977. The results of the analysis of historical data suggest a far C-1 smaller factor, as low as 9.5%, would be more than appropriate to cushion against potential losses, while maintaining a safe and efficient lending market. Therefore, MBA supports the proposed factor of 11% as a reasonable and conservative application of the results of that analysis.

Schedule BA: Indirect equity investments in real estate

The current C-1 factor for Schedule BA real estate assets is 23%. This factor is based on an implicit assumption that the indirect real estate investments (e.g., through structures such as LLCs) reported on Schedule BA are on average about 50% riskier than direct real estate investments reported on Schedule A.

It has become clear that the current 50% risk add-on does not accurately reflect the marginal additional risks. For example, the Jeffrey Fisher study cited in the ACLI submission found that the performance of real estate held through joint ventures was consistent with and perhaps even slightly better than wholly owned real estate. As the ACLI submission notes, real estate investments are typically executed through corporate structures such as LLCs specifically to reduce or mitigate risks. In fact, treating Schedule BA real estate investments on a par with Schedule B real estate investments would be consistent with prior NAIC action reclassifying certain wholly owned single-asset LLCs as Schedule A assets, recognizing that the LLC structure does not itself produce additional risk.

For the reasons above, MBA supports the proposed C-1 factor of 13 percent for Schedule BA real estate (applying a multiplier of about 1.18 vs. the current multiplier of 1.5) assets as reasonable and conservative.

RBC Adjustment for Real Estate Encumbrances

The proposal would update the treatment of encumbrances to incorporate the proposed revised C-1 factor for Schedule A real estate investments (as the Working Group may adopt) and the revised commercial mortgage factor adopted in 2012. Our understanding that this is essentially a technical update to the treatment of encumbrances that is necessary to conform it changes in the

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3 Jeffrey Fisher is Professor Emeritus of Finance & Real Estate, Indiana University Kelly School of Business; Visiting Professor, Johns Hopkins Carey School of Business; and a Research and Educational Consultant to the National Council of Real Estate Investment Fiduciaries (NCREIF).
MBA letter supporting ACLI real estate proposal
May 21, 2021
Page 3

treatment of the two components of that treatment (i.e., treatment of mortgages and of real estate investments). Accordingly, MBA supports the proposed change.

**Adjustment for Unrealized Capital Gains/Losses**

Under Statutory Accounting, a commercial property is accounted for at depreciated cost. As a result, over time, there will tend to be an increasing gap between the accounting value of a property on an insurer’s balance sheet and the property’s fair value. For example, a property could have a fair value of $150 and a depreciated cost of $100. ACLI’s proposed market value adjustment is a novel approach to capturing the impacts those unrealized gains or losses have on an insurer’s effective capital cushion against insolvency.

We have reviewed the Statutory Accounting Principles Working Group (SAPWG) Response to the Life Real Estate Proposal adopted on May 20, 2021, and we recognize the practical considerations the SAPWG raises. In light of those considerations, we recommend continued exploration of this and other possible approaches to recognizing the capital-like character of unrealized gains and losses on real estate investments.

* * *

Again, we appreciate the considerable time and attention the Chair and members of this Working Group have devoted to this proposal, and to the many other matters the Working Group has addressed over the past year and is currently addressing. We hope that these comments will be helpful as the Working Group considers these proposals.

Respectfully,

Mike Flood
Senior Vice President
Commercial/Multifamily Policy and Member Engagement
Steven Clayburn  
Senior Actuary, Health Insurance & Reinsurance  
steveclayburn@acli.com

May 24, 2021

Philip A. Barlow, FSA, MAAA  
Chair, Life Risk-Based Capital (E) Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

Sent via email: dfleming@naic.org

Re: Comments on Proposal 2021-06-L RBC Real Estate Instructions and Factors

Dear Mr. Barlow:

The American Council of Life Insurers (“ACLI”) is submitting the following comments on the exposure of Proposal 2021-06-L RBC Real Estate Instructions and Factors and providing additional perspective on the Life RBC Working Group’s referral response from Statutory Accounting Principles Working Group (“SAPWG”). We appreciate SAPWG’s contributions on this issue leveraging their accounting expertise.

Regulators and industry agree that the spread between real estate fair value and its depreciated book value over time generates a statutory capital “cushion” limiting losses of statutory capital in real estate equity during economic downturns. This statutory capital cushion should be reflected in a lower RBC charge for qualifying real estate equity.

SAPWG points out, however, that there are currently shortcomings in statutory fair value estimates reflected on statutory balance sheets – particularly for smaller insurance firms. In light of these findings, industry concedes that a one-year deferred implementation of the fair value adjustment component of the real estate equity RBC proposal is warranted to enable a more thorough review and possible modification of the accounting requirements and audit and exam procedures. Industry is willing to be a full partner in this review.
Since inclusion of a fair value adjustment reduces the RBC charge for real estate equity, deferring the fair value adjustment while maintaining the same base factors (11% for Schedule A and 13% for Schedule BA) inherently increases the conservatism of the 2021 industry proposal.

The statistics below, shown in Appendix A clarify and provide additional perspective on SAPWG’s comments. We feel these comments and clarifications are important to a thorough understanding of the existing issues surrounding the use of fair value in the proposed RBC adjustment methodology. These values are based on the 2019 annual statement database, the first chart showing numbers of properties similar to the SAPWG comments split by company-occupied, investment, and held-for-sale. We also show the same breakdowns by BACV to give an indication of RBC impact:

- About 4% of properties have no BACV. While these contracts generally have no FV reported, RBC is not impacted since an asset with no statutory value produces no statutory surplus, no risk to surplus, and no RBC.

- As noted at the Life RBC Working Group, company-occupied properties are not required to have an appraisal. That fact, combined with limited guidance on how to establish fair value in the absence of an appraisal, leads to more than ½ of those properties having a fair value that is either zero or equal to the BACV. We agree that these are not likely to represent actual fair value, and that additional guidance on reporting would be appropriate.

- For properties requiring an appraisal, nearly 90% have an appraisal from the last 2 years. The remaining 10% of properties have no appraisal, an outdated appraisal, or an appraisal that is several years old.

- For these properties with appraisals, the reported fair values are generally in a reasonable range relative to the cost and the BACV. Some have FV that is approximately equal to the BACV, either because they were recently purchased or because properties held for sale often set BACV to lower of cost or market.

We believe the issues with the existing data quality and consistency for Schedule A, while imperfect, could be materially improved through reporting clarifications and changes in requirements for relatively small segments of the portfolios, specifically:

- Consider standards for reporting fair value of company occupied assets where an appraisal is not required or obtained

- Consider whether any enhancements are needed to the standards for the development of appraisals, and

- Consider enhancements to the review and examination procedures related to fair value.
Concerns expressed for Schedule BA assets include:

- There is a choice in the accounting basis which can lead to different values. Industry believes that this is a reporting issue.

- Fair values are not required to be audited. Industry believes appraisal standards of SSAP40 should be reviewed as discussed above.

- Unclear standards for classification of assets as having characteristics of real estate

We appreciate the opportunity offer these comments as the Life RBC Working Group continues its work on this project. We look forward to discussing these comments with the Working Group.

Sincerely,

Steven Clayburn

cc: Dave Fleming, NAIC Senior Insurance Reporting Analyst
    John Bruins, Consultant for ACLI
**APPENDIX A**

**Schedule A**

By number of properties

<table>
<thead>
<tr>
<th></th>
<th>TOTAL</th>
<th>Company Occupied</th>
<th>Investment</th>
<th>For Sale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>properties</td>
<td>Percent</td>
<td>properties</td>
<td>Percent</td>
</tr>
<tr>
<td>Total</td>
<td>1935</td>
<td>100%</td>
<td>540</td>
<td>28%</td>
</tr>
<tr>
<td>BACV = 0</td>
<td>76</td>
<td>4%</td>
<td>38</td>
<td>2%</td>
</tr>
<tr>
<td>FV = 0</td>
<td>180</td>
<td>9%</td>
<td>99</td>
<td>5%</td>
</tr>
<tr>
<td>FV &lt; 95%</td>
<td>69</td>
<td>4%</td>
<td>24</td>
<td>1%</td>
</tr>
<tr>
<td>FV = BACV *</td>
<td>380</td>
<td>20%</td>
<td>135</td>
<td>7%</td>
</tr>
<tr>
<td>105 &lt; FV &lt; 150</td>
<td>597</td>
<td>31%</td>
<td>77</td>
<td>4%</td>
</tr>
<tr>
<td>151 &lt; FV &lt; 200</td>
<td>258</td>
<td>13%</td>
<td>50</td>
<td>3%</td>
</tr>
<tr>
<td>200 &lt; FV</td>
<td>375</td>
<td>19%</td>
<td>117</td>
<td>6%</td>
</tr>
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</table>

By BACV ($000,000s)

<table>
<thead>
<tr>
<th></th>
<th>TOTAL</th>
<th>Company Occupied</th>
<th>Investment</th>
<th>For Sale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BACV</td>
<td>Percent</td>
<td>BACV</td>
<td>Percent</td>
</tr>
<tr>
<td>Total</td>
<td>23,503</td>
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<td>6,110</td>
<td>26%</td>
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<tr>
<td>BACV = 0</td>
<td>-</td>
<td>0%</td>
<td>-</td>
<td>0%</td>
</tr>
<tr>
<td>FV = 0</td>
<td>803</td>
<td>3%</td>
<td>716</td>
<td>3%</td>
</tr>
<tr>
<td>FV &lt; 95%</td>
<td>933</td>
<td>4%</td>
<td>104</td>
<td>0%</td>
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<tr>
<td>FV = BACV *</td>
<td>7,358</td>
<td>31%</td>
<td>1,914</td>
<td>8%</td>
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<tr>
<td>105 &lt; FV &lt; 150</td>
<td>8,262</td>
<td>35%</td>
<td>1,765</td>
<td>8%</td>
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<tr>
<td>151 &lt; FV &lt; 200</td>
<td>3,416</td>
<td>15%</td>
<td>422</td>
<td>2%</td>
</tr>
<tr>
<td>200 &lt; FV</td>
<td>2,732</td>
<td>12%</td>
<td>1,189</td>
<td>5%</td>
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</tbody>
</table>

* To account for rounding, etc., we have used 95% < FV < 105% to be FV = BACV
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met May 20, 2021. The following Working Group members participated: Philip Barlow, Chair (DC); Jennifer Li (AL); Thomas Reedy (CA); Wanchin Chou (CT); Sean Collins (FL); Mike Yanacheak and Carrie Mears (IA); John Robinson (MN); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Mike Boerner and Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. Discussed the Bond Size Adjustment

Mr. Barlow said this has been discussed previously and that he is comfortable with making an adjustment to the factors included in the American Academy of Actuaries’ (Academy) proposal. He said there are two issues related to the bond size adjustment. The first is whether the expansion of the number of thresholds is problematic, and he asked if there had been any feedback on this. Dave Fleming (NAIC) said nothing has been submitted formally, but it appears changing the number of thresholds may not be problematic. Mr. Barlow said the second issue is the actual factors assigned to those thresholds, and he said he is in favor of making an adjustment to mitigate the impact on smaller companies. He suggested the Working Group go forward with the assumption that changing the number of thresholds is not an issue. He noted that a comparison of the bond size adjustments was included in the meeting materials. He said the current factor is 2.5 for the first 50 issuers, while the Academy proposal has a factor of 7.5 for the first 10 issuers. He suggested changing the thresholds to match the current ones of the first 50 and the next 50 and changing the factors applied to the first 50 to 2.9 with the factor applied to the next 50 remaining at the Academy’s proposed 1.75, which would mitigate the impact for smaller companies having less than 50 issuers. Mr. Boerner said he supports those changes. David Neve (Global Atlantic) asked if the same adjustment would be made to the Moody’s/ACLI’s proposal. Mr. Barlow directed NAIC staff to create and distribute a document for the Working Group members.

2. Discussed the Moody’s Analytics Report on Risk Premium

Amnon Levy (Moody’s Analytics) provided a presentation (Attachment Four-D1) on the ACLI/Moody’s Analytics proposal to updating the bond factors and risk premium. He noted that the proposal intends to replace the economic state model with a correlation model, update the default rate and recovery rate, set risk premium at expected loss plus 0.5 standard deviations, and update the tax rate to 21% and the discount rate to 3.47%.

Mr. Barlow stated that there are currently exposures for both the Academy and the Moody’s Analytics/ACLI proposals. He stated that after the exposure period ends, the Working Group will select a proposal with the possibility of another public exposure if that is needed. Mr. Carmello stated that the 70 CTE in VM-20, Requirements for Principle-Based Reserves for Life Products, VM-21, Requirements for Principle-Based Reserves for Variable Annuities, and principle-based reserving (PBR) only applies to what is modeled stochastically, which includes Treasury rates and stock returns for equities, and not for defaults, mortality or lapse risk. Paul Graham (ACLI) stated that the defaults in PBR are set at the 70 CTE level. Nancy Bennett (Academy) stated that her recommendation is to continue with the same solvency framework. Mr. Graham asked if the Academy would have had separate factors if asset valuation reserve (AVR) were to be set at zero. Jerry Holman (Academy) stated that AVR would not affect the base factors but would have an impact on RBC.

Mr. Barlow asked Moody’s Analytics to provide a calculation using the Academy’s risk premium assumptions. Mr. Chou stated that this appears that the Working Group has selected the risk premium assumptions from the Academy’s proposal. Mr. Barlow stated that this will allow for a further exposure, if needed, and is the best approach given the compressed time frame.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
Scope: What we were asked to do
Develop RBC C1 bond factors that better reflect economic risks

Heuristic Performance Criteria
MA C1 Factors*

- Better represent the historical experience of life insurers’ holdings
- More accurately reflect empirically observed issuer diversification benefits
- Challenges:
  - C1 factors are cardinal, and a function of MA’s default rates estimated using MIS corporate default rates that reflect the historical experience of life insurance corporate holdings for each MIS rating, which are opinions of ordinal, horizon-free credit risk, rather than cardinal
  - C1 factors are static while risks change over time, across ratings and asset classes
  - Applied to range of credit assets, based on their NAIC designations (i.e., the second lowest NRSRO rating)
- While the ACLI, the industry, the NAIC, and commissioners have been engaged extensively, the views are solely those of MA and based on an objective assessment of supporting documentation, and data and modeling approaches that in MA’s experience viewed as best practice

*MA’s Revisions to the RBC C1 Bond Factors' April 2021 report articulates the data, methodology and limitations associated with the MA’s C1 factors
Risk Premium is one of several interconnected modifications with largest impact

» Replace the economic state model with a correlation model to better align with default correlation and issuer diversification observed empirically, which also affects PAFs

» Update the default rate and recovery rate to better align with historical experience of the company’s holdings

» Set Risk Premium at expected loss plus 0.5 standard deviation (compared to just expected loss) to better align with current reserving standards

» Update tax rate to 21% and discount rate to 3.47% as requested by NAIC; compared with 5% under the current and Academy formula

Overview of Risk Premium Modification

» C1 RBC is the minimum required capital above statutory reserves to buffer against a tail loss

» Risk Premium acts as an offset to C1 RBC

» Variation in industry reserving standards

» VM-20 and VM-21 explicitly require that reserves cover CTE 70, or approximately 88th percentile, default loss, without accounting for any assets backing Asset Valuation Reserve (AVR)

» VM-22 applies to new life products after 2017, with increasing coverage for new bond purchases

’Existing policies follow industry reserving standards, which generally aim to cover moderately adverse conditions, AVR used in Cash Flow Testing (CFT) of reserves is excluded from Total Adjusted Capital (TAC), and thus functions as additional CFT reserves rather than available capital

MA’s Modifications

» Together with many other interconnected model features described in later slides, Risk Premium is updated to be expected loss plus 0.5 standard deviation recognizing variation in industry reserving standards and to closer align with PBR and other reserving standards generally aimed to cover moderately adverse conditions

Aligning C1 Factors with AVR

The Academy raised concerns related to Risk Premium and AVR consistency

» AVR is an allocation of surplus to smooth the cyclicality of credit default events

» Allocation of surplus across AVR and unassigned surplus does not affect RBC Ratio

» While historically the basic contribution of AVR has been set to be the same as Risk Premium, the alignment between AVR and Risk Premium is not relevant as they measure different things: AVR is to help “identify potentially weakly capitalized companies”

Sensitivity Analysis of Risk Premium

All values are based on MA’s formula including all targeted modifications

» Risk Premium level:

- Expected loss (used by the Academy) along with MA’s targeted modifications not included in the Academy’s proposal
- Expected loss + 0.5 standard deviation (used by MA)
- Expected loss + 1 standard deviation

» Higher level of Risk Premium leads to lower C1 base factors, as more losses will be covered by Risk Premium

- On average, a decrease (increase) of 0.5 standard deviation from MA’s Risk Premium, increases (decreases) C1 base factors by ~20% for investment grade and around 15% for high yield
**Risk Premium for Different Rating Categories**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Base Factors</th>
<th>Portfolio Adjustment Factors (PAFs)</th>
<th>Risk Premium, May 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caa1</td>
<td>3.424%</td>
<td>53.0%</td>
<td>3.787%</td>
</tr>
<tr>
<td>Caa2</td>
<td>1.031%</td>
<td>56.7%</td>
<td>1.168%</td>
</tr>
<tr>
<td>Baa1</td>
<td>0.134%</td>
<td>56.7%</td>
<td>0.168%</td>
</tr>
<tr>
<td>Baa2</td>
<td>0.187%</td>
<td>55.1%</td>
<td>0.229%</td>
</tr>
<tr>
<td>Aaa</td>
<td>0.003%</td>
<td>75.0%</td>
<td>0.007%</td>
</tr>
<tr>
<td>Aa3</td>
<td>0.032%</td>
<td>59.2%</td>
<td>0.046%</td>
</tr>
<tr>
<td>Aa2</td>
<td>0.022%</td>
<td>61.4%</td>
<td>0.032%</td>
</tr>
<tr>
<td>Aa1</td>
<td>0.008%</td>
<td>66.4%</td>
<td>0.015%</td>
</tr>
<tr>
<td>Ba1</td>
<td>0.493%</td>
<td>55.0%</td>
<td>0.579%</td>
</tr>
<tr>
<td>Ba3</td>
<td>1.071%</td>
<td>54.5%</td>
<td>1.225%</td>
</tr>
<tr>
<td>B2</td>
<td>1.933%</td>
<td>53.2%</td>
<td>2.168%</td>
</tr>
<tr>
<td>B1</td>
<td>1.429%</td>
<td>53.9%</td>
<td>1.619%</td>
</tr>
<tr>
<td>A3</td>
<td>0.390%</td>
<td>57.5%</td>
<td>0.092%</td>
</tr>
<tr>
<td>A1</td>
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<td>0.065%</td>
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<td>52.9%</td>
<td>2.834%</td>
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<td>1.933%</td>
<td>53.2%</td>
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<td>A1</td>
<td>0.048%</td>
<td>58.5%</td>
<td>0.065%</td>
</tr>
</tbody>
</table>

All values in the table are calculated based on MA’s correlation model including other targeted modifications.

**Recap of C1 Factors**

- MA default rates, correlation model and Risk Premium lead to more differentiated across the MIS ratings scale.
- Economic state model results in counterfactual increases (and decreases) to C1 base factors along the rating scale (e.g., Credit risk set at 5% under the Academy’s formula under the current economic conditions).
- The economic model results in a more differentiated across the MIS ratings scale.

**Impact of MA C1 Factors on All Life Companies**

- Impact on RBC
- Impact on RBC of Life Companies

**Most Impactful Targeted Modifications**

- Economic state model overstates diversification benefits.
- MA default rates are a more accurate reflection of the historical experience of life insurers’ experience of life insurers.
- Alternative rating categories, and PAFs that are a more accurate reflection of the historical experience of life insurers.

**MA C1 Factors**

- MA default rates tend to have a steeper slope (more differentiated across MIS categories). A higher Risk Premium lowers the C1 base factors and increases their differentiation across the MIS designation categories.
- Resulting increase in RBC with MA C1 factors is relatively evenly distributed across life companies of different sizes.
- Economic state model results in counterfactual increases (and decreases) to C1 base factors along the rating scale (e.g., Credit risk set at 5% under the Academy’s formula under the current economic conditions).
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met April 29, 2021. The following Working Group members participated: Philip Barlow, Chair (DC); Jennifer Li (AL); Thomas Reedy (CA); Wanchin Chou (CT); Sean Collins (FL); Mike Yanacheak and Carrie Mears (IA); Vincent Tsang (IL); John Robinson (MN); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Mike Boerner and Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. **Discussed Additional Instruction on Real Estate**

John Bruins (American Council of Life Insurers—ACLI) stated that after the prior exposure of the updated real estate factors, it was noted that the Asset Concentration LR010 needs to be adjusted to align with the real estate factors that had been exposed. Mr. Bruins stated that his recommendation is to make the instruction change for 2021 and noted that there will be a structural change for 2022 to incorporate the market value adjustment.

Mr. Barlow directed NAIC staff to modify the previous real estate exposure to include the revisions to the instructions, which will align with the real estate factors that had been exposed. The comment deadline for this exposure is May 24.

2. **Discussed Life Reinsurance**

Dave Fleming (NAIC) said the Working Group was directed to review the credit risk charge and to verify that reciprocal jurisdiction reinsurers were being treated consistently with the other categories. He noted that this proposal would modify Line 15 of LR016 to allow for the reporting of reinsurance with reinsurers from reciprocal jurisdictions.

Steve Clayburn (ACLI) said the proposal addresses the charge from the Capital Adequacy (E) Task Force and clarifies the instructions for risk-based capital (RBC).

Mr. Barlow directed NAIC staff to expose the proposed edits to LR016 to allow reporting for reciprocal jurisdiction reinsurers for a 30-day public comment period ending May 27.

3. **Discussed Longevity Risk**

Ms. Ahrens stated that the base factors for longevity risk are applied in a decreasing order, where 1.35% is used for the first $250 million, 0.85% is used for $250 million to $500 million, 0.75% is used for $500 million to $1 billion, and 0.70% is used for all amounts greater than $1 billion. She noted that when this data is viewed across the industry, it would appear that the factor used was 0.70%, but when viewing individual companies, it is clearer. She noted that when this is exposed, she wants commenters to consider covariance of negative 0.25 with a guardrail of 1, covariance of negative 0.30 with a guardrail of 1, covariance of positive 1 (making C-2 mortality and C-2 longevity purely additive) with a guardrail of 1 (the guardrail will not alter the result since the calculation is additive), covariance of negative 0.25 with no guardrail (guardrail=0), and covariance of negative 0.30 with no guardrail (guardrail=0).

Mr. Barlow said the Working Group had previously adopted the structure, so any proposed changes would only be for the factors and instructions. Mr. Tsang suggested that the exposure include the preferences of the Working Group and an explanation for those preferences. Ms. Ahrens provided the rationale for the various options that she presented. Mr. Barlow recommended a memorandum be included with the exposure to explain the options for consideration. Mr. Chou asked if there would be a need for a meeting of the Longevity Risk (E/A) Subgroup. Ms. Ahrens stated that there is currently no plan to meet again for this topic. Mr. Barlow stated that the Working Group would meet in regulator-to-regulator session to discuss this topic further.

Mr. Barlow directed NAIC staff to expose the proposed longevity risk factors and instruction, with a memorandum explaining the rationale of the options presented for a 30-day public comment period ending May 27.
4. **Discussed Other Matters**

Paul Graham (ACLI) said there is an inconsistency in the earlier exposure for the tax rate change. He stated that in LR030, a hardcoded formula needed to be changed from 21% tax rate multiplied by a factor of 0.70 to be the 21% tax rate multiplied by a factor of 0.80, which would make this consistent with the other proposals. Nancy Bennett (American Academy of Actuaries—Academy) stated that she agrees.

Mr. Barlow directed NAIC staff to expose the revision to the prior exposure, which includes a hardcoded formula change from 21% tax rate multiplied by a factor of 0.70 to be 21% tax rate multiplied by a factor of 0.80 in LR030. The exposure is for a 30-day public comment period ending May 27.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met April 22, 2021. The following Working Group members participated: Philip Barlow, Chair (DC); Jennifer Li (AL); Wanchin Chou (CT); Sean Collins (FL); Mike Yanacheak and Carrie Mears (IA); Vincent Tsang (IL); John Robinson (MN); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Mike Boerner and Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. Discussed the Moody’s Analytics Updated Report on Bonds and the Academy’s Proposed Factors

Mr. Barlow said NAIC staff had supplied additional information on the impact of the factors based on the 2020 annual statement filings. He said the original file included an error in the calculation and that a new file would be sent to Working Group members when it is ready.

Mr. Barlow said there are several issues that he would like to have addressed in the presentations. He noted that the discount rate being used in the American Council of Life Insurers (ACLI) and Moody’s Analytics recommended approach (ACLI/Moody’s Analytics proposal) is similar to the American Academy of Actuaries’ (Academy’s) proposal and noted that the discount rates from 2017 are similar to today, when his assumption would be that these would change based on market conditions. He said the Academy provided a rationale for the risk premium used in its proposal, and the ACLI/Moody’s Analytics proposal uses a different standard, and he would like more information on why they would use a different risk premium. He said he would also like more information on the slope of the factors used in the ACLI/Moody’s Analytics proposal.

Amnon Levy (Moody’s Analytics) provided a presentation (Attachment Four-F1) on the ACLI/Moody’s Analytics proposal to updating the bond factors. He noted that he believes that his proposed C1 factors will allow data and methodologies to better capture economic risk, provide more accurate C1 base factors and portfolio adjustment factors and improve solvency by better identifying weakly capitalized firms.

Mr. Carmello asked if an earlier reference to VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities, should have been to VM-21, Requirements for Principle-Based Reserves for Variable Annuities. Mr. Levy noted that VM-20, Requirements for Principle-Based Reserves for Life Products, VM-21 and VM-22 are all relevant to this discussion and proposal.

Nancy Bennett (Academy) stated that she had considered using a different type of model instead of the economic state model but noted that in earlier discussion at the Investment Risk-Based Capital (E) Working Group, the more sophisticated model was found to be too complex for risk-based capital (RBC).

Mr. Carmello asked if an earlier reference to VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities, should have been to VM-21, Requirements for Principle-Based Reserves for Variable Annuities. Mr. Levy noted that VM-20, Requirements for Principle-Based Reserves for Life Products, VM-21 and VM-22 are all relevant to this discussion and proposal.

2. Discussed the Estimated Impact of Bond Proposals

Mr. Barlow stated that the Working Group’s meeting materials include a comparison between the ACLI/Moody’s Analytics proposal and the Academy’s proposals, which show the different impacts on companies of different sizes (Attachment Four-F2). Mr. Barlow said his recommendation is that the Working Group request that the ACLI/Moody’s Analytics proposal use the discount rate of 3.47% that has been suggested by the Academy instead of 4.32% in their proposal. Mr. Carmello agreed with this recommendation.

Nancy Bennett (Academy) stated that she had considered using a different type of model instead of the economic state model but noted that in earlier discussion at the Investment Risk-Based Capital (E) Working Group, the more sophisticated model was found to be too complex for risk-based capital (RBC).

Mr. Chou suggested holding two additional meetings, one meeting to further discuss the economic state model and a second meeting to discuss risk premium.

Mr. Carmello asked about how the Academy had established the risk premium. Ms. Bennett stated that it was at the mean, which is approximately the 60th percentile. Mr. Carmello asked how this compares to the ACLI/Moody’s Analytics proposal. Mr. Levy stated that the ACLI/Moody’s Analytics proposal is approximately 70th percentile.
3. Exposed the Bond Proposal Factors

Mr. Barlow directed NAIC staff to expose the Academy’s proposal (Attachment Four-F3) and the ACLI/Moody’s Analytics proposal, with the update to change the discount rate to 3.47% and any resulting factor changes (Attachment Four-F4), for a 30-day public comment period.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
Preliminary Proposed Updates to RBC C1 Bond Factors
For Discussion with Life Risk-Based Capital (E) Working Group

April 22, 2021

1. Overview of Impactful Targeted Improvements
2. Economic State Model and the MA Proposed Correlation Model
3. Default Rates
4. Risk Premium
5. Discount Rate and Tax Rate
6. Recap

Agenda

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Economic State Model Initially Outside Scope

Two material limitations:
- Economic state model is calibrated to default rates across contraction and expansion states, but it implies default correlations of ~0% for IG issuers, oversimplifying diversification across issuers relative to that observed empirically, resulting in:
  - C1 base factors that reflect empirically observed default correlations and issuer diversification benefits
  - Correlation Economic Scalars average 2.7495 across contraction states
  - MA proposed correlation model results in higher 96 percentile loss

Corporate default rate term structures estimated to historical experience of the company’s holdings:
- The Academy’s 10-year simulation model was adopted
- Default rate Economic Scalars set to 1 (this effectively disables the economic state model)
- MA proposed correlation model is calibrated to default correlations observed empirically
  - Default correlations, consistent with empirically observed default correlations and issuer diversification benefits
  - Several benchmarks for default correlation
    - Joint default events
    - CDS implied
    - MIS ratings implied
    - Equity market and financial statement

MA Proposed Correlation Model
Calibrated to default correlations observed empirically:
- The Academy’s 10-year simulation model was adopted
- Correlation Economic Scalars set to 1 (this effectively disables the economic state model)
- MA proposed correlation model results in:
  - C1 base factors that reflect empirical default correlations and are more differentiated across IG issuers relative to that implied by the economic state model, and
  - PAFs that more accurately reflect issuer diversification benefits, and that are less punitive (lenient) to portfolios with a smaller (larger) number of holdings, relative to those from Academy’s proposal

Economic State Model and the MA Proposed Correlation Model

MA’s Proposed C1 Factors
Targeted improvements with largest impact

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Proposed Updates to the RBC C1 Bond Factors

Incremental effects of replacing the economic state model with MA's proposed correlation model

MA's proposed correlation model generally increases C1 base factors

- In part, the economic state model and MA's proposed correlation model are different. MA's proposed correlation model:
  - Increases C1 factors for high yield by 27%
  - Increases C1 factors for investment grade by 23%

Economic Scalars lead to non-monotonic C1 base factors under some parameterizations, e.g., 4.794% for Ba3 to 4.778% for B1

Proposed PAF – MA’s Findings

Implications of MA’s proposed correlation model

- PAF’s calibrated to the economic state model overstate issuer diversification benefits.
- MA’s proposed correlation model is calibrated to default correlations and issuer diversification benefits observed empirically.

Thresholds* Current* Academy Proposed MA Preliminary Proposed PAF

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*Current PAF converted to Academy’s proposed thresholds for better comparison.

Default Rates

Generally, portfolios with fewer than 10 issuers, sometimes a single issuer:

- 37.82
- 43.19
- 40.46

Total Industry Post-PAF C1 RBC (Pre-Tax)*

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Safety levels under MA’s proposed factors:

- 96 percentile safety level under MA’s proposed factors
- 95.25 percentile safety level under MA’s proposed factors
MA Proposed 10-Year Cumulative Default Rates

More closely reflect historical experience of life companies' corporate holdings

- Incremental effects of MA-proposed default rates
- Different rating structures representing experience of life insurance holdings tend to be more differentiated across risk factors than Academy proposed, and more aligned to benchmarks.
- The resulting C1 base factors under MA's proposed default rates are generally more differentiated across the Aa3 to Baa3 range.
- The ratio of the Aa3 factor to the Aa3 factor is approximately 2.9X under MA's proposed factors being approximately 15% larger on average than under Academy proposed default rates.

Proposed C1 Base Factors

Risk Premium

Holdings Composition Differ from Overall Issuance

Aligning parameters with Historical Experience

- Institutional features drive life insurers' holdings, with historical experience aligned with issuers holding longer dated financing issues (Maturity remaining maturity).
- Insurers hold a varying proportion of debt across the rating scale.
- Recent is an estimation of:
  - Default rates
  - LGD

Proposed Updates to the RBC C1 Bond Factors

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Risk Premium Updates

Aligning with reserves
- C1 RBC is the minimum required capital above statutory reserves to buffer against a tail loss.
- Risk Premium acts as an offset to C1 RBC; it is the part of statutory reserves provisioned against default loss.
- Variation in industry reserving standards:
  - Both VM-20 and VM-22 explicitly require that reserves cover CTE 70, or approximately 88th percentile default loss.
  - VM-20 only applies to new life products after 2017. Most existing policies follow industry reserving standards that are commonly understood to cover moderately adverse conditions.
- Recognizing variation in industry reserving standards and to closer align with PBR and reserving standards generally aim to cover moderately adverse conditions, Risk Premium is proposed to be set at expected loss plus 0.5 standard deviation.
  - At higher Risk Premium levels, C1 base factors are higher due to lower Moody’s and S&P ratings and should better identify weakly capitalized firms and mitigate risk shifting incentives with new bond purchases.
- On average, as we decrease (increase) the risk premium by 0.5 standard deviation from MA’s proposed level, the C1 base factors increase (decrease) around 20% for investment grade and around 15% for high yield factors.
- A transition to expected loss plus one standard deviation once VM-20 become more widely applicable and VM-22 is formally updated and widely applicable.

Discount Rate and Tax Rate

Discount rate
- Used to calculate the net present value of projected cash flows.
- MA recognizes the need to parameterize the discount rate with a long-term perspective of long-term interest rates, and the desire for this parameter to be relatively stable while also allowing a closer reflection of the current, low-rate, environment.
- 1993−2020 (4.32%) used in developing MA proposed C1 base factors.
- Compared with the discount rate of 5.25% (1993−2013) used by the Academy (8% increases C1 base factors by 0-4% for investment grade, 0-3% for high yield), 2000−2020 (3.47%) increases C1 base factors by 2-7% for investment grade, 2-3% for high yield.
- 2010−2020 (2.25%) increases C1 base factors by 7-13% for investment grade, 5-8% for high yield.

Tax rate
- Was updated from 35% to 21%.
- Used to calculate the net present value of projected cash flows.
- MA recognizes the need to parameterize the discount rate with a long-term perspective of long-term interest rates, and the desire for this parameter to be relatively stable while also allowing a closer reflection of the current, low-rate, environment.

Possible candidates

Discount and Tax Rate

Recap
**Post-PAF C1 RBC Industry Impact – Complete Portfolio Holdings**

Post-PAF RBC proposed by MA is higher than the current level.

- Total Industry
- Post-PAF C1 RBC (Pre-Tac)
- Post-PAF C1 RBC (Pre-Tac) for Life-Companies Holdings by Issuer Count

**Summary of MA Proposed C1 Factors and their Impact**

- Impact on post-PAF C1 RBC:
  - Higher post-PAF RBC, on average, across the life industry compared to current formula
  - Life- and PAF RBCs decrease compared to current formula, on average, for insurers with small and medium number of issuers, but much less so than for
    default-factors in a proposed formula.

- Limitations of economic state model and their impact on accuracy of C1 base factors & PAFs:
  - The economic state model captures diversification across issuers, as estimated empirically, resulting in higher expected default rates, as
    compared to C1 base factors and, all else equal, in a more lenient risk assessment on underwriting of small and medium-sized issuers, all else equal.
  - The economic state model does not capture issuer diversification, as estimated empirically, resulting in higher expected default rates, as
    compared to C1 base factors and, all else equal, in a more lenient risk assessment on underwriting of small and medium-sized issuers, all else equal.

- Higher post-PAF RBC, on average, across the life industry compared to current formula: MA proposed correlation model more accurately reflects empirically observed default correlations and issuer diversification benefits, and that addresses all limitations of the economic state model.

- Understated credit losses in C1 base factors, all else equal: MA proposed PAFs more accurately reflect issuer diversification benefits and are less punitive (lenient) to portfolios with a small number of issuers, relative to those from the Academy’s proposal.

---

**Better Fatter Decisions**

Moody's Analytics

moodysanalytics.com

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### Capital Adequacy (E) Task Force

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**2020 RBC Changes by Company Size – Current verse Proposed (Moody’s) Bond RBC Charges**

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### Distributions of Change in ACL RBC by Company Size under Proposed Bond RBC Charges (Academy)

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### NAIC Proceedings – Summer 2021

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Academy/Current 0% - 200% 200% - 400% 400% - 600% 600% - 1000% Over 1000% Total

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2020 Life RBC - Comparison of Action Levels by Company Size Between Current and Proposed Bonds RBC Charges

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Comparison of RBC Ratio Range between Current and Proposed Bond RBC Charges (Academy)

Comparison of RBC Ratio Range between Current and Proposed Bond RBC Charges (Moody’s)

Attachment Four-F2
Capital Adequacy (E) Task Force
7/28/21
## Agenda Item # 2021-10-L

**DATE:** 4/22/21

**CONTACT PERSON:** Dave Fleming

**TELEPHONE:** 816-783-8121

**EMAIL ADDRESS:** dfleming@naic.org

**ON BEHALF OF:** Life Risk-Based Capital (E) Working Group

**NAME:** Philip Barlow, Chair

**TITLE:** Associate Commissioner of Insurance

**AFFILIATION:** District of Columbia

**ADDRESS:** 1050 First Street, NE Suite 801

Washington, DC 20002

### IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

- [ ] Health RBC Blanks
- [ ] Property/Casualty RBC Blanks
- [ ] Life and Fraternal RBC Instructions
- [ ] Health RBC Instructions
- [ ] Property/Casualty RBC Instructions
- [ ] Life and Fraternal RBC Blanks
- [ ] OTHER ____________________________

### DESCRIPTION OF CHANGE(S)

This proposal incorporates bond factors proposed by the American Academy of Actuaries (Academy) for the expanded presentation of bond designation categories in the annual statement and risk-based capital (RBC) schedules.

### REASON OR JUSTIFICATION FOR CHANGE **

The expanded presentation of bonds is a result of the work of the Investment Risk-Based Capital (E) Working Group. The factors represent the Academy’s work on this project. The Academy’s proposed factors had been previously discussed and exposed for comment at the Investment Risk-Based Capital (E) Working Group in the Academy’s 2015 and 2017 reports. The factors included in this proposal have been updated for tax changes that occurred after the initial factors were presented.

**Addition Staff Comments:**

- 4-22-21: Proposal was exposed for comments (DBF)

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For Total Long-Term Bonds, Column (1) should equal Column 3 Line 1 + Schedule DL Part 1 Column 6 Line 7000000.
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<td>(19) Reduction in RBC for MOOC/Funds</td>
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<td>(20) Increase in RBC for MOOC/Funds</td>
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<td>(22) Non-exempt U.S. Schedule D Part 1, in part†</td>
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<td>(24) Number of Issuers</td>
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<td>(25) Size Factor for Bonds</td>
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<td>(26) Bonds Subject to Size Factor where the Size Factor is Applied</td>
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<td>(27) Total Bonds</td>
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* Only investments in U.S. Government agency bonds previously reported in Lines 2.8 and 10.8, but not included on Line 19, plus the portion of Line 20 attributable to ceding companies’ Lines 2.8 and 10.8 should be included on Line 22. No other bonds should be included on this line. Except U.S. Government bonds shown on Line 11 and 19 should not be included on Line 22. Refer to the bond section of the risk-based capital instructions for more clarification.

Denotes items that must be manually entered on the filing software.
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| † After the ten largest issuer exposures are chosen, any NAIC 1 bonds or preferred stocks from any of these issuers should be included.
‡ Refer to the instructions for the Asset Concentration Factor for details of this calculation.
Denotes items that must be manually entered on the filing software.
### ASSET CONCENTRATION FACTOR (CONTINUED)

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| (62) Total of Issuer = Sum of Lines (1) through (61)                      |                |        |    |                |             |

**NOTE:** Ten issuer sections and a grand total page will be available on the filing software. The grand total page is calculated as the sum of issuers 1-10 by asset type.

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† Refer to the instructions for the Asset Concentration Factor for details of this calculation.

Denotes items that must be manually entered on the filing software.
**HEDGED ASSET BOND SCHEDULE**

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**Note:** For the intermediate category of hedging, we recommend that the risk mitigation and resulting RBC credit be determined as if each specific security common to both the index basket hedge and the portfolio is a basic hedge with the entire basic hedge methodology applied to each matching name. This includes the application of the maturity mismatch formula and the maximum RBC credit of 94% of the C-1 asset charge for fixed income hedges.

† Columns are derived from Investment schedules.
‡ The portion of Column (2) Notional Amount of the Hedging Instrument that hedges Column (7) Book / Adjusted Carrying Value. This amount cannot exceed Column (7) Book / Adjusted Carrying Value.
§ Factor based on Column (10) NAIC Designation and NAIC C-1 RBC factors table.
* Column (7) Book / Adjusted Carrying Value multiplied by Column (11) RBC Factor.
** Column (12) Gross RBC Charge minus Column (13) RBC Credit for Hedging Instruments.

Denotes manual entry items that do not come directly from the annual statement.
### OFF-BALANCE SHEET COLLATERAL

(INCLUDING ANY SCHEDULE DL, PART 1 ASSETS NOT INCLUDED IN THE ASSET VALUATION RESERVE)

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† The factor for common stock can vary depending on the type of stock. The factor would be subject to a minimum of 22.5 percent and a maximum of 45 percent.

Denotes items that must be manually entered on the filing software.
BONDS
LR002

Basis of Factors

The bond factors are based on cash flow modeling using historically adjusted default rates for each bond category. For each of 2,000 trials, annual economic conditions were generated for the 10-year modeling period. Each bond of a 400-bond portfolio was annually tested for default (based on a “roll of the dice”) where the default probability varies by designation category and that year’s economic environment. When a default takes place, the actual loss considers the expected principal loss by category, the time until the sale actually occurs and the assumed tax consequences.

Actual surplus needs are reduced by incorporating anticipated annual contributions to the asset valuation reserve (AVR) as offsetting cash flow. Required surplus for a given trial is calculated as the amount of initial surplus funds needed so that the accumulation with interest of this initial amount and subsequent cash flows will not become negative at any point throughout the modeling period. The factors chosen for the proposed formula produce a level of surplus at least as much as needed in 92 percent of the trials by category and a 96 percent level for the entire bond portfolio.

The factor for NAIC 6 bonds recognizes that the book/adjusted carrying value of these bonds reflects a loss of value upon default by being marked to market.

Specific Instructions for Application of the Formula

Lines (1) through (7)
The book/adjusted carrying value of all bonds and related fixed-income investments should be reported in Column (1). The bonds are split into seven different risk classifications. For long-term bonds, these classifications are found on Lines 1 through 7 of the Asset Valuation Reserve Default Component, Page 30 of the annual statement.

Line (8)
The total should equal long-term bonds and other fixed-income instruments reported on Page 2, Column 3, Line 1 plus Schedule DL Part 1, Column 6, Line 7099999.

Lines (9) through (15)
The book/adjusted carrying value of all bonds and related fixed-income investments should be reported in Column (1). The bonds are split into seven different risk classifications. For short-term bonds, these classifications are found on Lines 18 through 24 of the Asset Valuation Reserve Default Component, Page 30 of the annual statement.

Line (16)
The total should equal short-term bonds reported on Schedule DA, Part 1, Line 8399999 plus Schedule DL Part 1, Column 6, Line 8999999 plus LR012 Miscellaneous Assets Column (1) Line (2.2).

Line (22)
Class 1 bonds (highest quality) issued by a U.S. government agency that are not backed by the full faith and credit of the U.S. government should be reported on this line. The loan-backed securities of the Federal National Mortgage Association (FNMA) and the Federal Home Loan Mortgage Corporation (FHLMC) would be examples of the securities reported on this line. Line (22) should not be larger than the sum of Lines (2) and (10). Exempt obligations should not be included on this line.

Line (24)
Bonds should be aggregated by issuer (the first six digits of the CUSIP number can be used). Exempt U.S. government bonds and bonds reported on Line (22) are not counted in determining the size factor. The RBC for those bonds will not be included in the base to which the size factor is applied. If this field is left blank, the maximum size factor adjustment of 2.5 will be used.
The size factor reflects the higher risk of a bond portfolio that contains relatively fewer bonds. The overall factor decreases as the portfolio size increases. Portfolios with more than 1,300 issuers will receive a discount. The size factor is based on the weighted number of issuers. (The calculation shown below will not appear on the RBC filing software but will be calculated automatically.)

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<th>(b) Number of Issuers</th>
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<td>Over 400 Company Records</td>
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Total Number of Issuers from Line (23)

Total Weighted Issuers

Size Factor = Total Weighted Issuers divided by Total Number of Issuers
ASSET CONCENTRATION FACTOR
LR010

Basis of Factors

The purpose of the concentration factor is to reflect the additional risk of high concentrations in single exposures (represented by an individual issuer of a security or a holder of a mortgage, etc.) The concentration factor doubles the risk-based capital pre-tax factor (with a maximum of 45 percent pre-tax) of the 10 largest asset exposures excluding various low-risk categories or categories that already have a maximum factor. Since the risk-based capital of the assets included in the concentration factor has already been counted once in the basic formula, the asset concentration factor only serves to add in the additional risk-based capital required. The calculation is completed on a consolidated basis; however, the concentration factor is reduced by amounts already included in the concentration factors of subsidiaries to avoid double-counting.

Specific Instructions for Application of the Formula

The 10 largest asset exposures should be developed by consolidating the assets of the parent with the assets of the company’s insurance and investment subsidiaries. The concentration factor component on any asset already reflected in the subsidiary’s RBC for the concentration factor should be deducted from Column (4). This consolidation process affects higher tiered companies only. Companies on the lowest tier of the organizational chart will prepare the asset concentration on a “stand alone” basis.

The 10 largest exposures should exclude the following: affiliated and non-affiliated common stock, affiliated preferred stock, home office properties, policy loans, bonds for which AVR and RBC are zero, NAIC 1 bonds, NAIC 1 unaffiliated preferred stock, NAIC 1 Hybrids, CM 1 Commercial and Farm Mortgages and any other asset categories with RBC factors less than 0.8 percent post-tax (this includes residential mortgages in good standing, insured or guaranteed mortgages, and cash and short-term investments).

In determining the assets subject to the concentration factor for both C-1o and C-1cs, the ceding company should exclude any asset whose performance inures primarily (>50 percent) to one reinsurer under modified coinsurance or funds withheld arrangements. The reinsurer should include 100 percent of such asset. Any asset where no one reinsurer receives more than 50 percent of its performance should remain with the ceding company.

Assets should be aggregated by issuer before determining the 10 largest exposures. Aggregations should be done separately for bonds and preferred stock (the first six digits of the CUSIP number can be used as a starting point) (please note that the same issuer may have more than one unique series of the first six digits of the CUSIP), mortgages and real estate. Securities held within Schedule BA partnerships should be aggregated by issuer as if the securities are held directly. Likewise, where joint venture real estate is mortgaged by the insurer, both the mortgage and the joint venture real estate should be considered as part of a single exposure. Tenant exposure is not included. For bonds and unaffiliated preferred stock, aggregations should be done first for classes 2 through 6. After the 10 largest issuer exposures are chosen, any NAIC 1 bonds, NAIC 1 unaffiliated preferred stock or NAIC 1 hybrids from any of these issuers should be included before doubling the risk-based capital. For some companies, following the above steps may generate less than 10 “issuer” exposures. These companies should list all available exposures.

Replicated assets other than synthetically created indices should be included in the asset concentration calculation in the same manner as other assets.

The book/adjusted carrying value of each asset is listed in Column (2).

The RBC factor will correspond to the risk-based capital category of the asset reported previously in the formula before application of the size factor for bonds. The RBC filing software automatically allows for an overall 45 percent RBC cap.
Lines (17) through (22)
The Asset Concentration RBC Requirement for a particular property plus the Real Estate RBC Requirement for a particular property cannot exceed the book/adjusted carrying value of the property. Any properties exceeding the book/adjusted carrying value must be adjusted down to the book/adjusted carrying value in Column (6) of the Asset Concentration.

Line (18), Column (4) is calculated as Line (17), Column (2) multiplied by 0.2300 plus Line (18), Column (2) multiplied by 0.2000, but not greater than Line (17), Column (2).

Line (20), Column (4) is calculated as Line (19), Column (2) multiplied by 0.1500 plus Line (20), Column (2) multiplied by 0.1200, but not greater than Line (19), Column (2).

Line (22), Column (4) is calculated as Line (21), Column (2) multiplied by 0.2300 plus Line (22), Column (2) multiplied by 0.2000, but not greater than Line (21), Column (2).

Lines (23) through (54)
The Asset Concentration RBC Requirement for a particular mortgage plus the LR004 Mortgages RBC Requirement or LR009 Schedule BA Mortgages RBC Requirement for a particular mortgage cannot exceed 45 percent of the book/adjusted carrying value of the mortgage. Any mortgages exceeding 45 percent of the book/adjusted carrying value must be adjusted down in Column (6) of the Asset Concentration.

Line (32), Column (4) is calculated as the greater of 0.1800 multiplied by [(Line (31) plus Line (32)] less Line (32) or Line (31) multiplied by the appropriate factor for the CM class to which the loan is assigned.

Line (34), Column (4) is calculated as the greater of 0.0140 multiplied by [(Line (33) plus Line (34)] less Line (34) or Line (33) multiplied by 0.0068.

Line (36), Column (4) is calculated as the greater of 0.1800 multiplied by [(Line (35) plus Line (36)] less Line (36) or Line (35) multiplied by the appropriate factor for the CM class to which the loan is assigned.

Line (38), Column (4) is calculated as the greater of 0.2200 multiplied by [(Line (37) plus Line (38)] less Line (38) or Line (37) multiplied by the appropriate factor for the CM class to which the loan is assigned.

Line (40), Column (4) is calculated as the greater of 0.0270 multiplied by [(Line (39) plus Line (40)] less Line (40) or Line (39) multiplied by 0.0068.

Line (42), Column (4) is calculated as the greater of 0.2200 multiplied by [(Line (41) plus Line (42)] less Line (42) or Line (41) multiplied by the appropriate factor for the CM class to which the loan is assigned.

Line (43), Column (4) is calculated as Line (43) multiplied by the appropriate factor for the CM class to which the loan is assigned.

Line (52), Column (4) is calculated as the greater of 0.1800 multiplied by [(Line (51) plus Line (52)] less Line (52) or Line (51) multiplied by the appropriate factor for the CM class to which the loan is assigned.

Line (54), Column (4) is calculated as the greater of 0.2200 multiplied by [(Line (53) plus Line (54)] less Line (54) or Line (53) multiplied by the appropriate factor for the CM class to which the loan is assigned.
HEDGED ASSET BOND AND COMMON STOCK SCHEDULES
LR014 and LR015

(Instructions related to intermediate hedges are in italics.)

Hedging

The concept of hedging credit, equity and other risks is widely accepted and understood among insurers and their regulators. In order for regulators to distinguish between insurers that have effectively reduced their risks from those insurers that have not, the risk based capital computation should be sensitive to such differences. Increasing or decreasing exposure to different asset classes in relation to a benchmark asset allocation tailored to meet the long term obligations to policy owners is critical to successfully managing an insurance company. Hedging is the process of using derivative instruments to most efficiently limit risk associated with a particular asset in a manner consistent with the insurer’s long term objectives. The relative advantage of using cash market transactions versus derivative market transactions depends upon market conditions.

The NAIC model investment laws and regulations establish specific constraints on the use of derivatives. Governance of derivative use starts with approved and documented authorities from the insurer’s Board of Directors to management. These authorities are coordinated with and enhanced by limits established by the insurer’s domiciliary state.

Hedging strategies currently employed by insurers range from straightforward relationships between the hedged asset and the derivative instrument (the hedge) to more complex relationships. The purpose of this section of the RBC calculation is to measure and reflect in RBC the risk reduction achieved by an insurer’s use of the most straightforward types of hedges involving credit default and equity C-1 risks.

To avoid the possible double counting of RBC credits, excluded from this section are any RBC credits arising from hedges that are part of the Clearly Defined Hedging Strategy (CDHS) required for C-3 cash flow testing or other risk mitigation techniques (e.g. reinsurance) which produce reduced levels of RBC by operation of other parts of the RBC formula.

RBC and Measuring the Risk Reduced by Hedging

To measure the risks reduced by hedging and reflect the effects in RBC it is important to understand the characteristics and purpose of the hedge. A portfolio manager seeking to hedge a particular asset or portfolio risk must determine if the derivative instruments available will do a suitable job of risk mitigation.

Default risk - A portfolio manager may determine that the default risk of a particular debt security which matures in 8 years needs to be hedged because of a near term credit concern which may resolve before the debt matures. A credit default swap (CDS) would be the most effective hedging instrument. In some circumstances the manager may purchase a CDS with 8 years to maturity which fully mitigates the default risk and shall result in an RBC credit which fully offsets the C-1 default risk charge on the debt security. However, seeking the most liquid and cost efficient market for the purchase of such an instrument may lead to the purchase of a 5 year CDS which the manager plans to renew (roll) as the credit circumstances evolve in the coming years. In this case there is a 3 year maturity mismatch between the debt security and the hedging instrument. To account for the difference between insurers that have hedged the debt security to full maturity versus those with a mismatched position, the determination of the RBC credit shall be made in accordance with the following formula which limits the results to a fraction of the C-1 charge for the hedged asset.
RBC Credit As % of C1 Asset Charge = \( \text{Min} \left( 1 - \frac{\text{Time to Maturity of CDS}}{\text{Time to Maturity of Bond}} \right) \times (94\% - 10\%) + 10\% \)

This accounts for mismatched maturities and provides a regulatory margin of safety within a range of 94%-10% of the C-1 asset charge.

There may also be circumstances where default risk is reduced by hedging specific portfolios using a basket or index-based derivative (e.g. CDX family of derivatives) with the same or very similar components as the portfolio. For these hedges the risk reduction shall be measured based on the number of issuers common to both the insurer’s portfolio and the index/basket CDS. A minimum of 50% overlap of the derivative instrument notional amount and the book/adjusted carrying value of the hedged bonds shall be required to qualify for any RBC credit. Additionally, if the insurer hedges an index, each bond must be listed (e.g. if the insurer acquires a CDX that hedges 125 names equally, then the insurer must list all 125 names on the schedule), regardless if the insurer owns all the bonds in the index.

As RBC is currently measured and reported annually and to an extent provides a regulator with an indicator of capital sufficiency for the near term future; default risk protection as provided by CDS (based on a specific security or an index of securities) shall have more than 1 year remaining to maturity in order to receive any RBC credit, provided that the remaining maturity of the hedged debt security or average maturity of the hedged portfolio is greater than 1 year. When both the default risk protection and the hedged debt security have less than one year to maturity, full RBC credit shall be allowed provided that the maturity of the protection is later than the maturity of the debt security; otherwise no RBC credit is allowed.

Equity market risk - A portfolio manager may determine that the market risk of holding a particular common stock needs to be reduced. Because an outright sale at that point in time might be disadvantageous to the insurer and/or policy owners, a short futures contract may be purchased to eliminate the current market risk by establishing a sale price in the future. The C-1 RBC equity risk credit shall be limited to 94%.

There may also be circumstances where equity market risk is reduced by hedging equity portfolios using derivatives based on equity market indices (e.g. S&P 500 futures contracts). Unless the equity portfolio is exactly matched to the index, the hedge will not provide precise one-to-one protection from fluctuations in value. The insurer must list all positions in the equity index individually (e.g. all 500 common stocks that are part of the S&P 500), regardless if the insurer owns all the stocks in the index.

Definitions and Instructions for the Spreadsheet Computation of Risk Reduction

(Numeric references represent spreadsheet columns)

Bonds

(1) Description - Reported on Schedule DB.

(2) Notional Amount - Amount reported on Schedule DB.

(3) Relationship Type of the Hedging Instrument and Hedged Asset. There are two categories; Basic and Intermediate relationships. Basic relationship = Single issuer credit default swap on a single issuer name to hedge the credit risk of a specific hedged asset. Intermediate relationship = A portfolio of insurer assets paired with a basket or index based hedging instrument with the same or very similar components as the portfolio. For intermediate relationships, a minimum of 50% overlap of the derivative instrument notional amount and the book adjusted carrying value of the hedged bonds shall be required to qualify for any RBC credit.

(4) Maturity Date - Date reported on Schedule DB.
(5) Description - Bond description found in Schedule D. *For intermediate relationships, each bond must be listed (e.g. if the insurer acquires a credit default index that hedges 125 names equally, then the insurer must list all 125 names on the schedule.)*

(6) CUSIP Identification - Bond unique identifier found in Schedule D.

(7) Book Adjusted Carrying Value - Value found on Schedule D.

(8) Overlap with Insurer’s Bond Portfolio – The portion of Column (2) Notional Amount of the Hedging Instrument that hedges Column (7) Book Adjusted Carrying Value. This amount cannot exceed Column (7) Book Adjusted Carrying Value.

(9) Maturity Date - The date is found in Schedule D.

(10) NAIC Designation - Designation found in Schedule D. Necessary to determine correct RBC Factor for the Bonds.

(11) RBC Factor - Factor based on Column (10) NAIC Designation and NAIC C-1 RBC factors table.

(12) Gross RBC Charge – This is the C-1 RBC charge based on holdings at the end of the year. Calculation: Columns (7) Book Adjusted Carrying Value multiplied by (11) RBC Factor.

(13) RBC Credit for Hedging Instruments – If Column (8) Overlap with Insurer’s Bond Portfolio is zero; the RBC Credit would also be zero. The Hedging Instrument must have more than 1 year remaining to maturity in order to receive any RBC credit provided that the remaining time to maturity of the Hedged Asset - Bonds is greater than 1 year. If both the Hedging Instrument and the Hedged Asset - Bonds maturity dates are less than 1 year, the maximum RBC credit determined using the formula below shall be allowed provided that the maturity of the hedging instrument is equal to or later than the maturity of the bond. Calculation is Column (8) Overlap with Insurer’s Bond Portfolio multiplied by RBC Credit as % of C-1 Asset Charge formula (formula listed below) multiplied by Column (11) RBC Factor.

\[
\text{RBC Credit as } \% \text{ of C1 Asset Charge} = \min\left\{1, \frac{\text{Time to Maturity of Hedging Instrument}}{\text{Time to Maturity of Bond}}\right\} \times (94\% - 10\%) + 10\%
\]

Time to Maturity of Hedging Instrument divided by Time to Maturity of Bond cannot exceed 1.

(14) Net RBC Charge – Column (12) Gross RBC Charge minus (13) RBC Credit for Hedging Instruments.

Common Stocks

(1) Description - Reported on Schedule DB.

(2) Notional Amount - Amount reported on Schedule DB.

(3) Relationship Type of the Hedging Instrument and Hedged Asset. There are two categories; Basic relationships or Intermediate relationships. Basic relationship = Single name equity Hedging Instrument paired with a specific common stock. Intermediate relationship = A portfolio of common stocks paired with a basket or index based Hedging Instrument with the same or very similar components as the portfolio. For intermediate relationships, a minimum of 50% overlap of the derivative instrument notional amount and the book adjusted carrying value of the hedged common stocks shall be required to qualify for any RBC credit.
For intermediate relationships, each common stock must be listed (e.g., if the insurer acquires a short futures contract that hedges the S&P 500, then the insurer must list all 500 stocks on the schedule).
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**Common Stock Type Factor**

- Other Unaffiliated Public Common Stock: 0.4500 †
- Money Market Mutual Funds: 0.0040
- Federal Home Loan Bank Common Stock: 0.0110
- Unaffiliated Private Common Stock: 0.3000

† - 30 percent adjusted up or down by the weighted average beta for the publicly traded common stock portfolio subject to a minimum of 22.5 percent and a maximum of 45 percent.
OFF-BALANCE SHEET COLLATERAL
(Including any Schedule DL, Part 1 Assets not Included in the Asset Valuation Reserve)
LR018

Basis of Factors

Security lending programs are required to maintain collateral. Some entities post the collateral supporting security lending programs on their financial statements, and incur C-1 risk charges on those assets. Other entities have collateral that is not recorded on their financial statements. While not recorded on the financial statements of the company, such collateral has risks that are not otherwise captured in the RBC formula.

Annual Statement Schedule DL, Part 1, Securities Lending Collateral Assets reported on the balance sheet (Assets Page, Line 10) should be included on the schedule with the Off-Balance Sheet Collateral if they are not already reflected in the Asset Valuation Reserve and are reflected in another portion of the Life RBC formula.

The collateral in these accounts is maintained by a third-party (typically a bank or other agent). The collateral agent maintains on behalf of the company detail asset listings of the collateral assets, and this data is the source for preparation of this schedule. The company should maintain such asset listings, at a minimum CUSIP, market value, book/carrying value, and maturity date. The asset risk charges are derived from existing RBC factors for bonds, preferred and common stocks, other invested assets, and invested assets not otherwise classified (aggregate write-ins).

Specific Instructions for Application of the Formula

Off-balance sheet collateral included in General Interrogatories, Part 1, Lines 24.05 and 24.06 of the annual statement should agree with Line (19).

Lines (1) through (8) – Bonds
Bond factors are described on page LR002 Bonds.

Line (9) through (15) – Preferred Stocks
Preferred stock factors are described on page LR005 Unaffiliated Preferred and Common Stock.

Line (16) – Common Stock
Common stock factors are described on page LR005 Unaffiliated Preferred and Common Stock.

Line (17) – Schedule BA – Other Invested Assets
Other invested assets factors are described on page LR008 Other Long Term Assets.

Line (18) – Aggregate Write-ins for Other Invested Assets
Aggregate write-ins for other invested assets factors are described on page LR012 Miscellaneous Assets.
March 11, 2021

Philip Barlow
Chair
Life Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners (NAIC)

Dear Philip,

On behalf of the American Academy of Actuaries' C1 Work Group (C1WG), we present to the Life Risk-Based Capital (E) Working Group updated base bond factors and a companion portfolio adjustment formula to reflect corporate tax rates enacted by the Tax Cuts and Jobs Act of 2017 for the Life Risk-Based Capital (LRBC) formula. The C1WG’s most recent recommendation on updated bond factors was provided to the NAIC’s Investment Risk-Based Capital Working Group on October 10, 2017. No other changes have been made to the October 17, 2017, recommendation.

As we have done in previous reports to the NAIC, we are providing direct model output for the base factors. As is the case with the current capital requirements for bonds, we recommend capping the base factor for the lowest-quality bond designation at 30%. Note that this approach caps the capital requirement for bonds at the base factor for unaffiliated common stock. In addition to capping the factor, we have not rounded any of the factors, as was done for the current bond factors.

A. UPDATED BASE FACTORS

The table below shows updated bond factors using a 21% corporate tax rate and the factors recommended in October 2017. These factors are used in the first step in calculating the basic capital requirements for bonds. These factors have been established at the statistical safety level specified by regulators. These factors in combination with the portfolio adjustment are expected to establish required capital at the 96th percentile over a 10-year time horizon. The assumptions used in developing these factors are based on expected loss given default experience for a portfolio of bonds that is representative of a typical life insurer’s bond portfolio.

In the development of the capital requirements for credit risk, recall that the tax rate affects the net loss flowing through statutory surplus. The factor is based on a discounted after-tax cash flows. As such, an after-tax discount is used in the calculation. In the October 2017 recommendation, the after-tax cash flows were discounted at 3.25%. The updated bond factors are based on after-tax cash flows discounted at

1 The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

3.95%. Note that both sets of factors are based on a 5% pre-tax rate; only the after-tax discount rate has changed.

### Base C1 Bond Factors

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<th>10.17.2017 Recommendation (Pre-Tax)</th>
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### B. UPDATED PORTFOLIO ADJUSTMENT FORMULA

The table below shows an updated portfolio adjustment formula, as developed for the updated base factors above. As a reminder, the purpose of the adjustment is to modify the base calculation for the diversification of the insurer’s bond portfolio, relative to the representative portfolio. The portfolio adjustment increases or decreases the base capital requirement (equal to the arithmetic sum of the base factor times the statutory carrying value of each bond) based on the number of issuers in the insurer’s portfolio.
The representative bond portfolio used in developing the base factors contained 824 issuers. As per the October 2017 recommended portfolio adjustment, the updated portfolio adjustment is neutral or approximately equal to 1.0 for an average portfolio (i.e., a portfolio with the same number of bonds as contained in the representative portfolio.) The updated approach meets that criterion because the exact percentile confidence level of the base factors was selected to reproduce aggregate industry C1 requirements when the base factors are applied to each company portfolio. That said, the confidence level for the base factors is close to the 96th percentile for each rating class, and the portfolio adjustment only captures differences in a company’s diversification risk relative to the representative portfolio.

### Portfolio Adjustment Factors

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### C. COMMENTS ON THE AGE OF ASSUMPTIONS

The C1WG began its work on the C1 Bond Capital Requirements in 2011. With input from regulators (NAIC’s C1 Factor Review Subgroup, NAIC’s Investment RBC Working Group, and the NAIC’s Life Risk-Based Capital Working Group), the C1WG updated the capital requirements to be used within the U.S. Solvency framework.

Many of the assumptions used in these factors, such as the bond default and recovery assumptions, are based on the experience for corporate bonds through 1983–2012. Other assumptions, notably the discount rate, are also based on data from a similar time period.

We understand that regulators are intent on adopting updated bond factors for the 2021 Life Risk-Based Capital calculation, particularly given the shortfall of the current requirements to meet regulators’ desired statistical safety level for credit risk. However, we would be remiss in not stating our concern about adopting a set of factors based on outdated assumptions.

While we have not modeled any assumption changes, we are concerned that the factors in this letter may be lower than what an analysis of updated data would produce. The base factors recommended in 2017
for bonds, exclusive of the impact of increased requirements from the tax change, increase the capital requirements for credit risk approximately 15-20% for the industry, on average. Updated assumptions might indicate that capital requirements should be increased further. We understand the desire to now adopt factors that move the capital requirements closer to the desired statistical level but encourage regulators to consider more frequent reviews of the assumptions and the resulting factors.

We appreciate your consideration of this update. Please contact Nancy Bennett, senior life fellow (bennett@actuary.org), or Khloe Greenwood, life policy analyst (greenwood@actuary.org), with any questions.

Sincerely,

Nancy Bennett, MAAA, FSA, CERA
Co-Chairperson, C1 Work Group
American Academy of Actuaries

Jerry Holman, MAAA, FSA, CFA
Co-Chairperson, C1 Work Group
American Academy of Actuaries
Agenda Item # 2021-11-L

Year 2021

DISPOSITION
[ ] ADOPTED
[ ] REJECTED
[ ] DEFERRED TO
[ ] REFERRED TO OTHER NAIC GROUP
[ X ] EXPOSED 4/22/21
[ ] OTHER (SPECIFY)

DESCRIPTION OF CHANGE(S)
This proposal incorporates bond factors proposed by the American Council of Life Insurers (ACLI) for the expanded presentation of bond designation categories in the annual statement and risk-based capital (RBC) schedules.

REASON OR JUSTIFICATION FOR CHANGE **
The expanded presentation of bonds is a result of the work of the Investment Risk-Based Capital (E) Working Group. This proposal presents alternative factors to those proposed by the American Academy of Actuaries (Academy).

Additional Staff Comments:
- 4-22-21: Proposal was exposed for comments (DBF)

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Total Long-Term Bonds: 0.30000

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*Note: All calculations are based on the specified factors and columns.*
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**Total Short-Term Bonds**

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**Total Long-Term and Short-Term Bonds**

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**Credit for Hedging**

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**Reduction in RBC for NOCD Offst (Pre-MODCO/Funds Withheld Reinsurance Ceded Agreements)**

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**Increase in RBC for NOCD Offst (Pre-MODCO/Funds Withheld Reinsurance Assumed Agreements)**

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<table>
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**Bonds Subject to Size Factor**

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**Number of Issuers**

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**Size Factor for Bonds**

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**Total Bonds**

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1. OM investments in U.S. Government agency bonds purchased prior to 2000 in Line (9) and (11), are those included in Line (19), plus the portion of Line (18) attributable to other agencies and are subject to a maximum of 10%. These bonds should be excluded in Line (22). No other bonds should be excluded on this line. Exempt U.S. Government agency bonds shown on Lines (1) and (9) should not be included in Line (12). Refer to the bond section of the risk-based capital instructions for more clarification.

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Denotes items that must be manually entered on the filing software.
# Asset Concentration Factor

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<tr>
<td>(29) Commercial Mortgages - Category CM4</td>
<td>X 0.03000</td>
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<td>(30) Commercial Mortgages - Category CM5</td>
<td>X 0.07500</td>
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</tbody>
</table>

† After the ten largest issuer exposures are chosen, any NAIC 1 bonds or preferred stocks from any of these issuers should be included.
‡ Refer to the instructions for the Asset Concentration Factor for details of this calculation.

Denotes items that must be manually entered on the filing software.
## ASSET CONCENTRATION FACTOR (CONTINUED)

<table>
<thead>
<tr>
<th>Asset Type</th>
<th>Book / Adjusted Carrying Value</th>
<th>Factor</th>
<th>Additional Adjustment</th>
<th>Subsidiary RBC</th>
<th>Requirement</th>
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<tbody>
<tr>
<td>(31) Farm Mortgages - 90 Days Overdue</td>
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<tr>
<td>(32) Farm Mortgages - 90 Days Overdue - Cumulative Writedowns</td>
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<tr>
<td>(33) Residential Mortgages - 90 Days Overdue</td>
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<tr>
<td>(34) Residential Mortgages - 90 Days Overdue - Cumulative Writedowns</td>
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<tr>
<td>(35) Commercial Mortgages - 90 Days Overdue</td>
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<td>(36) Commercial Mortgages - 90 Days Overdue - Cumulative Writedowns</td>
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<tr>
<td>(37) Farm Mortgages in Foreclosure</td>
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<tr>
<td>(38) Farm Mortgages in Foreclosure - Cumulative Writedowns</td>
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<td>(41) Commercial Mortgages in Foreclosure</td>
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<td>(42) Commercial Mortgages in Foreclosure - Cumulative Writedowns</td>
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<td>(43) Unaffiliated Mortgages with Covenants</td>
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<tr>
<td>(44) Unaffiliated Mortgages - Defeased with Government Securities</td>
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<td>(45) Unaffiliated Mortgages - Primarily Senior</td>
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<tr>
<td>(46) Unaffiliated Mortgages - All Other</td>
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<td>(47) Affiliated Mortgages - Category CM2</td>
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<td>(48) Affiliated Mortgages - Category CM3</td>
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<td>(49) Affiliated Mortgages - Category CM4</td>
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<td>(51) Schedule BA Mortgages 90 Days Overdue</td>
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<td>(52) Schedule BA Mortgages 90 Days Overdue - Cumulative Writedowns</td>
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<tr>
<td>(53) Schedule BA Mortgages in Process of Foreclosure</td>
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<td>(54) Schedule BA Mortgages Foreclosed - Cumulative Writedowns</td>
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<tr>
<td>(55) Federal Guaranteed Low Income Housing Tax Credits</td>
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<tr>
<td>(56) Federal Non-Guaranteed Low Income Housing Tax Credits</td>
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<td>(57) State Guaranteed Low Income Housing Tax Credits</td>
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<tr>
<td>(58) State Non-Guaranteed Low Income Housing Tax Credits</td>
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<tr>
<td>(59) All Other Low Income Housing Tax Credits</td>
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<tr>
<td>(60) NAIC 52 Working Capital Finance Notes</td>
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<tr>
<td>(61) Other Schedule BA Assets</td>
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<tr>
<td>(62) Total of issuer = Sum of Lines (1) through (61)</td>
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</table>

**NOTE:** Ten issuer sections and a grand total page will be available on the filing software. The grand total page is calculated as the sum of issuers 1-10 by asset type.

‡ Refer to the instructions for the Asset Concentration Factor for details of this calculation.

Denotes items that must be manually entered on the filing software.
### HEDGED ASSET BOND SCHEDULE

As of:

<table>
<thead>
<tr>
<th>Type of Hedged Asset</th>
<th>Hedging Instruments</th>
<th>Hedged Asset - Bonds</th>
<th>RBC Credit</th>
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<table>
<thead>
<tr>
<th>Bonds</th>
<th>Description</th>
<th>Notional Amount</th>
<th>Maturity Date</th>
<th>Description</th>
<th>CUSIP</th>
<th>Book / Adjusted Carrying Value</th>
<th>Overlap with Insurer's Bond Portfolio</th>
<th>Maturity Date</th>
<th>NAIC Designation Category</th>
<th>RBC Factor</th>
<th>Gross RBC Charge</th>
<th>Net RBC Charge</th>
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</table>

### Notes:
- For the intermediate category of hedging, we recommend that the risk mitigation and resulting RBC credit be determined as if each specific security common to both the index/basket hedge and the portfolio is a basic hedge with the entire basic hedge methodology applied to each matching name. This includes the application of the maturity mismatch formula and the maximum RBC credit of 94% of the C-1 asset charge for fixed income hedges.
- Columns are derived from investment schedules.
- The portion of Column (2) Notional Amount of the Hedging Instrument that hedges Column (7) Book / Adjusted Carrying Value. This amount cannot exceed Column (7) Book / Adjusted Carrying Value.
- Factor based on Column (10) NAIC Designation and NAIC C-1 RBC Factors table.
- Column (7) Book Adjusted Carrying Value multiplied by Column (11) RBC Factor.
- Column (13) is calculated according to the risk-based capital instructions.
- Column (12) Gross RBC Charge minus Column (13) RBC Credit for Hedging Instruments.

Denotes manual entry items that do not come directly from the annual statement.
| NAIC Designation Category 1.A | X | 0.01208 | (2.1) Exempt Obligations |
| NAIC Designation Category 1.B | X | 0.01464 | |
| NAIC Designation Category 2.A | X | 0.02090 | |
| NAIC Designation Category 2.B | X | 0.02375 | |
| NAIC Designation Category 2.C | X | 0.03000 | |
| NAIC Designation Category 3.A | X | 0.03707 | |
| NAIC Designation Category 3.B | X | 0.04399 | |
| NAIC Designation Category 3.C | X | 0.05849 | |
| Subtotal NAIC 3 | X | 0.08149 | |
| NAIC Designation Category 4.A | X | 0.07176 | |
| NAIC Designation Category 4.B | X | 0.09291 | |
| NAIC Designation Category 4.C | X | 0.12132 | |
| Subtotal NAIC 4 | X | 0.28599 | |
| NAIC Designation Category 5.A | X | 0.16950 | |
| NAIC Designation Category 5.B | X | 0.23230 | |
| NAIC Designation Category 5.C | X | 0.30000 | |
| Subtotal NAIC 5 | X | 0.50180 | |
| NAIC 6 | X | 0.30000 | |
| Total Bonds | | | (2.8) Subtotal NAIC 1 through (2.7) |
| (2.9) Sum of Lines (2.1) through (2.7) | X | 0.01288 | |

| NAIC Designation Category 1.A | X | 0.00390 | |
| NAIC Designation Category 1.B | X | 0.01260 | |
| NAIC Designation Category 2.A | X | 0.04460 | |
| NAIC Designation Category 2.B | X | 0.09700 | |
| NAIC Designation Category 2.C | X | 0.22310 | |
| NAIC Designation Category 6 | X | 0.30000 | |
| Total Preferred Stock | | | (9) Asset NAIC 1 through (14) |
| (10) Sum of Lines (9) through (14) | X | 0.30000 | |

| Common Stock | X | 0.45000 | |
| Schedule BA - Other Invested Assets | X | 0.30000 | |
| Other Invested Assets | X | 0.30000 | |
| Total Off-Balance Sheet Collateral | | | (19) Total Off-Balance Sheet Collateral |

<table>
<thead>
<tr>
<th>Carrying Value</th>
<th>Factor</th>
<th>Requirement</th>
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<tbody>
<tr>
<td>X 0.00000</td>
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</tbody>
</table>

Denotes items that must be manually entered on the filing software.

† The factor for common stock can vary depending on the type of stock. The factor would be subject to a minimum of 22.5 percent and a maximum of 45 percent.
Bonds LR002

Basis of Factors

The bond factors are based on cash flow modeling using historically adjusted default rates for each bond category. For each of 2,000 trials, annual economic conditions were generated for the 10-year modeling period. Each bond of a 400-bond portfolio was annually tested for default (based on a “roll of the dice”) where the default probability varies by designation category and that year’s economic environment. When a default takes place, the actual loss considers the expected principal loss by category, the time until the sale actually occurs and the assumed tax consequences.

Actual surplus needs are reduced by incorporating anticipated annual contributions to the asset valuation reserve (AVR) as offsetting cash flow. Required surplus for a given trial is calculated as the amount of initial surplus funds needed so that the accumulation with interest of this initial amount and subsequent cash flows will not become negative at any point throughout the modeling period. The factors chosen for the proposed formula produce a level of surplus at least as much as needed in 92 percent of the trials by category and a 96 percent level for the entire bond portfolio.

The factor for NAIC 6 bonds recognizes that the book/adjusted carrying value of these bonds reflects a loss of value upon default by being marked to market.

Specific Instructions for Application of the Formula

Lines (1) through (7)
The book/adjusted carrying value of all bonds and related fixed-income investments should be reported in Column (1). The bonds are split into seven different risk classifications. For long-term bonds, these classifications are found on Lines 1 through 7 of the Asset Valuation Reserve Default Component, Page 30 of the annual statement.

Line (8)
The total should equal long-term bonds and other fixed-income instruments reported on Page 2, Column 3, Line 1 plus Schedule DL Part 1, Column 6, Line 7099999.

Lines (9) through (15)
The book/adjusted carrying value of all bonds and related fixed-income investments should be reported in Column (1). The bonds are split into seven different risk classifications. For short-term bonds, these classifications are found on Lines 18 through 24 of the Asset Valuation Reserve Default Component, Page 30 of the annual statement.

Line (16)
The total should equal short-term bonds reported on Schedule DA, Part 1, Line 8399999 plus Schedule DL Part 1, Column 6, Line 8999999 plus LR012 Miscellaneous Assets Column (1) Line (2.2).

Line (22)
Class 1 bonds (highest quality) issued by a U.S. government agency that are not backed by the full faith and credit of the U.S. government should be reported on this line. The loan-backed securities of the Federal National Mortgage Association (FNMA) and the Federal Home Loan Mortgage Corporation (FHLMC) would be examples of the securities reported on this line. Line (22) should not be larger than the sum of Lines (2) and (10). Exempt obligations should not be included on this line.

Line (24)
Bonds should be aggregated by issuer (the first six digits of the CUSIP number can be used). Exempt U.S. government bonds and bonds reported on Line (22) are not counted in determining the size factor. The RBC for those bonds will not be included in the base to which the size factor is applied. If this field is left blank, the maximum size factor adjustment of 2.5 will be used.
The size factor reflects the higher risk of a bond portfolio that contains relatively fewer bonds. The overall factor decreases as the portfolio size increases. Portfolios with more than 1,300 issuers will receive a discount. The size factor is based on the weighted number of issuers. (The calculation shown below will not appear on the RBC filing software but will be calculated automatically.)

<table>
<thead>
<tr>
<th>Source</th>
<th>Number of Issuers</th>
<th>Weighted Issuers</th>
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<tbody>
<tr>
<td>First 50</td>
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<td>2.5</td>
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<tr>
<td>Next 50</td>
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<td>1.3</td>
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<td>Next 300</td>
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<tr>
<td>Over 400</td>
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<tr>
<td>Total Number of Issuers from Line (23)</td>
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<tr>
<td>Total Weighted Issuers</td>
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<tr>
<td>Size Factor = Total Weighted Issuers divided by Total Number of Issuers</td>
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ASSET CONCENTRATION FACTOR
LR010

Basis of Factors

The purpose of the concentration factor is to reflect the additional risk of high concentrations in single exposures (represented by an individual issuer of a security or a holder of a mortgage, etc.) The concentration factor doubles the risk-based capital pre-tax factor (with a maximum of 45 percent pre-tax) of the 10 largest asset exposures excluding various low-risk categories or categories that already have a maximum factor. Since the risk-based capital of the assets included in the concentration factor has already been counted once in the basic formula, the asset concentration factor only serves to add in the additional risk-based capital required. The calculation is completed on a consolidated basis; however, the concentration factor is reduced by amounts already included in the concentration factors of subsidiaries to avoid double-counting.

Specific Instructions for Application of the Formula

The 10 largest asset exposures should be developed by consolidating the assets of the parent with the assets of the company’s insurance and investment subsidiaries. The concentration factor component on any asset already reflected in the subsidiary’s RBC for the concentration factor should be deducted from Column (4). This consolidation process affects higher tiered companies only. Companies on the lowest tier of the organizational chart will prepare the asset concentration on a “stand alone” basis.

The 10 largest exposures should exclude the following: affiliated and non-affiliated common stock, affiliated preferred stock, home office properties, policy loans, bonds for which AVR and RBC are zero, NAIC 1 bonds, NAIC 1 unaffiliated preferred stock, NAIC 1 Hybrids, CM 1 Commercial and Farm Mortgages and any other asset categories with RBC factors less than 0.8 percent post-tax (this includes residential mortgages in good standing, insured or guaranteed mortgages, and cash and short-term investments).

In determining the assets subject to the concentration factor for both C-1o and C-1cs, the ceding company should exclude any asset whose performance inures primarily (>50 percent) to one reinsurer under modified coinsurance or funds withheld arrangements. The reinsurer should include 100 percent of such asset. Any asset where no one reinsurer receives more than 50 percent of its performance should remain with the ceding company.

Assets should be aggregated by issuer before determining the 10 largest exposures. Aggregations should be done separately for bonds and preferred stock (the first six digits of the CUSIP number can be used as a starting point) (please note that the same issuer may have more than one unique series of the first six digits of the CUSIP), mortgages and real estate. Securities held within Schedule BA partnerships should be aggregated by issuer as if the securities are held directly. Likewise, where joint venture real estate is mortgaged by the insurer, both the mortgage and the joint venture real estate should be considered as part of a single exposure. Tenant exposure is not included. For bonds and unaffiliated preferred stock, aggregations should be done first for classes 2 through 6. After the 10 largest issuer exposures are chosen, any NAIC 1 bonds, NAIC 1 unaffiliated preferred stock or NAIC 1 hybrids from any of these issuers should be included before doubling the risk-based capital. For some companies, following the above steps may generate less than 10 “issuer” exposures. These companies should list all available exposures.

Replicated assets other than synthetically created indices should be included in the asset concentration calculation in the same manner as other assets.

The book/adjusted carrying value of each asset is listed in Column (2).

The RBC factor will correspond to the risk-based capital category of the asset reported previously in the formula before application of the size factor for bonds. The RBC filing software automatically allows for an overall 45 percent RBC cap.
Lines (17) through (22)
The Asset Concentration RBC Requirement for a particular property plus the Real Estate RBC Requirement for a particular property cannot exceed the book/adjusted carrying value of the property. Any properties exceeding the book/adjusted carrying value must be adjusted down to the book/adjusted carrying value in Column (6) of the Asset Concentration.

Line (18), Column (4) is calculated as Line (17), Column (2) multiplied by 0.2300 plus Line (18), Column (2) multiplied by 0.2000, but not greater than Line (17), Column (2).
Line (20), Column (4) is calculated as Line (19), Column (2) multiplied by 0.1500 plus Line (20), Column (2) multiplied by 0.1200, but not greater than Line (19), Column (2).
Line (22), Column (4) is calculated as Line (21), Column (2) multiplied by 0.2300 plus Line (22), Column (2) multiplied by 0.2000, but not greater than Line (21), Column (2).

Lines (23) through (54)
The Asset Concentration RBC Requirement for a particular mortgage plus the LR004 Mortgages RBC Requirement or LR009 Schedule BA Mortgages RBC Requirement for a particular mortgage cannot exceed 45 percent of the book/adjusted carrying value of the mortgage. Any mortgages exceeding 45 percent of the book/adjusted carrying value must be adjusted down in Column (6) of the Asset Concentration.

Line (32), Column (4) is calculated as the greater of 0.1800 multiplied by [(Line (31) plus Line (32)) less Line (32)] or Line (31) multiplied by the appropriate factor for the CM class to which the loan is assigned.
Line (34), Column (4) is calculated as the greater of 0.0140 multiplied by [(Line (33) plus Line (34))] less Line (34) or Line (33) multiplied by 0.0068.
Line (36), Column (4) is calculated as the greater of 0.1800 multiplied by [(Line (35) plus Line (36))] less Line (36) or Line (35) multiplied by the appropriate factor for the CM class to which the loan is assigned.
Line (38), Column (4) is calculated as the greater of 0.2200 multiplied by [(Line (37) plus Line (38))] less Line (38) or Line (37) multiplied by the appropriate factor for the CM class to which the loan is assigned.
Line (40), Column (4) is calculated as the greater of 0.0270 multiplied by [(Line (39) plus Line (40))] less Line (40) or Line (39) multiplied by 0.0068.
Line (42), Column (4) is calculated as the greater of 0.2200 multiplied by [(Line (41) plus Line (42))] less Line (42) or Line (41) multiplied by the appropriate factor for the CM class to which the loan is assigned.
Line (43), Column (4) is calculated as Line (43) multiplied by the appropriate factor for the CM class to which the loan is assigned.
Line (52), Column (4) is calculated as the greater of 0.1800 multiplied by [(Line (51) plus Line (52))] less Line (52) or Line (51) multiplied by the appropriate factor for the CM class to which the loan is assigned.
Line (54), Column (4) is calculated as the greater of 0.2200 multiplied by [(Line (53) plus Line (54))] less Line (54) or Line (53) multiplied by the appropriate factor for the CM class to which the loan is assigned.
HEDGED ASSET BOND AND COMMON STOCK SCHEDULES
LR014 and LR015

(Instructions related to intermediate hedges are in italics.)

Hedging

The concept of hedging credit, equity and other risks is widely accepted and understood among insurers and their regulators. In order for regulators to distinguish between insurers that have effectively reduced their risks from those insurers that have not, the risk based capital computation should be sensitive to such differences. Increasing or decreasing exposure to different asset classes in relation to a benchmark asset allocation tailored to meet the long term obligations to policy owners is critical to successfully managing an insurance company. Hedging is the process of using derivative instruments to most efficiently limit risk associated with a particular asset in a manner consistent with the insurer’s long term objectives. The relative advantage of using cash market transactions versus derivative market transactions depends upon market conditions.

The NAIC model investment laws and regulations establish specific constraints on the use of derivatives. Governance of derivative use starts with approved and documented authorities from the insurer’s Board of Directors to management. These authorities are coordinated with and enhanced by limits established by the insurer’s domiciliary state.

Hedging strategies currently employed by insurers range from straightforward relationships between the hedged asset and the derivative instrument (the hedge) to more complex relationships. The purpose of this section of the RBC calculation is to measure and reflect in RBC the risk reduction achieved by an insurer’s use of the most straightforward types of hedges involving credit default and equity C-1 risks.

To avoid the possible double counting of RBC credits, excluded from this section are any RBC credits arising from hedges that are part of the Clearly Defined Hedging Strategy (CDHS) required for C-3 cash flow testing or other risk mitigation techniques (e.g. reinsurance) which produce reduced levels of RBC by operation of other parts of the RBC formula.

RBC and Measuring the Risk Reduced by Hedging

To measure the risks reduced by hedging and reflect the effects in RBC it is important to understand the characteristics and purpose of the hedge. A portfolio manager seeking to hedge a particular asset or portfolio risk must determine if the derivative instruments available will do a suitable job of risk mitigation.

Default risk - A portfolio manager may determine that the default risk of a particular debt security which matures in 8 years needs to be hedged because of a near term credit concern which may resolve before the debt matures. A credit default swap (CDS) would be the most effective hedging instrument. In some circumstances the manager may purchase a CDS with 8 years to maturity which fully mitigates the default risk and shall result in an RBC credit which fully offsets the C-1 default risk charge on the debt security. However, seeking the most liquid and cost efficient market for the purchase of such an instrument may lead to the purchase of a 5 year CDS which the manager plans to renew (roll) as the credit circumstances evolve in the coming years. In this case there is a 3 year maturity mismatch between the debt security and the hedging instrument. To account for the difference between insurers that have hedged the debt security to full maturity versus those with a mismatched position, the determination of the RBC credit shall be made in accordance with the following formula which limits the results to a fraction of the C-1 charge for the hedged asset.

\[
\text{RBC Credit} = \min\left(\frac{\text{Maturity of CDS}}{\text{Maturity of Debt Security}}, 1\right) \times \text{C-1 Charge}
\]
RBC Credit As % of C-1 Asset Charge $= \min\left(1, \frac{\text{Time to Maturity of CDS}}{\text{Time to Maturity of Bond}}\right) \times (94\% - 10\%) + 10\%$

This accounts for mismatched maturities and provides a regulatory margin of safety within a range of 94%-10% of the C-1 asset charge.

There may also be circumstances where default risk is reduced by hedging specific portfolios using a basket or index-based derivative (e.g. CDX family of derivatives) with the same or very similar components as the portfolio. For these hedges the risk reduction shall be measured based on the number of issuers common to both the insurer’s portfolio and the index/basket CDS. A minimum of 50% overlap of the derivative instrument notional amount and the book/adjusted carrying value of the hedged bonds shall be required to qualify for any RBC credit. Additionally, if the insurer hedges an index, each bond must be listed (e.g. if the insurer acquires a CDX that hedges 125 names equally, then the insurer must list all 125 names on the schedule), regardless if the insurer owns all the bonds in the index.

As RBC is currently measured and reported annually and to an extent provides a regulator with an indicator of capital sufficiency for the near term future; default risk protection as provided by CDS (based on a specific security or an index of securities) shall have more than 1 year remaining to maturity in order to receive any RBC credit, provided that the remaining maturity of the hedged debt security or average maturity of the hedged portfolio is greater than 1 year. When both the default risk protection and the hedged debt security have less than one year to maturity, full RBC credit shall be allowed provided that the maturity of the protection is later than the maturity of the debt security; otherwise no RBC credit is allowed.

Equity market risk - A portfolio manager may determine that the market risk of holding a particular common stock needs to be reduced. Because an outright sale at that point in time might be disadvantageous to the insurer and/or policy owners, a short futures contract may be purchased to eliminate the current market risk by establishing a sale price in the future. The C-1 RBC equity risk credit shall be limited to 94%.

There may also be circumstances where equity market risk is reduced by hedging equity portfolios using derivatives based on equity market indices (e.g. S&P 500 futures contracts). Unless the equity portfolio is exactly matched to the index, the hedge will not provide precise one-to-one protection from fluctuations in value. The insurer must list all positions in the equity index individually (e.g. all 500 common stocks that are part of the S&P 500), regardless if the insurer owns all the stocks in the index.

Definitions and Instructions for the Spreadsheet Computation of Risk Reduction

(Numeric references represent spreadsheet columns)

Bonds

(1) Description - Reported on Schedule DB.

(2) Notional Amount - Amount reported on Schedule DB.

(3) Relationship Type of the Hedging Instrument and Hedged Asset. There are two categories; Basic and Intermediate relationships. Basic relationship = Single issuer credit default swap on a single issuer name to hedge the credit risk of a specific hedged asset. Intermediate relationship = A portfolio of insurer assets paired with a basket or index based hedging instrument with the same or very similar components as the portfolio. For intermediate relationships, a minimum of 50% overlap of the derivative instrument notional amount and the book adjusted carrying value of the hedged bonds shall be required to qualify for any RBC credit.

(4) Maturity Date - Date reported on Schedule DB.
(5) Description - Bond description found in Schedule D. For intermediate relationships, each bond must be listed (e.g. if the insurer acquires a credit default index that hedges 125 names equally, then the insurer must list all 125 names on the schedule.)

(6) CUSIP Identification - Bond unique identifier found in Schedule D.

(7) Book Adjusted Carrying Value - Value found on Schedule D.

(8) Overlap with Insurer’s Bond Portfolio – The portion of Column (2) Notional Amount of the Hedging Instrument that hedges Column (7) Book Adjusted Carrying Value. This amount cannot exceed Column (7) Book Adjusted Carrying Value.

(9) Maturity Date - The date is found in Schedule D.

(10) NAIC Designation - Designation found in Schedule D. Necessary to determine correct RBC Factor for the Bonds.

(11) RBC Factor - Factor based on Column (10) NAIC Designation and NAIC C-1 RBC factors table.

(12) Gross RBC Charge – This is the C-1 RBC charge based on holdings at the end of the year. Calculation: Columns (7) Book Adjusted Carrying Value multiplied by (11) RBC Factor.

(13) RBC Credit for Hedging Instruments – If Column (8) Overlap with Insurer’s Bond Portfolio is zero, the RBC Credit would also be zero. The Hedging Instrument must have more than 1 year remaining to maturity in order to receive any RBC credit provided that the remaining time to maturity of the Hedged Asset - Bonds is greater than 1 year. If both the Hedging Instrument and the Hedged Asset - Bonds maturity dates are less than 1 year, the maximum RBC credit determined using the formula below shall be allowed provided that the maturity of the hedging instrument is equal to or later than the maturity of the bond. Calculation is Column (8) Overlap with Insurer’s Bond Portfolio multiplied by RBC Credit as % of C-1 Asset Charge formula (formula listed below) multiplied by Column (11) RBC Factor.

\[ \text{RBC Credit as } \% \text{ of C-1 Asset Charge} = \min \left( 1, \frac{\text{Time to Maturity of Hedging Instrument}}{\text{Time to Maturity of Bond}} \right) \times (94\% - 10\%) + 10\% \]

Time to Maturity of Hedging Instrument divided by Time to Maturity of Bond cannot exceed 1.

(14) Net RBC Charge – Column (12) Gross RBC Charge minus (13) RBC Credit for Hedging Instruments.

Common Stocks

(1) Description - Reported on Schedule DB.

(2) Notional Amount - Amount reported on Schedule DB.

(3) Relationship Type of the Hedging Instrument and Hedged Asset. There are two categories; Basic relationships or Intermediate relationships. Basic relationship = Single name equity Hedging Instrument paired with a specific common stock. Intermediate relationship = A portfolio of common stocks paired with a basket or index based Hedging Instrument with the same or very similar components as the portfolio. For intermediate relationships, a minimum of 50% overlap of the derivative instrument notional amount and the book adjusted carrying value of the hedged common stocks shall be required to qualify for any RBC credit.
For intermediate relationships, each common stock must be listed (e.g. if the insurer acquires a short futures contract that hedges the S&P 500, then the insurer must list all 500 stocks on the schedule).

Overlap with Insurer’s Stock Portfolio – The portion of Column (2) Notional Amount of the Hedging Instrument that hedges Column (6) Book/Adjusted Carrying Value. This amount cannot exceed the Column (6) Book Adjusted Carrying Value.

RBC Credit for Hedging Instruments - RBC credit for equity market risk reduction is limited to 94% of the C-1 Asset charge. Calculation: Column (7) Overlap with Insurer’s Stock Portfolio multiplied by (8) RBC Factor multiplied by 94%.

Net RBC Charge - Column (9) Gross RBC Charge minus (10) RBC Credit for Hedging Instruments.
### Factors Table
As determined by the NAIC

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<td>Money Market Mutual Funds</td>
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† - 30 percent adjusted up or down by the weighted average beta for the publicly traded common stock portfolio subject to a minimum of 22.5 percent and a maximum of 45 percent.
OFF-BALANCE SHEET COLLATERAL
(Including any Schedule DL, Part 1 Assets not Included in the Asset Valuation Reserve)
LR018

Basis of Factors

Security lending programs are required to maintain collateral. Some entities post the collateral supporting security lending programs on their financial statements, and incur C-1 risk charges on those assets. Other entities have collateral that is not recorded on their financial statements. While not recorded on the financial statements of the company, such collateral has risks that are not otherwise captured in the RBC formula.

Annual Statement Schedule DL, Part 1, Securities Lending Collateral Assets reported on the balance sheet (Assets Page, Line 10) should be included on the schedule with the Off-Balance Sheet Collateral if they are not already reflected in the Asset Valuation Reserve and are reflected in another portion of the Life RBC formula.

The collateral in these accounts is maintained by a third-party (typically a bank or other agent). The collateral agent maintains on behalf of the company detail asset listings of the collateral assets, and this data is the source for preparation of this schedule. The company should maintain such asset listings, at a minimum CUSIP, market value, book/carrying value, and maturity date. The asset risk charges are derived from existing RBC factors for bonds, preferred and common stocks, other invested assets, and invested assets not otherwise classified (aggregate write-ins).

Specific Instructions for Application of the Formula

Off-balance sheet collateral included in General Interrogatories, Part 1, Lines 24.05 and 24.06 of the annual statement should agree with Line (19).

Lines (1) through (8) – Bonds
Bond factors are described on page LR002 Bonds.

Line (9) through (15) – Preferred Stocks
Preferred stock factors are described on page LR005 Unaffiliated Preferred and Common Stock.

Line (16) – Common Stock
Common stock factors are described on page LR005 Unaffiliated Preferred and Common Stock.

Line (17) – Schedule BA – Other Invested Assets
Other invested assets factors are described on page LR008 Other Long Term Assets.

Line (18) – Aggregate Write-ins for Other Invested Assets
Aggregate write-ins for other invested assets factors are described on page LR012 Miscellaneous Assets.
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Moody's Corporation is comprised of two separate companies: Moody's Investors Service (MIS) and Moody's Analytics (MA).

Moody's Investors Service (MIS) provides investors with a comprehensive view of global debt markets through credit ratings and research. Moody's Analytics (MA) provides data, analytics, and insights to equip leaders of financial, non-financial, and government organizations with effective tools to understand a range of risks.

Throughout this document, “MIS rating” refers to a MIS credit rating. And while references to MIS are made, the views and opinions in this document are solely of MA.
1. Executive Summary
2. Comparison of C1 Factors and C1 RBC Industry Impact
3. Impact of Proposed Targeted Improvements
Proposed Updates to the RBC C1 Bond Factors

Executive Summary

Proposing RBC C1 bond factors using data and methodologies that better reflect economic risks with capital requirements, across NAIC ratings and across number of issuers in portfolio, allowing for better identification of weakly capitalized firms; C1 factors should not incentivize poor business decisions that can adversely impact solvency.

Methodologies and data rely entirely on public sources that are accessible and reproducible by NAIC and industry.

Articulated limitations.

NAIC to use at its discretion in setting the final C1 factors.

Challenges:
- C1 factors are cardinal, a function of MA's default rates estimated for each MIS ratings that are opinions on ordinal, horizon-free credit risk, rather than cardinal ratings over time, across ratings and asset classes, resulting in a potential misalignment between the C1 factors and the underlying risks of varied holdings in insurers' portfolios.
- Applied to range of credit assets, based on the second lowest NRSRO rating with statistical properties that can be different from MIS ratings.

How We’re Doing It

Heuristic Performance Criteria

Scope

Proposing RBC C1 bond factors using data and methodologies that better reflect economic risks with capital requirements, across NAIC ratings and across number of issuers in portfolio, allowing for better identification of weakly capitalized firms; C1 factors should not incentivize poor business decisions that can adversely impact solvency.

Challenges:
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- Applied to range of credit assets, based on the second lowest NRSRO rating with statistical properties that can be different from MIS ratings.

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Executive Summary

Findings

What We Found

MA proposed C1 factors result in a general overall C1 RBC increase across the industry:
- C1 base factors are more differentiated across ratings (i.e., steeper slope) than the current C1 base factors or those proposed by the Academy
- Portfolio adjustment factors (PAF) for portfolios with small number of issuers are significantly less punitive than those under the Academy’s proposal, and sit between the current PAFs and those proposed by the Academy

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<th>MIS Rating</th>
<th>Current Factors</th>
<th>Academy’s Proposed Factors [2021]</th>
<th>MA Preliminary Proposed Base Factors</th>
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Next

Immediate Next Steps

- Achieve consensus on data and methodology
- Provide transparency on approaches and resulting impact
- Provide guidance on limitations of use and best practice
Comparison of C1 Factors and C1 RBC Industry Impact
Comparison of C1 Base Factors

MA proposed base factors have a steeper slope

Targeted improvements with largest impact on C1 base factors

- **Economic state model**, initially outside scope, limitations viewed to be sufficiently material that MA recommends replacing with correlation model parameterized to default correlations observed empirically
  - Economic state scalars in the economic state model are generally more punitive for higher MIS ratings, resulting in a counterfactual flattening of risk across MIS ratings, and possible non-monotonic C1 base factors
  - MA proposed correlation model results in C1 base factors that are more conservative and differentiated across MIS ratings, while also correcting for PAF issues described subsequently under PAF section.

- **Corporate default rate term structures** are estimated to represent the historical experience of life insurance holdings
  - Life holdings differ from overall issuance; e.g., life portfolio holdings have less weight on financial institutions that tend to issue shorter term debt
  - MA proposed default rates tend to have a steeper slope (more separated across MIS ratings) than those proposed by the Academy, with separation more closely aligning with benchmarks

- **Risk Premium** conservatively set at expected loss plus 0.5 standard deviation recognizing variation in industry reserving standards and to closer align with PBR and reserving standards generally aiming to cover moderately adverse conditions. A higher Risk Premium lowers the C1 base factors and mildly increases the cross-sectional variation (or slope) and should be set to better identify of weakly capitalized firms identify and mitigate risk shifting incentives with new bond purchases.
Proposed Portfolio Adjustment Factor (PAF)

Most impacted by replacing the economic state model with MA correlation model

Initially outside scope, economic state model limitations viewed to be sufficiently material that MA recommends replacing with correlation model that reflects diversification benefits observed empirically.

**The economic state model:**

- While calibrated to the level of defaults observed in economic contractions and recessions
- Implies more issuer diversification benefits (i.e., lower default correlations) than observed empirically
- Implies PAFs that are overly punitive (lenient) to portfolios with small (larger) number of issuers

**MA proposes a correlation model** calibrated to default correlations observed empirically allowing for a more accurate and conservative reflection of issuer diversification benefits

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<td>0.75</td>
<td>0.72</td>
<td>0.82</td>
</tr>
</tbody>
</table>

*Current PAF converted to Academy’s proposed thresholds for better comparison.
Post-PAF C1 RBC Industry Impact – Complete Portfolio Holdings

Post-PAF RBC proposed by MA is higher than the current level

*Data on ~85% life companies in US that have reported as of 03/19/2021
Proposed Updates to the RBC C1 Bond Factors

Post-PAF C1 RBC Impact by Life Company

Complete portfolio holdings

- MA proposed correlation model is parameterized to default correlations observed empirically allowing for a more accurate and conservative reflection of issuer diversification benefits.

- MA’s proposal are generally higher than current. The difference is relatively constant across life companies of different sizes.

- Academy’s proposal are generally higher for portfolios with a small or medium number of issuers, often several times higher than under the current formula, driven largely by the economic state model implying more issuer diversification benefits (i.e., lower default correlations) than observed empirically.

Note: Life companies with Current Post-PAF RBC below $100K are not displayed in this figure.
Summary of Proposed Targeted Improvements to the C1 Factors
### Part 1 of 2: Most Impactful Targeted Improvements

<table>
<thead>
<tr>
<th>Stakeholder Agreed-on Targeted Improvements</th>
<th>Current Formula</th>
<th>Academy Proposal</th>
<th>MA Proposal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Economic State Model</strong></td>
<td>Five-state model; affects both default and LGD; MA did not analyze extensively, but likely similar properties to Academy proposal</td>
<td>A combination of two and four-state model; affects both default and LGD; Model results in C1 base factors that are not sufficiently differentiated across MIS ratings and may be non-monotonic, and a PAF that provides more diversification benefits than observed empirically</td>
<td>Initially outside scope, economic state model limitations viewed to be sufficiently material that MA proposes replacing with correlation model that reflects default correlations and diversification benefits observed empirically. Resulting C1 base factors are more differentiated and conservative, and PAF is more accurate and conservative reflection of diversification benefits.</td>
</tr>
<tr>
<td><strong>Default Rates</strong></td>
<td>Based on data from, Moody’s 1991 Special Comment: Corporate Default and Recovery Rates, 1970-1990”. Documentation on data smoothing and filtering is limited</td>
<td>Smoothed corporate default rate term structures grouped by MIS alphanumeric rating using Academy’s algorithm.</td>
<td>Smoothed corporate default rate term structures representing the historical experience of life insurance holdings using default data grouped by MIS alphanumeric rating using MA’s DRD. MA proposed default rates tend to have a steeper slope (more separated across MIS ratings) than those proposed by the Academy, with separation more closely aligning with benchmarks.</td>
</tr>
<tr>
<td><strong>Risk Premium</strong></td>
<td>Set equal to expected loss</td>
<td>Set equal to expected loss</td>
<td>Conservatively set at expected loss plus 0.5 standard deviation recognizing variation in industry reserving standards and to closer align with PBR and reserving standards generally aiming to cover moderately adverse conditions. A higher Risk Premium lowers the C1 base factors and mildly increases their cross-sectional variation (or slope) and should be set to better identify of weakly capitalized firms identify and mitigate risk shifting incentives with new bond purchases.</td>
</tr>
<tr>
<td><strong>Portfolio Adjustment Factor (PAF)</strong></td>
<td>Documentation is limited</td>
<td>Based on economic state model that implies more benefits to diversification across issuers than observed empirically, resulting in a PAF that is overly punitive (lenient) to portfolios with a small (larger) number of issuers</td>
<td>Initially outside scope, economic state model limitations viewed to be sufficiently material that MA proposes replacing the economic state model with a correlation model calibrated to default correlations and diversification benefits observed empirically allowing for a more accurate and conservative reflection of issuer diversification benefits.</td>
</tr>
</tbody>
</table>
### Part 2 of 2: Remaining Targeted Improvements

<table>
<thead>
<tr>
<th>Stakeholder Agreed-on Targeted Improvements</th>
<th>Current Formula</th>
<th>Academy Proposal</th>
<th>MA Proposal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fix errors in engine that replicates Academy’s factors</td>
<td>Limited documentation</td>
<td>Replicated code suggests default rates and LGD were drawn from separate economic states for Baa-Caa</td>
<td>Error fix for Baa-Caa MIS ratings, where default rates and LGD can be drawn from separate economic states in simulation</td>
</tr>
<tr>
<td>Loss Given Default (LGD)</td>
<td>Limited documentation Average LGD by NAIC designation 37.25% (NAIC 1), 52.17% (NAIC 2), 56.67% (NAIC 3-5).</td>
<td>Does not align with the date of default. This deviation can result in bias with recovery rate levels, as well as their relationships with default rates. Average value of LGD = 53%</td>
<td>Use MA’s Default &amp; Recovery Database (DRD) over 1987–2019 window, reflects the loss experience of life insurance U.S. corporate holdings across sectors, reflects issuer-level LGD to avoid overweighting outliers, align ultimate recovery with default date and DRD reported MIS’ recommended recovery data source for each default. Average value of LGD = 52%</td>
</tr>
<tr>
<td>Bounds on Base Factors</td>
<td>Upper bound set at 30% unaffiliated common stock factor</td>
<td>Upper bound set at 30% unaffiliated common stock factor</td>
<td>Upper bound set at 30% unaffiliated common stock factor. Consider alignment of C1 factors with values falling below those of other assets to avoid unintended risk-shifting incentives.</td>
</tr>
<tr>
<td>Concentration Factors</td>
<td>Doubling C1 factor of top ten holdings</td>
<td>Doubling C1 factor of top ten holdings</td>
<td>Further explore changes to the identification of top concentration risk contributors, and to the measurement of their contribution to concentration risk.</td>
</tr>
</tbody>
</table>
## Pre-Tax Proposed Base Factors

Incremental effects of targeted improvements; last column includes impact of full MA proposal

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aaa</td>
<td>0.390%</td>
<td>0.290%</td>
<td>0.319%</td>
<td>0.313%</td>
<td>0.310%</td>
<td>0.292%</td>
<td>0.245%</td>
<td>0.278%</td>
<td>0.153%</td>
<td>0.153%</td>
</tr>
<tr>
<td>Aa1</td>
<td>0.390%</td>
<td>0.420%</td>
<td>0.430%</td>
<td>0.444%</td>
<td>0.441%</td>
<td>0.426%</td>
<td>0.360%</td>
<td>0.397%</td>
<td>0.260%</td>
<td>0.260%</td>
</tr>
<tr>
<td>Aa2</td>
<td>0.390%</td>
<td>0.550%</td>
<td>0.570%</td>
<td>0.572%</td>
<td>0.567%</td>
<td>0.552%</td>
<td>0.460%</td>
<td>0.532%</td>
<td>0.406%</td>
<td>0.406%</td>
</tr>
<tr>
<td>Aa3</td>
<td>0.390%</td>
<td>0.700%</td>
<td>0.720%</td>
<td>0.722%</td>
<td>0.716%</td>
<td>0.690%</td>
<td>0.577%</td>
<td>0.695%</td>
<td>0.503%</td>
<td>0.503%</td>
</tr>
<tr>
<td>A1</td>
<td>0.390%</td>
<td>0.840%</td>
<td>0.860%</td>
<td>0.870%</td>
<td>0.865%</td>
<td>0.828%</td>
<td>0.674%</td>
<td>0.865%</td>
<td>0.635%</td>
<td>0.635%</td>
</tr>
<tr>
<td>A2</td>
<td>0.390%</td>
<td>1.020%</td>
<td>1.060%</td>
<td>1.044%</td>
<td>1.001%</td>
<td>0.970%</td>
<td>0.789%</td>
<td>1.015%</td>
<td>0.790%</td>
<td>0.790%</td>
</tr>
<tr>
<td>A3</td>
<td>0.390%</td>
<td>1.190%</td>
<td>1.240%</td>
<td>1.194%</td>
<td>1.161%</td>
<td>1.106%</td>
<td>0.886%</td>
<td>1.208%</td>
<td>0.977%</td>
<td>0.977%</td>
</tr>
<tr>
<td>Baa1</td>
<td>1.260%</td>
<td>1.370%</td>
<td>1.420%</td>
<td>1.445%</td>
<td>1.410%</td>
<td>1.344%</td>
<td>1.004%</td>
<td>1.343%</td>
<td>1.208%</td>
<td>1.208%</td>
</tr>
<tr>
<td>Baa2</td>
<td>1.260%</td>
<td>1.630%</td>
<td>1.690%</td>
<td>1.710%</td>
<td>1.593%</td>
<td>1.555%</td>
<td>1.250%</td>
<td>1.587%</td>
<td>1.464%</td>
<td>1.464%</td>
</tr>
<tr>
<td>Baa3</td>
<td>1.260%</td>
<td>1.940%</td>
<td>2.000%</td>
<td>2.017%</td>
<td>1.910%</td>
<td>1.866%</td>
<td>1.487%</td>
<td>1.891%</td>
<td>2.090%</td>
<td>2.090%</td>
</tr>
<tr>
<td>Ba1</td>
<td>4.460%</td>
<td>3.650%</td>
<td>3.750%</td>
<td>3.716%</td>
<td>3.475%</td>
<td>3.301%</td>
<td>2.738%</td>
<td>3.822%</td>
<td>3.070%</td>
<td>3.070%</td>
</tr>
<tr>
<td>Ba2</td>
<td>4.460%</td>
<td>4.660%</td>
<td>4.760%</td>
<td>4.710%</td>
<td>4.393%</td>
<td>4.385%</td>
<td>3.634%</td>
<td>4.681%</td>
<td>4.399%</td>
<td>4.399%</td>
</tr>
<tr>
<td>Ba3</td>
<td>4.460%</td>
<td>5.970%</td>
<td>6.160%</td>
<td>6.258%</td>
<td>5.744%</td>
<td>5.756%</td>
<td>5.812%</td>
<td>5.849%</td>
<td>5.849%</td>
<td>5.849%</td>
</tr>
<tr>
<td>B1</td>
<td>9.700%</td>
<td>6.150%</td>
<td>6.350%</td>
<td>6.287%</td>
<td>5.909%</td>
<td>5.874%</td>
<td>5.778%</td>
<td>7.672%</td>
<td>7.176%</td>
<td>7.176%</td>
</tr>
<tr>
<td>B3</td>
<td>9.700%</td>
<td>11.480%</td>
<td>11.820%</td>
<td>11.461%</td>
<td>10.739%</td>
<td>10.691%</td>
<td>9.163%</td>
<td>12.329%</td>
<td>12.131%</td>
<td>12.131%</td>
</tr>
<tr>
<td>Caa1</td>
<td>22.310%</td>
<td>16.830%</td>
<td>17.310%</td>
<td>16.563%</td>
<td>14.932%</td>
<td>14.847%</td>
<td>13.180%</td>
<td>15.753%</td>
<td>16.590%</td>
<td>16.590%</td>
</tr>
<tr>
<td>Caa2</td>
<td>22.310%</td>
<td>22.800%</td>
<td>23.220%</td>
<td>22.637%</td>
<td>20.283%</td>
<td>20.167%</td>
<td>18.492%</td>
<td>19.535%</td>
<td>23.320%</td>
<td>23.320%</td>
</tr>
<tr>
<td>Caa3</td>
<td>22.310%</td>
<td>33.860%</td>
<td>34.110%</td>
<td>34.046%</td>
<td>32.431%</td>
<td>32.373%</td>
<td>31.140%</td>
<td>28.883%</td>
<td>32.284%</td>
<td>32.284%</td>
</tr>
</tbody>
</table>

The economic state scalars are generally more punitive for higher MIS ratings, resulting in a counterfactual flattening of risk across MIS ratings. Default rate term structures representing experience of life insurance holdings tend to be more separated across MIS ratings than Academy proposed, and closer aligned to benchmarks. A higher Risk Premium lowers the C1 base factors and mildly increases their cross-sectional variation (or slope).

---

**MOODY’S ANALYTICS**

**Proposed Updates to the RBC C1 Bond Factors**

15
Proposed Updates to the RBC C1 Bond Factors 16

Impact on post-PAF C1 RBC
- Higher post-PAF RBC, on average, across the life industry compared to current
- Larger post-PAF RBC increase compared to current, on average, for insurance companies with small and medium number of issuers, but much less so than that under Academy’s proposal

Identification of weakly capitalized firms
- MA’s proposed C1 base factors are more differentiated across MIS ratings (i.e., have a steeper slope) compared to both the current and Academy proposed, in the investment grade range in particular, more accurately reflecting the underlying economic risks
  - Correlation model overcomes an undesirable property of the economic state model resulting in C1 base factors not sufficiently differentiated across MIS ratings and may even result in non-monotonic factors (higher for higher MIS rating categories)
- MA’s proposed PAFs are more conservative than the Academy proposed
  - Sit between the current PAFs and the Academy proposed
  - MA proposed correlation model
    - calibrated to default correlations and diversification benefits observed empirically allowing for a more accurate and conservative reflection of issuer diversification benefits
    - overcomes an undesirable property of the economic state model resulting in more issuer diversification benefits (i.e., lower default correlations) than observed empirically. The economic state model implies PAFs that are overly punitive (lenient) to portfolios with small (larger) number of issuers

Summary of MA Proposed C1 Factors and their Impact
- Improved solvency; Better identified weakly capitalized firms; Reduce risk shifting
- More accurate C1 base factors and PAF
- Data and methodologies to better capture economic risks

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10-892

Attachment Four-F4

Capital Adequacy (E) Task Force 7/28/21

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NAIC Proceedings – Summer 2021

Attachment Four-F4

MOODY’S ANALYTICS

Proposed Updates to the RBC C1 Bond Factors 16
Timeline
Phase 1

» By March 31
  – V1 proposed factors, iterating with NAIC and ACLI
    • Consensus on methodology, data, and performance criteria
    • Consensus on target probability
  – V1 light documentation
  – V1 initial industry impact analysis
  – Focus group discussions

» By April 30
  – Proposed factors for public comment
  – Initial documentation and validation
  – Impact analysis, iterating with NAIC and ACLI
    • Consensus on methodology, data, and limitations
    • Consensus on target probability
  – Continued focus group discussions

» By mid-June - June 30
  – Iterating with NAIC and ACLI as needed
    • Final proposed factors
    • Final documentation and validation of factors that meet financial industry standards
  – Continued focus group discussions

» Through August
  – Continued focus group discussions
MOODY'S ANALYTICS

Proposed Updates to the RBC C1 Bond Factors
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met April 15, 2021. The following Working Group members participated: Philip Barlow, Chair (DC); Jennifer Li (AL); Thomas Reedy (CA); Wanchin Chou (CT); Mike Yanacheak and Carrie Mears (IA); John Robinson (MN); William Leung (MO); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Mike Boerner and Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. Discussed Comment Letters on the Academy’s Proposed Bond Factors

Jim Hodges (National Alliance of Life Companies—NALC) stated that his company provided a comment letter (Attachment Four-G1). He recommended that the Working Group provide real-world examples of the impact that the bond factor changes would have on smaller companies. He noted that the NALC primarily represents smaller life insurance companies. He said that the NALC conducted a survey of its member companies, and of the 12 companies that responded, all but one reported the new factors would require a change of company capital between 7% and 17% and noted a negative impact on their risk-based capital (RBC) ratio between 6.6% and 11.14%. He said this would have an adverse impact on the capital position of smaller life insurance companies without any change in portfolio or risk.

Mr. Hodges stated that commercial transactions—such as loan documents, reinsurance agreements and other agreements—contain RBC covenants that provide for defaults to be declared if RBC covenants are violated. He stated that he is concerned that the proposed changes would force some companies into noncompliance with financial covenants, triggering a material and adverse impact on these companies.

Mr. Barlow noted that it is likely that the affected calculations were related to the portfolio adjustments and said that the Working Group is willing to modify these. He said that the Working Group’s focus is on identifying weakly capitalized companies and not on covenants that are based on RBC. He stated that RBC is not static and would change over time, so there is a risk for companies that use RBC in various financial covenants.

Mr. Robinson asked if there has been a calculation that shows the impact of the new factors when applied to all companies. Dave Fleming (NAIC) said that he had sent a preliminary calculation to Mr. Barlow for his review, which will be sent to the Working Group.

Steve Clayburn (American Council of Life Insurers—ACLI) stated that his company provided a comment letter (Attachment Four-G2), which lists his five main issues. He stated that his concerns are primarily with the portfolio adjustment factor and that this can be punitive for smaller and mid-sized life insurers. He noted that he believes that the issues that he has noted in his comment letter are addressed by the Moody’s Analytics proposal.

Nancy Bennett (Academy) stated that the Academy has given consideration to the age of assumptions used to develop the factors.

2. Discussed the Moody’s Analytics Updated Report on Bonds

Amnon Levy (Moody’s Analytics) provided a presentation (Attachment Four-G3) on Moody’s Analytics recommended approach to updating the bond factors. He noted that he believes that his proposed C1 factors will allow data and methodologies to better capture economic risk, provide more accurate C1 base factors and portfolio adjustment factors, and improve solvency by better identifying weakly capitalized firms.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
April 8, 2021

Mr. Philip Barlow
Chair, Life Risked Based Capital E Working Group
National Association of Insurance Commissioners
Kansas City, Missouri

Re: Bond Factors and Companion Portfolio Adjustment Formulas

Dear Mr. Barlow:

I am the Executive Director of the National Alliance of Life Companies (the NALC), a trade group of more than fifty (50) members and associates that represents the interests of small life insurance companies in the United States. We have closely followed the work of the American Academy of Actuaries regarding proposed changes in the bond factors and the portfolio adjustment factors (herein new bond factors) for investments held by life insurance companies. We have also read the preliminary report of Moody’s Analytics commissioned by the American Council of Life Insurers (the ACLI) on the impact of such changes.

We felt it would be helpful for the Working Group to hear real-world examples of the impact of these proposed bond factor changes, so we surveyed a number of small life insurance companies around the country to better assess the impact. In our survey, we looked at the Required Change in Company Capital Level based on new bond factors, as well as the RBC Ratio Percentage Change using the new bond factors. The survey was done prior to the Academy update for the decrease in the corporate tax rate.

Of the twelve companies responding to the survey, all but one reported the new factors would require a change of company capital between 7% and 17%. Those same companies reported a negative impact on their RBC Ratio of between 6.6% and 11.14%. This clearly demonstrates that the proposed bond factor changes would have a significant adverse impact on the capital position of smaller life insurance companies without any change in portfolio or risk.

One other important point is worth making - it does not appear that the impact of these proposed changes on commercial transactions for life insurance companies has been adequately explored. Many commercial transactions, such as loan documents, reinsurance agreements and other agreements, contain RBC covenants which provide for defaults to be declared if RBC covenants are violated. Of course, those provisions were negotiated and agreed to under current bond factors and RBC calculations. We are very concerned that the proposed changes would force some companies into non-compliance with those covenants, triggering a material and adverse impact on these companies. We would note further that this an issue for companies of all sizes with such covenants in place.
Based upon these and other considerations, the NALC urges the Task Force to closely examine the potential adverse business consequences of the proposed changes on small life insurance companies and their policyholders. We appreciate the positive comments that have been made about regulatory discretion as a means to mitigate the adverse effects of these changes. That approach could reduce the negative impact of the changes on a company by company basis. An additional approach would be to allow a generous phase in period that would allow companies sufficient time to make the necessary adjustments to their bond portfolios.

Thank you for allowing us to comment. We are happy to provide summary details regarding our surveys if helpful.

Sincerely,

Jim Hodges
Executive Director
NALC
April 9, 2021
Mr. Philip Barlow
Chair
NAIC Life Risk-Based Capital Working Group

Sent via email: dfleming@naic.org

RE: Updated Corporate Bond Risk-Based Capital (RBC) Factors with 21% Tax Rate

Dear Philip:

The American Council of Life Insurers (ACLI) appreciates the opportunity to comment on the most recent RBC C-1 factors and portfolio adjustment factors provided by the American Academy of Actuaries (“Academy”) dated March 11, 2021, which were updated to reflect the current corporate tax rate of 21%.

As stated in several previous comment letters¹, ACLI has concerns with the underlying model and are not supportive of the implementation of the proposed factors. Of greatest concern are the following:

1. Default correlations and the resulting portfolio adjustment. The Academy’s economic state model implies very low default correlations, leading to a portfolio adjustment factor that is overly punitive to portfolios with a small number of holdings and overly lenient to portfolios with a large number of holdings. A near-zero assumption of default correlations runs counter to historical observations and may tend to overstate diversification benefits.

2. Modeling approach and the resulting slope of factors. The proposed factors are based on a projection of defaults for each rating category, leading to a misstated assessment of risk for bond portfolios as a whole. This modeling choice leads to an overestimation of projected losses on investment-grade bonds relative to below-investment-grade bonds.

¹https://content.naic.org/sites/default/files/nine-files/Academy%27s%20August%202015%20Report_Comment%20Letters.pdf (p 1-7);
https://content.naic.org/sites/default/files/nine-files/Academy%27s%20June%202017%20Report_Comment%20Letters.pdf (p 5-12);
https://content.naic.org/sites/default/files/nine-files/Academy%27s%20October%202017%20Report_Comment%20Letters.pdf
3. **LGD approach and resulting misestimated factors.** The underlying model’s approach to loss given default (LGD) uses issue-level data, which tends to overweight outlier data points. This approach gives undue influence to defaulted issuers that had many issues.

4. **Risk premium assumption.** The underlying model’s assumed risk premium, which is set equal to the expected loss, is inconsistent with the statutory reserving framework. The risk premium assumption should reflect the fact that reserves make provision for more than mean expected loss. This is explicit at a CTE 70 level in Principle-Based Reserves (PBR) and is implicitly evident in pre-PBR reserves. As the Academy stated in its 2015 report on its proposal, “The general consensus in the actuarial community is that statutory policy reserves (tabular plus additional reserves due to cash flow testing) at least cover credit losses up to one standard deviation (approximately 67th percentile).” We note that one standard deviation above the mean is actually closer to the 83rd percentile in a Normal distribution, as all of the losses below the mean are covered (rather than just being within one standard deviation both below and above the mean).

5. **Omission of recent historical data.** The underlying model does not include historical default and recovery data more recent than 2012. As the Academy states in the exposed letter, “While we have not modeled any assumption changes, we are concerned that the factors in this letter may be lower than what an analysis of updated data would produce.” It is important to include as much recent and relevant experience as possible.

Aside from these direct model limitations, the underlying model has characteristics that may not produce valid factors for certain asset classes.

ACLI has consistently conveyed its concerns with the modeling for the proposed factors. Corporate bonds are the largest life industry asset class (over $3 trillion), and it is important for the regulatory capital requirements to reflect the risk appropriately. We appreciate the willingness of the Financial Condition (E) Committee and the Life RBC Working Group to consider an alternative set of factors currently being developed by Moody’s Analytics. We look forward to discussing the Moody’s Analytics proposal with the Working Group in the near future.

Sincerely,

Steven Clayburn

cc: Dave Fleming, NAIC Senior Insurance Reporting Analyst
    Paul Graham, Senior Vice President, Policy Development

---

2 Model Construction and Development of RBC Factors for Fixed Income Securities for the NAIC’s Life Risk-Based Capital Formula, American Academy of Actuaries C1 Work Group, August 3, 2015
1. Executive Summary
2. Comparison of C1 Factors and C1 RBC Industry Impact
3. Impact of Proposed Targeted Improvements
Executive Summary

Scope

Proposing C1 factors to reflect economic risks with capital requirements across NAIC ratings and sectors of insurers' portfolios, aiming to cover moderately adverse conditions. A higher risk premium lowers the C1 base factors and mildly increases the cross-sectional range within ratings, resulting in a counterfactual flattening of risk across NAIC ratings, while also correcting for PAF issues described in Step 1.

New Metrics:

- MA proposed default rates tend to have a steeper slope (more separated across MIS ratings) than those proposed by the Academy, with separation more closely aligning with financial institutions that tend to issue shorter term debt under PAF section.
- MA proposed C1 factors are more differentiated across ratings, while also correcting for PAF issues described in Step 1.
- MA proposed correlation model results in C1 base factors that are more conservative and mitigate risk shifting incentives with new bond purchases.
- MA proposed default rates tend to have a steeper slope (more separated across MIS ratings) than those proposed by the Academy, with separation more closely aligning with financial institutions that tend to issue shorter term debt under PAF section.
- MA proposed correlation model results in C1 base factors that are more conservative and mitigate risk shifting incentives with new bond purchases.
- MA proposed correlation model results in C1 base factors that are more conservative and mitigate risk shifting incentives with new bond purchases.
- MA proposed correlation model results in C1 base factors that are more conservative and mitigate risk shifting incentives with new bond purchases.

Findings

- MA proposed C1 factors are more differentiated across ratings, while also correcting for PAF issues described in Step 1.
- MA proposed correlation model results in C1 base factors that are more conservative and mitigate risk shifting incentives with new bond purchases.
- MA proposed C1 factors are more differentiated across ratings, while also correcting for PAF issues described in Step 1.
- MA proposed correlation model results in C1 base factors that are more conservative and mitigate risk shifting incentives with new bond purchases.
- MA proposed correlation model results in C1 base factors that are more conservative and mitigate risk shifting incentives with new bond purchases.
- MA proposed correlation model results in C1 base factors that are more conservative and mitigate risk shifting incentives with new bond purchases.
- MA proposed correlation model results in C1 base factors that are more conservative and mitigate risk shifting incentives with new bond purchases.
- MA proposed correlation model results in C1 base factors that are more conservative and mitigate risk shifting incentives with new bond purchases.

Immediate Next Steps

- Provide guidance on approaches and data and methodology best practice
- Provide proposals for development of actuarial standards and forms

Performance

- Provide guidance on approaches and data and methodology best practice
- Provide proposals for development of actuarial standards and forms
Initially outside scope, economic state model limitations viewed to be sufficiently material that MA recommends replacing with correlation model that reflects diversification benefits observed empirically.

The economic state model:
- While calibrated to the level of defaults observed in economic contractions and recessions
- Implies more issuer diversification benefits (i.e., lower default correlations) than observed empirically
- Implies PAFs that are overly punitive (lenient) to portfolios with small (larger) number of issuers

MA proposes a correlation model calibrated to default correlations observed empirically allowing for a more accurate and conservative reflection of issuer diversification benefits.

### Proposed Portfolio Adjustment Factor (PAF)

<table>
<thead>
<tr>
<th>Thresholds</th>
<th>Current</th>
<th>Proposed</th>
<th>MA Preliminary Proposed PAF</th>
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<tr>
<td>(Up to) 10</td>
<td>2.50</td>
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<td>7.80</td>
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<tr>
<td>(Next) 90</td>
<td>1.83</td>
<td>1.75</td>
<td>1.75</td>
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<tr>
<td>(Next) 100</td>
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<td>1.00</td>
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<tr>
<td>(Next) 300</td>
<td>0.86</td>
<td>0.85</td>
<td>0.80</td>
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<tr>
<td>(Above) 500</td>
<td>0.90</td>
<td>0.75</td>
<td>0.75</td>
</tr>
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</table>

*Current PAF converted to Academy's proposed thresholds for better comparison.

### Post-PAF C1 RBC Industry Impact – Complete Portfolio Holdings

Post-PAF RBC proposed by MA is higher than the current level.

#### Post-PAF C1 RBC Impact by Life Company

Complete portfolio holdings

- MA proposed correlation model is parameterized to default correlations observed empirically allowing for a more accurate and conservative reflection of issuer diversification benefits.
- MA's proposal are generally higher than current. The difference is relatively constant across life companies of different sizes.
- Academy's proposal are generally higher for portfolios with a small or medium number of issuers, often several times higher than current levels. This is driven largely by the economic state model implying more issuer diversification benefits (i.e., lower default correlations) than observed empirically.

Life companies with Current Post-PAF RBC below $100K are not displayed in this figure.

### Summary of Proposed Targeted Improvements to the C1 Factors

- MA's proposal are generally higher than current. The difference is relatively constant across life companies of different sizes.
- Academy's proposal are generally higher for portfolios with a small or medium number of issuers, often several times higher than current levels. This is driven largely by the economic state model implying more issuer diversification benefits (i.e., lower default correlations) than observed empirically.
Part 1 of 2: Most Impactful Targeted Improvements

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Academy Proposal</th>
<th>ARS Proposal</th>
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</thead>
<tbody>
<tr>
<td>Economic State Model</td>
<td>Incorporates an economic state model with a correlation model to capture economic risks</td>
<td>Incorporates an economic state model with a correlation model to capture economic risks</td>
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<tr>
<td>Credit Ratings</td>
<td>Groups credit ratings into alphabetical categories</td>
<td>Groups credit ratings into alphabetical categories</td>
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<tr>
<td>Risk Premiums</td>
<td>Ratios are set based on corporate default rates</td>
<td>Ratios are set based on corporate default rates</td>
</tr>
<tr>
<td>Pre-Tax Proposed Base Factors</td>
<td>Incorporates additional factors, including a correlation model</td>
<td>Incorporates additional factors, including a correlation model</td>
</tr>
</tbody>
</table>

Part 2 of 2: Remaining Targeted Improvements

<table>
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<tr>
<th>Stakeholder Group</th>
<th>Academy Proposal</th>
<th>ARS Proposal</th>
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<td>Incorporates an economic state model with a correlation model to capture economic risks</td>
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<tr>
<td>Credit Ratings</td>
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<tr>
<td>Risk Premiums</td>
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<td>Ratios are set based on corporate default rates</td>
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<td>Pre-Tax Proposed Base Factors</td>
<td></td>
<td>Incorporates additional factors, including a correlation model</td>
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Pre-Tax Proposed Base Factors

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<th>MIS Rating</th>
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<th>ARS</th>
<th>Pre-Tax</th>
<th>Academy</th>
<th>ARS</th>
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<td>2.000%</td>
<td>2.017%</td>
<td>1.910%</td>
<td>1.898%</td>
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<tr>
<td>Baa2</td>
<td>1.260%</td>
<td>1.630%</td>
<td>1.690%</td>
<td>1.710%</td>
<td>1.593%</td>
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<tr>
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<td>1.370%</td>
<td>1.420%</td>
<td>1.445%</td>
<td>1.410%</td>
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</tr>
<tr>
<td>B2</td>
<td>9.700%</td>
<td>8.320%</td>
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<td>0.430%</td>
<td>0.444%</td>
<td>0.444%</td>
<td>0.441%</td>
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</table>

Summary of MA Proposed C1 Factors and their Impact

- Impact on post-PNC C1-RBC
  - Higher post-PNC RBC, on average, across the life industry compared to current
  - Lower post-PNC RBC, increase compared to current, an average, for insurance companies with small and medium number of issuers, but much less so than that under Academy’s proposal

- Identification of weakly capitalized firms
  - MA’s proposed C1 base factors are more differentiated across MIS ratings (i.e., have a steeper slope) compared to both the current and Academy proposal. In the investment grade range in particular, more accurately reflecting the underlying economic risks
  - Correlation model overcomes an underestimation property of the economic state model resulting in C1 base factors not sufficiently differentiated across MIS ratings and may even result in non-monotonic factors (higher for higher MIS rating categories)
  - MA’s proposed PAFs are more differentiated than the Academy proposal
  - B2 between the current PAFs and the Academy proposal
  - MA proposed correlation model
  - Calibration to default correlations and diversification benefits observed empirically allowing for a more accurate and conservative reflection of issuer diversification benefits
  - Overcomes an undesirable property of the economic state model resulting in more issuer diversification benefits (i.e., lower default correlation) than observed empirically

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Timeline
Phase 1

- By March 31
  - V1 proposed factors, iterating with NAIC and ACLI
  - Consensus on methodology, risks, and performance criteria
  - Final documentation

- By April 30
  - Impact analysis, iterating with NAIC and ACLI
  - Consensus on target probability

- By mid-June - June 30
  - Final proposed factors
  - Final documentation and validation of factors that meet financial industry standards
  - Continual focus group discussions

- Through August
  - Continual focus group discussions

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The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met April 6, 2021. The following Working Group members participated: Philip Barlow, Chair (DC); Jennifer Li (AL); Thomas Reedy (CA); Wanchin Chou (CT); Sean Collins (FL); Mike Yanacheak and Carrie Mears (IA); Vincent Tsang (IL); John Robinson (MN); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); and Mike Boerner and Rachel Hemphill (TX).

1. Discussed the ACLI Real Estate Proposal

John Bruins (American Council of Life Insurers—ACLI) stated that there are three attachments that he would be discussing: 1) a summary of the edits (Attachment Four-H1); 2) proposal 2021-06-L (Instructions and Factors); and 3) proposal 2021-01-L (Structure).

Mr. Bruins stated that the intent of the revisions was to add in conservatism to the factors. He noted that the proposal will keep the Schedule A factor at 11%, will increase the Schedule BA factor from 12% to 13%, decrease the amount of the excess of fair value over book value from two-thirds to one-half, and retain the factor for encumbrances at 1.75%.

Mr. Barlow asked if there were any questions or comments from members of the Working Group regarding the decrease in the amount of the excess of fair value over book value from two-thirds to one-half. Mr. Robinson stated that there may be other asset classes that deserve a similar treatment. Mr. Barlow stated that it is unlikely that the Working Group would address that issue at this time, but it may be addressed next year.

Edward Toy (Risk & Regulatory Consulting) noted that the fair value reporting instructions come from the statutory accounting principles. He noted that the guidance is general and vague, that the guidance does not require an independent third-party to do the appraisal, can use an internal appraiser and only requires that an appraisal be done every five years.

Mr. Barlow stated that the market value of real estate, as it is reported now, only serves as information and does not affect the financial statements and does not affect anything outside of risk-based capital (RBC).

Julie Gann (NAIC) stated that she agrees with Mr. Barlow and noted that the fair value that is reported is used as a proxy for the entity to use when assessing other the temporary impairment for statutory accounting, but it is not used for anything else unless there are impairment issues noted. She stated that her data reviews agree with the comments from Mr. Toy.

Mr. Carmello said he believes making a structural change during the COVID-19 pandemic is a mistake, and Mr. Leung and Mr. Reedy agreed. Mr. Tsang stated that when these revisions are exposed, he would like to hear comments related to whether the decrease in the amount of the excess of fair value over book value from two-thirds to one-half is adequate.

Ms. Mears suggested a referral be sent to the Statutory Accounting Principles (E) Working Group. Ms. Gann agreed and suggested a referral also be sent to the Examination Oversight (E) Task Force. Dave Fleming (NAIC) suggested that a referral be sent to the Risk-Focused Surveillance (E) Working Group.

Mr. Barlow asked if the Working Group should consider different factors for different types of real estate. Mr. Tsang stated that he believes one factor for all real estate reported on Schedule A is adequate. Mr. Barlow asked if there were any objections to there being different factors for assets reported on Schedule A versus Schedule BA, and no objections were noted.

Mr. Barlow directed NAIC staff to expose the proposal 2021-06-L (Instructions and Factors) from the ACLI for a 45-day public comment period.

Mr. Bruins noted that in the earlier exposure of Proposal 2021-01-L, the note at the bottom of Figure 7 needed to be revised to clarify that it cannot go below zero.
Mr. Robinson made a motion, seconded by Ms. Mears, to adopt the real estate structure that was previously exposed (see NAIC Proceedings – Summer 2021, Capital Adequacy (E) Task Force, Attachment Two-A), with the revision to the note to clarify that Column 7 cannot go below zero. The motion passed unanimously.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
A. Proposal Modifications

We are proposing to add further conservatism to the proposal in two aspects to address any ongoing concerns:

a. retain the proposed factor for Schedule A real estate of 11%
b. increase the proposed factor for Schedule BA real estate from 12% to 13%
c. decrease the amount of the excess of fair value over book value used to recognize reduced risk from 2/3 to ½
d. retain the factor for encumbrances of 1.75%

B. Floor of zero on adjusted factor

<table>
<thead>
<tr>
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<th>FV</th>
<th>Adjusted - no floor</th>
<th>Adjusted - floor</th>
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</tr>
<tr>
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<td>2000</td>
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<td>5.50%</td>
</tr>
<tr>
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<tr>
<td>1000</td>
<td>5000</td>
<td>-11.00%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met March 30, 2021. The following Working Group members participated: Philip Barlow, Chair (DC); Jennifer Li (AL); Thomas Reedy (CA); Wanchin Chou (CT); Sean Collins (FL); Mike Yanacheck and Carrie Mears (IA); Vincent Tsang (IL); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Mike Boerner and Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. Discussed the Academy’s Bond Factors Updated for Tax

Nancy Bennett (American Academy of Actuaries—Academy) presented the Academy’s latest set of bond factors. She stated that the Academy used its recommended bond factors from Oct. 17, 2017, and updated the model for the 21% corporate tax rate. She noted that there may be a need to round the factors or to include a cap for the factors at 30%, similar to that used for common stock. She noted that the proposal includes updates to the portfolio adjustment formula for the two base factors and provides a statistical safety level in the 96th percentile.

Jerry Holman (Academy) stated the Working Group could adjust the factors for smaller companies to reduce the potential for a negative impact. Scott Harrison (National Alliance of Life Companies—NALC) stated that his group will provide comments with alternative factors for smaller companies.

Mr. Barlow noted that the Working Group has two potential tracks to completing the bond factors project by the end of 2021. First is the work that the Academy has done on bonds that have been reviewed by the Investment Risk-Based Capital (E) Working Group. Second is to consider the American Council of Life Insurers (ACLI) project, with Moody’s Analytics, which is an alternative to the Academy’s approach.

Mr. Barlow directed NAIC staff to expose the Academy’s updated bond factors, included in the Academy’s March 11 letter, (Attachment Four-I1) for a 10-day public comment period ending on April 9.

2. Received an Update on the Moody’s Analytics Bond Report

Amnon Levy (Moody’s Analytics) provided a report on Moody’s Analytics (Attachment Four-I2) recommended approach to updating the bond factors. He stated that Moody’s Analytics included a modification to fix an error with ratings where the default rates and loss given default can be drawn from separate states in simulation. He also stated that the Moody’s Analytics update provided several updates to the input parameters, including evaluating a range of discount rates with the updated tax rates, updating the loss given default distribution to align with empirical patterns, updating the risk premium to align with reserving, updating baseline default rates to utilize Moody’s historical data and internal benchmarks, and updating the portfolio adjustment factors.

Mr. Chou asked for clarification on the approach that was being presented and how this would work with the Working Group’s current schedule. Mr. Levy stated that the Moody’s Analytics proposal would follow the Working Group’s schedule. Mr. Tsang stated the risk premium item will need more discussion. Mr. Barlow asked if Mr. Levy can do additional sensitivity analysis on the risk premium. Mr. Carmello asked for clarification on the Academy’s assumptions. Mr. Holman stated that the Academy’s expected losses is approximately the 60th percentile. Ms. Bennett noted that the Academy had considered the issue of moving loss given default from issue to issuer but had found this caused issues with reporting.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.

W:\QA\RBC\LRBC\2021\Calls and Meetings\3_30_21 Call\Att Life RBC 3-30-21 Minutes.docx
March 11, 2021

Philip Barlow
Chair
Life Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners (NAIC)

Dear Philip,

On behalf of the American Academy of Actuaries\(^1\) C1 Work Group (C1WG), we present to the Life Risk-Based Capital (E) Working Group updated base bond factors and a companion portfolio adjustment formula to reflect corporate tax rates enacted by the Tax Cuts and Jobs Act of 2017 for the Life Risk-Based Capital (LRBC) formula. The C1WG’s most recent recommendation on updated bond factors was provided to the NAIC’s Investment Risk-Based Capital Working Group on October 10, 2017.\(^2\) No other changes have been made to the October 17, 2017, recommendation.

As we have done in previous reports to the NAIC, we are providing direct model output for the base factors. As is the case with the current capital requirements for bonds, we recommend capping the base factor for the lowest-quality bond designation at 30%. Note that this approach caps the capital requirement for bonds at the base factor for unaffiliated common stock. In addition to capping the factor, we have not rounded any of the factors, as was done for the current bond factors.

### A. UPDATED BASE FACTORS

The table below shows updated bond factors using a 21% corporate tax rate and the factors recommended in October 2017. These factors are used in the first step in calculating the basic capital requirements for bonds. These factors have been established at the statistical safety level specified by regulators. These factors in combination with the portfolio adjustment are expected to establish required capital at the 96\(^{th}\) percentile over a 10-year time horizon. The assumptions used in developing these factors are based on expected loss given default experience for a portfolio of bonds that is representative of a typical life insurer’s bond portfolio.

In the development of the capital requirements for credit risk, recall that the tax rate affects the net loss flowing through statutory surplus. The factor is based on a discounted after-tax cash flows. As such, an after-tax discount is used in the calculation. In the October 2017 recommendation, the after-tax cash flows were discounted at 3.25%. The updated bond factors are based on after-tax cash flows discounted at

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\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

\(^2\)https://www.actuary.org/sites/default/files/files/publications/Academy_C1WG_Comments_to_NAIC_IRBC_101017.pdf.

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3.95%. Note that both sets of factors are based on a 5% pre-tax rate; only the after-tax discount rate has changed.

### Base C1 Bond Factors

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<th>10.17.2017 Recommendation</th>
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<td>34.11%</td>
<td>33.86%</td>
</tr>
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</table>

### B. UPDATED PORTFOLIO ADJUSTMENT FORMULA

The table below shows an updated portfolio adjustment formula, as developed for the updated base factors above. As a reminder, the purpose of the adjustment is to modify the base calculation for the diversification of the insurer’s bond portfolio, relative to the representative portfolio. The portfolio adjustment increases or decreases the base capital requirement (equal to the arithmetic sum of the base factor times the statutory carrying value of each bond) based on the number of issuers in the insurer’s portfolio.
The representative bond portfolio used in developing the base factors contained 824 issuers. As per the October 2017 recommended portfolio adjustment, the updated portfolio adjustment is neutral or approximately equal to 1.0 for an average portfolio (i.e., a portfolio with the same number of bonds as contained in the representative portfolio.) The updated approach meets that criterion because the exact percentile confidence level of the base factors was selected to reproduce aggregate industry C1 requirements when the base factors are applied to each company portfolio. That said, the confidence level for the base factors is close to the 96th percentile for each rating class, and the portfolio adjustment only captures differences in a company’s diversification risk relative to the representative portfolio.

### Portfolio Adjustment Factors

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<td>Next 90</td>
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<td>0.80</td>
</tr>
<tr>
<td>Over 500</td>
<td>0.75</td>
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</tbody>
</table>

### C. COMMENTS ON THE AGE OF ASSUMPTIONS

The C1WG began its work on the C1 Bond Capital Requirements in 2011. With input from regulators (NAIC’s C1 Factor Review Subgroup, NAIC’s Investment RBC Working Group, and the NAIC’s Life Risk-Based Capital Working Group), the C1WG updated the capital requirements to be used within the U.S. Solvency framework.

Many of the assumptions used in these factors, such as the bond default and recovery assumptions, are based on the experience for corporate bonds through 1983–2012. Other assumptions, notably the discount rate, are also based on data from a similar time period.

We understand that regulators are intent on adopting updated bond factors for the 2021 Life Risk-Based Capital calculation, particularly given the shortfall of the current requirements to meet regulators’ desired statistical safety level for credit risk. However, we would be remiss in not stating our concern about adopting a set of factors based on outdated assumptions.

While we have not modeled any assumption changes, we are concerned that the factors in this letter may be lower than what an analysis of updated data would produce. The base factors recommended in 2017
for bonds, exclusive of the impact of increased requirements from the tax change, increase the capital requirements for credit risk approximately 15-20% for the industry, on average. Updated assumptions might indicate that capital requirements should be increased further. We understand the desire to now adopt factors that move the capital requirements closer to the desired statistical level but encourage regulators to consider more frequent reviews of the assumptions and the resulting factors.

We appreciate your consideration of this update. Please contact Nancy Bennett, senior life fellow (bennett@actuary.org), or Khloe Greenwood, life policy analyst (greenwood@actuary.org), with any questions.

Sincerely,

Nancy Bennett, MAAA, FSA, CERA
Co-Chairperson, C1 Work Group
American Academy of Actuaries

Jerry Holman, MAAA, FSA, CFA
Co-Chairperson, C1 Work Group
American Academy of Actuaries
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Moody’s Corporation is comprised of two separate companies: Moody’s Investors Service and Moody’s Analytics.

Moody’s Investors Service (MIS) provides investors with a comprehensive view of global debt markets through credit ratings and research. Moody’s Analytics provides data, analytics, and insights to equip leaders in financial, non-financial, and government organizations with effective tools to understand a range of risks.

Throughout this document, “Moody’s” refers to an MIS rating, and while references to MIS are made, the views and opinions in this document are solely of Moody’s Analytics.

**Scope**
Moody’s Analytics to provide default probability term structures for each Moody’s corporate rating and resulting C1 Bond Factors, with articulated limitations providing transparency using data and methodologies accessible and repeatable to the NAIC and industry on an ongoing basis.
- NAIC to use as they choose in setting the final C1 factors that are applied to a broad set of credit assets with NAIC ratings.
- Moody’s Analytics is not “certifying”/”validating” default rates for each NAIC rating.

**Heuristic Performance Criteria:**
Align default rates (and C1 factors) with economic risks, mitigating incentives for “regulatory arbitrage”.
- Arbitrage opportunities arise when expected spread-to-capital ratios diverge across ratings.

**Challenges**
- Expected spreads change over time at different magnitudes across ratings and asset classes.
- C1 factors will be applied to a broad range of credit assets, based on the second lowest NRSROs ratings which can have different statistical properties than Moody’s corporate ratings.
- Moody’s credit ratings are opinions of ordinal, horizon-free credit risk, rather than cardinal measures.

**C1 Bond Factors (C1 Factors)**
Scope and performance criteria

- In addition, Moody’s Analytics to provide C1 Bond Factors that can leverage Moody’s expertise and methodologies.
- NAIC to use as they choose in setting the final C1 factors that are applied to a broad set of credit assets with NAIC ratings.
- Moody’s Analytics is not “certifying”/”validating” default rates for each NAIC rating.

**Heuristic Performance Criteria:**
Align default rates (and C1 factors) with economic risks, mitigating incentives for “regulatory arbitrage”.
- Arbitrage opportunities arise when expected spread-to-capital ratios diverge across ratings.

**Challenges**
- Expected spreads change over time at different magnitudes across ratings and asset classes.
- C1 factors will be applied to a broad range of credit assets, based on the second lowest NRSROs ratings which can have different statistical properties than Moody’s corporate ratings.
- Moody’s credit ratings are opinions of ordinal, horizon-free credit risk, rather than cardinal measures.

**Targeted C1 Base Factors Updates**

**Engine & Input Updates**
- **Modifications** to simulation engine that replicated Academy’s factors
  - Error fix for Baa-Caa ratings, where default rates and Loss Given Default (LGD) can be drawn from separate economic states in simulation
  - Assessed impact of simulation noise by increasing the number of simulation trials
- **Updates to input parameters**
  - A. Updated LGD distribution to more closely align with empirical patterns
  - B. Updated Risk Premium to more closely align with reserving
  - C. Updated economic state models and updated baseline default rates to utilize Moody’s historic data and internal benchmarks
  - D. Updated portfolio adjustment factors
  - E. Updated concentration factor (doubling of top-ten holdings)

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A

Explored range of discount rates based on several time windows

Moody's Analytics recognizes the need to parameterize the discount rate with a long-term perspective of long-term interest rates, and the desire for this parameter to be relatively stable while also allowing a closer reflection of the current, low-rate, environment. Several possible candidate windows are considered with sensitivity analysis presented later in the deck:

- 1993−2020 (4.32%)
- 2000−2020 (3.47%)
- 2010−2020 (2.25%)

Discount rate used to calculate the net present value of projected cash flows.

The Academy's model sets the Discount Rate at (5.02%), the average 10-year LIBOR swap rate from 1993−2013. The exact source is not referenced, and the time-series data is not made available to Moody's Analytics.

B

Updated LGD distribution to more closely align with empirical patterns

LGD Distribution

Moody's Analytics estimates using the Default & Recovery Database (DRD)

- Expand the time window to 1967−2019.
  2020 is excluded for two reasons: (1) some bonds may still be at the early stage of recovery due to the lengthy process; (2) current economic state has not yet been officially declared at time of writing.
- Estimate bond LGD to align ultimate recovery with Moody's analyst's recommendation for each default (e.g., settlement, liquidity, or trading price).
- Use issuer-level LGD to construct empirical distribution instead of bond-level LGD, to rule out undue influence of issuers that had many defaults.
- Group issuer-level LGD data into expansion years and contraction years by the year of default rather than the year of emergence.
- Moody's Analytics proposed LGD is higher than the current or the LGD proposed by the Academy.

Tax rate was updated from 35% to 21%.
Updated Risk Premium to align more closely with reserving

**Measuring the Risk Premium**

Within the context of Risk Based Capital:

- **C1 RBC** is the minimum required capital beyond statutory reserves to buffer against a tail loss credit loss scenario.
- Statutory reserves are liabilities ensuring policy claims can be paid off under a moderate downturn scenario.
- Risk Premium is an offset to RBC; it is part of statutory reserves provisioned against default loss under a moderate downturn scenario.

**Default Loss Under Statutory Reserves**

VM-20 coverage exceeds expected loss.

Under VM-20 DR and SR CTE 70, default loss (baseline Default Cost Factor) is subtracted from investment return in the asset model:

- **CTE70** represents the mean between the 70th and 100th percentiles.
- CTE70 can be approximated by the 88th percentile default loss.

Under VM-21 (applicable to all in force), the Variable Annuity asset model also reflects default cost prescribed by VM-20. In addition, VM-22, the Payout Annuity asset model, is being updated with the same framework in mind.

If we strictly follow these rules, the Risk Premium can be set at around the 88th percentile or mean plus one standard deviation of the default loss distribution (as shown in the next slide).

Separately, C3 Phase 1 will be applicable to all in force Fixed and Indexed Annuities and includes updated to include a similar default cost. Once finalized, the Risk Premium should be reevaluated to avoid double counting of credit risk.

**Revisited economic state models and updated baseline default rates to utilize Moody’s historic data and internal benchmarks.**
Moody's credit ratings are opinions of ordinal, horizon-free credit risk.*
- They do not target specific default rates or expected loss rates.

Assessments of relative credit risk rather than cardinal risk measures.*

"If ratings targeted specific default and loss rates, this would likely require frequent widespread rating actions in anticipation of economic and market changes that might broadly push default and loss rates sharply higher or lower for a set period of time. Due to the inherent volatility of general credit and market conditions, such widespread rating changes would likely soon need to be reversed. Therefore, the use of cardinal targets would result in much higher rating volatility and disruption for investors without meaningfully improving the cardinal predictive power of ratings over medium and long-term horizons."

Rating Symbols and Definitions 26 January 2021.

Moody's Investor Service Annual Default Study provides historical default rate term structures.
- Raw empirical term structures are useful, but not appropriate in raw form, and in this context:
  - While default rates along the ratings scale are highly monotonic, instances of non-monotonicity will flow into non-monotonicity in capital along the ratings scale. These instances are observed across horizons ranging from 1-10 years, thus requiring subjective overrides to ensure monotonicity in cumulative default rate term structures across ratings.
  - Have point estimates with limited statistical reliability at higher end of the credit rating scale.
- There have been 6 defaults within 10 years of being assigned a Aaa rating since 1983.
  - Getty Oil and Texaco were the two issuers that defaulted within 10-years of Aaa rating, and they experienced extremely high recovery (~97% and ~88%).

Idealized default rates from Rating Symbols and Definitions.
- Used as benchmarks by Moody's analysts across asset classes and recognized as having a relationship with actual default rates that has varied over time. Moody's ongoing use of the Idealized Rates for modeling purposes does not depend on the strength of that relationship over any particular time horizon.
- In addition, it is recognized that different asset classes are driven by different risk factors, attributed to different fundamental strengths, weaknesses, and the inherent nature of each sector.
- While originally constructed in 1989, Moody's Investors Service has periodically reviewed its idealized default rate tables and has no plans to revise them at the time of this writing.
- 10-year idealized default rates based on historic defaults from 1970-1989 for all but Aaa and Aa, that were set lower than their historical default rates.
  - At upper end of the credit spectrum, death of defaults and possibly high recovery makes default events difficult to use in isolation given the context. Between 1970-1989:
    - Getty Oil and Texaco were the two issuers that defaulted within 10 years of Aaa rating, and they experienced extremely high recovery (~97% and ~88%).
  - There were 10 Aa defaults.
Broader Set of Pre-Tax Factors
Considerations when setting C1 bond factors

C1 bond factors should align with the broader set of C1 factors, to avoid unintended risk-shifting incentives.

- C1 RBC factors that may be worth considering on the lower bound:
  - Cash, cash equivalent, short-term investment 0.40%
  - Federal guaranteed low-income housing tax credits 0.14%
  - Receivables for securities 0.14%
  - Residential mortgages — insured or guaranteed 0.14%
  - Government full-faith bonds 0%

- C1 RBC factors that may be enter into considerations on the upper bound:
  - Common stock 30%
  - Hedge fund, private equity 30%

Considerations when setting C1 bond factors

Updated portfolio adjustment factors

Portfolio Adjustment Factors (PAF)
Overview of Moody's Analytics findings

- Moody's Analytics has been able to closely replicate the Academy's PAF when the framework is parametrized to the PD, LGD, and Risk Premium proposed by the Academy.
- The economic state model implies investment grade default correlations at approximately zero (within simulation noise), and much lower than those observed empirically.
- This suggests adjustment factors calibrated to the economic state model is not appropriate for use as it overstates name diversification benefits.
- Intuitively, if assets are perfectly correlated, diversification is achieved with a single asset.
- The lower the correlation, the more assets are needed to hit an asymptote, suggesting the adjustment function calibrated to the economic state model is overly punitive (lenient) to portfolios with a small (larger) number of holdings.
- Using a benchmark framework calibrated to empirical default correlations suggests an adjustment function that sits somewhere in between the current adjustment factors and those proposed by the Academy.
- A full update to align the entire framework with empirical default correlations is beyond Phase 1 scope.
necessary measures so that the information it uses in assigning a credit rating is of sufficient quality and from sources MOODY'S considers to be reliable.

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Moody's Investors Service operates as a credit rating agency subsidiary of Moody's Corporation. Moody's Investors Service's credit ratings are an opinion as to the relative likelihood of a credit event, usually default, occurring within the time period of the rating. Moody's Investors Service operates within a framework of independent credit rating processes and standards across its global business units and 更新了的信用评估方法。信用评级是基于对评级对象的财务状况、经营历史、行业趋势和其他经济因素的评估，以确定其偿债能力。

信用评级基于对评级对象的财务状况、经营历史、行业趋势和其他经济因素的评估，以确定其偿债能力。信用评级是基于对评级对象的财务状况、经营历史、行业趋势和其他经济因素的评估，以确定其偿债能力。信用评级是基于对评级对象的财务状况、经营历史、行业趋势和其他经济因素的评估，以确定其偿债能力。信用评级是基于对评级对象的财务状况、经营历史、行业趋势和其他经济因素的评估，以确定其偿债能力。
What RBC Pages Should Be Submitted?

For year-end 2021 life and fraternal risk-based capital (RBC), submit hard copies of pages LR001 through LR049 to any state that requests a hard copy in addition to the electronic filing. Starting with year-end 2007 RBC, a hard copy was not required to be submitted to the NAIC. However, a portable document format (PDF) file representing the hard copy filing is part of the electronic filing.

If any actuarial certifications are required per the RBC instructions, those should be included as part of the hard copy filing. Starting with year-end 2008 RBC, the actuarial certifications were also part of the electronic RBC filing as PDF files, similar to the financial annual statement actuarial opinion.

Other pages, such as the mortgage and real estate worksheets, do not need to be submitted. However, they still need to be retained by the company as documentation.

Real Estate Factors

The Capital Adequacy (E) Task Force adopted proposal 2021-06-L during its June 30 meeting. This proposal was developed by the American Council of Life Insurers (ACLI) to update the RBC calculation for real estate to reflect the updated experience and analysis since RBC was first developed. A proposed adjustment based on fair value was not adopted and is set to zero for year-end 2021.

Bond Factors

The Capital Adequacy (E) Task Force adopted proposal 2021-11-L during its June 30 meeting. This proposal incorporates bond factors proposed by the ACLI, which are based on the work of Moody’s Analytics for the expanded presentation of bond designation categories in the annual statement and RBC schedules. This includes factors on the Bonds page (LR002), Asset Concentration page (LR010), Hedged Asset Bond Schedule (LR014), Off Balance Sheet Collateral page (LR017), and Calculation of Tax Effect (LR030). In addition to the base factors on LR002, the bond size adjustment factors were modified.

Longevity Risk Factors

As a result of the adoption of proposal 2021-13-L by the Capital Adequacy (E) Task Force during its June 30 meeting, factors for a longevity risk charge were incorporated into the life RBC formula.

Reinsurance

The Capital Adequacy (E) Task Force adopted proposal 2021-12-L during its June 30 meeting. This proposal changes the description on line 15 on LR016 to allow for the inclusion of amounts held for reciprocal jurisdiction reinsurance, and it is to avoid having both the total adjusted capital decreased by amounts reestablished as liabilities and the authorized control level (ACL) increased for the charge on reserve credit and recoverable amounts.

ACA Sensitivity Test

The Capital Adequacy (E) Task Force adopted proposal 2020-02-CA during its Nov. 19, 2020, meeting to delete the ACA Fee Sensitivity Test from the RBC formulas.

Incentives—Managed Care Credit

As a result of the adoption of proposal 2021-02-CA by the Capital Adequacy (E) Task Force during its April 29 meeting, the term “incentives” was incorporated into the managed care instructions and blanks as “Bonuses/Incentives.”
Investment Income Adjustment to Underwriting Risk Factors

As a result of the adoption of proposal 2021-04-CA by the Capital Adequacy (E) Task Force during its June 30 meeting, a 0.5% investment income adjustment was incorporated into the Underwriting Risk factors for comprehensive medical, Medicare Supplement, and dental and vision.

RBC Forecasting and Instructions

The Life and Fraternal RBC forecasting spreadsheet calculates RBC using the same formula presented in the 2021 Life and Fraternal Risk-Based Capital Forecasting & Instructions for Companies, and it is available to download from the NAIC Account Manager. The 2021 Life and Fraternal Risk-Based Capital Forecasting & Instructions for Companies publication is available for purchase in electronic format through the NAIC Publications Department. This publication is available on or about November 1 each year. The User Guide is no longer included in the Forecasting & Instructions.

WARNING: The RBC Forecasting Spreadsheet CANNOT be used to meet the year-end RBC electronic filing requirement. RBC filing software from an annual statement software vendor should be used to create the electronic filing. If the forecasting worksheet is sent instead of an electronic filing, it will not be accepted and the RBC will not have been filed.
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</tr>
</thead>
<tbody>
<tr>
<td>% of Companies Filed RBC</td>
<td>760</td>
<td>772</td>
<td>703</td>
<td>704</td>
<td>718</td>
<td>725</td>
<td>727</td>
<td>700</td>
<td>761</td>
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<tr>
<td>% of Companies Filed Annual Statement</td>
<td>794</td>
<td>798</td>
<td>722</td>
<td>739</td>
<td>750</td>
<td>763</td>
<td>770</td>
<td>798</td>
<td>811</td>
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<td># of Companies with RBC Ratio +150% &amp; ≤ 1000%</td>
<td>306</td>
<td>310</td>
<td>275</td>
<td>251</td>
<td>331</td>
<td>333</td>
<td>338</td>
<td>338</td>
<td>331</td>
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<tr>
<td># of Companies with RBC Ratio &gt; 1500% &amp; &lt; 5000%</td>
<td>377</td>
<td>312</td>
<td>331</td>
<td>275</td>
<td>270</td>
<td>270</td>
<td>270</td>
<td>270</td>
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<tr>
<td># of Companies with RBC Ratio &gt; 5000% &amp; &lt; 15000%</td>
<td>78</td>
<td>68</td>
<td>58</td>
<td>50</td>
<td>57</td>
<td>52</td>
<td>51</td>
<td>56</td>
<td>50</td>
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<tr>
<td># of Companies with RBC Ratio &gt; 15000% &amp; &lt; 25000%</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>4</td>
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<tr>
<td># of Companies with RBC Ratio &gt; 25000% &amp; ≤ 0.00%</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>5</td>
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<tr>
<td>Total Asset Risk - All Other</td>
<td>32.38%</td>
<td>32.31%</td>
<td>32.33%</td>
<td>32.30%</td>
<td>32.66%</td>
<td>32.92%</td>
<td>32.90%</td>
<td>32.46%</td>
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<tr>
<td>Total 0-10 Asset Risk - Common Stock</td>
<td>23.38%</td>
<td>23.71%</td>
<td>23.37%</td>
<td>23.30%</td>
<td>23.19%</td>
<td>23.19%</td>
<td>18.38%</td>
<td>18.38%</td>
<td>17.08%</td>
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<td>Total 1-10 Asset Risk - All Other</td>
<td>30.79%</td>
<td>30.72%</td>
<td>30.27%</td>
<td>30.21%</td>
<td>30.66%</td>
<td>30.46%</td>
<td>30.91%</td>
<td>30.91%</td>
<td>31.66%</td>
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<tr>
<td>Total C-0 Insurance Risk</td>
<td>14.98%</td>
<td>16.18%</td>
<td>17.72%</td>
<td>17.76%</td>
<td>17.99%</td>
<td>17.99%</td>
<td>17.99%</td>
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<tr>
<td>Total C-1 Interest Rate Risk</td>
<td>8.60%</td>
<td>8.64%</td>
<td>9.33%</td>
<td>11.08%</td>
<td>10.92%</td>
<td>11.15%</td>
<td>11.10%</td>
<td>10.98%</td>
<td>10.98%</td>
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<tr>
<td>Total C-2 Health Credit Risk</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
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<tr>
<td>Total C-3 Market Risk</td>
<td>3.17%</td>
<td>2.83%</td>
<td>2.44%</td>
<td>1.59%</td>
<td>1.59%</td>
<td>1.59%</td>
<td>1.59%</td>
<td>1.59%</td>
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<tr>
<td>Total C-4 Business Risk</td>
<td>4.52%</td>
<td>4.72%</td>
<td>4.40%</td>
<td>4.20%</td>
<td>4.04%</td>
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<td>Total Surplus (Liabilities Line 37)</td>
<td>543,174,496</td>
<td>521,516,943</td>
<td>476,856,643</td>
<td>456,943,103</td>
<td>454,248,163</td>
<td>458,688,524</td>
<td>439,928,318</td>
<td>424,124,329</td>
<td>430,481,152</td>
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<tr>
<td>Claims Incurred (Page 4 Lines 10 Through 13)</td>
<td>319,751,938</td>
<td>308,204,032</td>
<td>290,149,583</td>
<td>280,435,512</td>
<td>270,358,843</td>
<td>262,562,417</td>
<td>249,920,820</td>
<td>266,507,549</td>
<td>256,267,367</td>
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<td>Total Assets</td>
<td>6,297,856,486</td>
<td>6,297,670,761</td>
<td>6,297,444,725</td>
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<td>6,297,006,141</td>
<td>6,296,809,044</td>
<td>6,296,583,732</td>
<td>6,296,338,389</td>
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<td>Total Invested Assets</td>
<td>4,907,504,399</td>
<td>4,982,865,123</td>
<td>4,982,696,032</td>
<td>4,982,530,720</td>
<td>4,982,345,772</td>
<td>4,982,115,494</td>
<td>4,981,707,991</td>
<td>4,981,276,380</td>
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<td>Premiums Earned (Page 4 Line 1)</td>
<td>6,381,413,302</td>
<td>6,381,234,389</td>
<td>6,381,056,329</td>
<td>6,380,878,369</td>
<td>6,380,690,425</td>
<td>6,380,502,595</td>
<td>6,380,314,739</td>
<td>6,380,126,924</td>
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## AGGREGATED FRATERNAL RBC AND ANNUAL STATEMENT DATA

### 2018 Data as of 5/30/2019

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<tr>
<td>Total Companies Filed/Reported RBC</td>
<td>72</td>
<td>73</td>
<td>75</td>
<td>75</td>
<td>73</td>
<td>74</td>
<td>67</td>
<td>76</td>
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<tr>
<td>% of RBC Companies</td>
<td>79</td>
<td>77</td>
<td>79</td>
<td>79</td>
<td>80</td>
<td>83</td>
<td>83</td>
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<td>Company Action Level - Trend Test at 300%</td>
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<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
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<td>Company Action Level - Trend Test at 250%</td>
<td>1</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Authorized Control Level</td>
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<td>1</td>
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<td>Regulatory Action Level</td>
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<td>Mandatory Control Level</td>
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<td>5</td>
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<tr>
<td>Total</td>
<td>55.6%</td>
<td>2.7%</td>
<td>5.3%</td>
<td>6.67%</td>
<td>5.48%</td>
<td>6.76%</td>
<td>2.99%</td>
<td>2.63%</td>
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<tr>
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### Summary Data

- **Total Adjusted Capital**: $19,230,593,100
- **Premiums Earned**: $10,048,236,217
- **Claims Incurred**: $5,409,537,534
- **Surplus (Liabilities)**: $16,666,250,425
- **Total Assets**: $169,135,504,963
- **Total Invested Assets**: $138,076,495,522
- **Claims Incurred (Page 4 Lines 10 Through 13)**: $5,409,537,534
- **Premiums Earned (Page 4 Line 1)**: $10,048,236,217
- **Surplus (Liabilities Line 30)**: $16,666,250,425
- **Total C-2 Insurance Risk**: 8.32%
- **Total C-1o Asset Risk - All Other**: 30.31%
- **Total C-0 Asset Risk - Affiliates**: 1.54%
### Capital Adequacy (E) Task Force
#### Working Agenda Items for Calendar Year 2021

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<tr>
<th>#</th>
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<th>2021 Priority</th>
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<td><strong>Ongoing Items – Life RBC</strong></td>
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<tr>
<td>1</td>
<td>Life RBC WG</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>Make technical corrections to Life RBC instructions, blank and/or methods to provide for consistent treatment among asset types and among the various components of the RBC calculations for a single asset type.</td>
<td>CATF</td>
<td>Being addressed by the Variable Annuities Capital and Reserve (E/A) Subgroup</td>
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| 2 | Life RBC WG | 1 | 2021 or later | Monitor the impact of the changes to the variable annuities reserve framework and risk-based capital (RBC) calculation and determine if additional revisions need to be made.  
2. Develop and recommend appropriate changes including those to improve accuracy and clarity of variable annuity (VA) capital and reserve requirements. | | |
| 3 | Life RBC WG | 1 | 2021 or later | Provide recommendations for recognizing longevity risk in statutory reserves and/or RBC, as appropriate.  
Provide recommendations for the appropriate treatment of longevity risk transfers by the new longevity factors. | New Jersey | Being addressed by the Longevity (E/A) Subgroup |
| **Carry-Over Items Currently being Addressed – Life RBC** | | | | | | |
| 4 | Life RBC WG | 1 | 2021 or later | Update the current C-3 Phase I or C-3 Phase II methodology to include indexed annuities with consideration of contingent deferred annuities as well | AAA | |
| 5 | Life RBC WG | 1 | 2021 | Determine if any adjustment is needed to the XXX/AXXX RBC Shortfall calculation to address surplus notes issued by captives. | 11/1/17 Referral from the Reinsurance (E/A) Task Force | |
| 6 | Life RBC WG | 1 | 2021 | Determine if any adjustment is needed due to the changes made to the Life and Health Guaranty Association Model Act, Model #520. | | |
| 7 | Life RBC WG | 1 | 2021 | Determine if any adjustment is needed due to the changes made to the property RBC formula. | | |
| 8 | Life RBC WG | 1 | 2021 | Discuss and determine the bond factors for the 20 designations. | Referral from Investment RBC, July/2020 | |
| 9 | Life RBC WG | 1 | 2021 | Discuss and determine the need to adjust the real estate factors. | Referral from Investment RBC, July/2020 | |
| 10 | Life RBC WG | 1 | 2021 or later | Work with the Life Actuarial (A) Task Force and Conning to develop the economic scenario generator for implementation. | | |
| **New Items – Life** | | | | | | |
| 6 | Life RBC WG | 1 | 2021 | Develop guidance for regulators as it relates to the potential impact of the bond factor changes on 2021 RBC results and the trend test | | |
| 7 | Life RBC WG | 1 | 2021 or later | Review companies at action levels, including previous years, to determine what drivers of the events are and consider whether changes to the RBC statistics are warranted. | | |
Draft: 7/26/21

Property and Casualty Risk-Based Capital (E) Working Group
Virtual Meeting (in lieu of meeting at the 2021 Summer National Meeting)
July 22, 2021

The Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met July 22, 2021. The following Working Group members participated: Tom Botsko, Chair (OH); Wanchin Chou (CT); Robert Ridenour (FL); Judy Mottar (IL); Anna Krylova (NM); Halina Smosna (NY); Miriam Fisk (TX); and Randy Milquet (WI).

1. **Adopted its June 9 and April 27 Minutes**

Mr. Botsko said the Working Group met June 9 and April 27 and took the following action: 1) adopted proposal 2021-05-P (Underwriting Risk Line 1 Factors); 2) adopted proposal 2021-08-P (P/C Bond Factors and Instructions); 3) adopted proposal 2021-03-P (Credit Risk Instruction Modification); 4) forwarded the response to the Restructuring Mechanisms (E) Subgroup; and 5) heard a presentation on property/casualty (P/C) risk-based capital (RBC) underwriting risk factors from the American Academy of Actuaries (Academy).

Mr. Chou made a motion, seconded by Mr. Milquet, to adopt the Working Group June 9 (Attachment Five-A) and April 27 minutes (Attachment Five-B). The motion passed unanimously.

2. **Adopted the Report of the Catastrophe Risk (E) Subgroup**

Mr. Chou said the Subgroup met July 15 (Attachment Five-C) and took the following action: 1) adopted its June 1 and April 26 minutes, which included the following action: a) exposed and forwarded the response to a request for proposed changes to the P/C RBC catastrophe component; b) heard an update from its Catastrophe Model Technical Review Ad Hoc Group; and c) discussed the possibility of allowing additional third-party models or adjustments to the vendor models; 2) adopted its 2021 working agenda items; 3) received an update from its Catastrophe Model Technical Review Ad Hoc Group and 4) heard a presentation from AIR Worldwide on the wildfire model.

Mr. Chou made a motion, seconded by Ms. Smosna, to adopt the report of the Catastrophe Risk (E) Subgroup. The motion passed unanimously.

3. **Adopted the 2021 P/C RBC Newsletter**

Mr. Botsko said each year, NAIC staff incorporate all adopted current year proposals into the current year (RBC) formula. The 2021 changes have been incorporated into the P/C RBC newsletter.

Mr. Chou made a motion, seconded by Mr. Milquet, to adopt the 2021 P/C RBC newsletter (Attachment Five-D). The motion passed unanimously.

4. **Discussed 2020 P/C RBC Statistics**

Mr. Botsko said the results of the 2020 P/C RBC report compiled by NAIC staff were fairly consistent with prior years. There were 24 companies that triggered the trend test; only 1.7% of the total companies fell under the 200% RBC ratio, which is slightly less than the historical failing percentage of around 2.3%. Overall, the asset risk has slightly increased over time.

The Working Group unanimously approved the 2020 P/C RBC statistics to be posted to the Working Group’s web page.

5. **Discussed its 2021 Working Agenda**

Mr. Botsko summarized the changes to the Working Group’s 2021 working agenda, which included the following substantial changes: 1) changing the completion date of the “evaluate the possibility of allowing additional third-party models or adjustments to the vendor models to calculate the cat model losses,” “evaluate if changes should be made to the P/C formula to better assess companies in runoff,” “evaluate the underwriting risk line 1 factors in the P/C formula,” and “evaluate R3 adjustment for operational risk charge” items; and 2) deleting the “consider eliminating the different treatment of uncollateralized reinsurance recoverable from authorized versus unauthorized, unrated reinsurers” and “remove the embedded...
3% operational risk component contained in the reinsurance contingent credit risk factor of $R_{cat}$ items from the working agenda.

Mr. Chou made a motion, seconded by Mr. Milquet, to adopt the Working Group’s 2021 working agenda (see NAIC Proceedings – Summer 2021, Capital Adequacy (E) Task Force, Attachment Seven). The motion passed unanimously.

6. **Heard Updates on P/C RBC Underwriting Risk Projects from the Academy**

David Traugott (Academy) provided a status on different projects being conducted by the Academy that all related to calibrating various components of the premium risk and reserve risk in the P/C RBC formula. He said all the Academy projects are described in three different reports. The first report, which was distributed during the Spring National Meeting provided indicated premium and reserve risk line 4 factors based on an analysis of data through 2017. Mr. Traugott also said the second report, which will be shared with the Working Group by the end of 2021, related to updating the investment income adjustment factors (IIAs) in the RBC formula line 7 and line 8 for premium risk and reserve risk, respectively. As many of the line 4 factors are decreasing, Mr. Traugott said the Academy recommended the Working Group consider implementing the line 4 factors along with updated investment income adjustment factors to offset the decreases. Lastly, Mr. Traugott stated that the concentration factors for the underwriting premium and reserve risks have not been reviewed since the RBC formula was first implemented. The Academy planned to provide the last report, which is related to updating these factors during the first half of 2022. Furthermore, Mr. Traugott said there are two additional analyses requested by the Working Group, which are related to catastrophe adjustment factors and industry average development/loss ratios. Scott Williamson (Reinsurance Association of America—RAA) thanked the Academy for the improvements made to the calibration methodology for the R4 and R5 line 4 factors. Those improvements resolved the concerns RAA raised several years ago about the prior methodology. Mr. Williamson said the results from the recent update of the factors underscore that the improvements are working, as evidenced by the decreased volatility in the indicated change by line. He also asked the Academy to continue working to prevent double counting of CAT losses between underwriting risk and $R_{cat}$. With respect to proposed changes to the investment income adjustment factors, he recommended that the Academy consider using the discount method, corporate bond index yield curve segment rates, and payment patterns that are now prescribed for tax loss reserve discounting under the federal Tax Cuts and Jobs Act. He said these rates better approximate the industry’s investment yield and bond portfolio duration. Ralph Blanchard (Travelers) advised the Academy that the preliminary estimate of losses from Property Claims Services (PCS) may not be the same as the final estimate of losses. Mr. Traugott anticipated that the Academy will complete the review before mid-2022.

Mr. Botsko said he appreciates what all the Academy does for the Working Group. He said the Working Group will provide the needed support to ensure the projects are completed in time.

Having no further business, the Property and Casualty Risk-Based Capital (E) Working Group adjourned.
The following Working Group members participated: Tom Botsko, Chair (OH); Richard Ford (AL); Wanchin Chou (CT); Nicole Altieri Crockett (FL); Judy Mottar (IL); Anna Krylova (NM); Halina Smosna and Gloria Huberman (NY); Will Davis (SC); Miriam Fisk and Rebecca Armon (TX); and Randy Milquet (WI).

1. **Adopted Proposal 2021-05-P (Underwriting Risk Line 1 Factors)**

Mr. Botsko said the purpose of this proposal is to provide a routine annual update to the Line 1 premium and reserve industry underwriting factors in the property/casualty (P/C) risk-based capital (RBC) formula. He also stated that the Working Group received no comments during the exposure period.

Mr. Chou made a motion, seconded by Mr. Davis, to adopt proposal 2021-05-P (see NAIC Proceedings – Summer 2021, Capital Adequacy (E) Task Force, Attachment One-H). The motion passed unanimously.

2. **Adopted Proposal 2021-08-P (P/C Bond Factors and Instructions)**

Mr. Botsko said the purpose of this proposal is to modify the P/C RBC forecasting and instructions to: 1) incorporate 20 NAIC designation category bond factors; 2) modify the bond size factor formula; and 3) reclassify hybrid securities in PR006, PR011 and PR015. He also stated that the expansion of 20 NAIC designation categories will provide more robust and accurate results, primarily as it increases the granularity of the formula and reduces the cliffs between the different factors for the different categories. Mr. Botsko also stated that the Working Group received no comments during the exposure period. Mr. Chou said since the number of issuers for the first and second category of the bond size portfolio will change from first 50 and next 50 to first 10 and next 90, he asked the Working Group to consider updating the P/C formula to be consistent with the Life formula in the near future. Mr. Botsko agreed.

Mr. Chou made a motion, seconded by Mr. Davis, to adopt proposal 2021-08-P (see NAIC Proceedings – Summer 2021, Capital Adequacy (E) Task Force, Attachment One-J). The motion passed unanimously.

3. **Forwarded the Response to the Restructuring Mechanisms (E) Subgroup**

Mr. Botsko said the Runoff Ad Hoc Group met June 1 to continue discussing the best course of treatment of run-off companies. He stated that a response letter to request input regarding the definition of run-off companies was exposed for a 30-day public comment period ending May 26. The drafted response indicated that a run-off company should include the following characteristics: 1) no renewing of policies for at least 12 months; and 2) no new direct or assumed business. Mr. Botsko also said the Ad Hoc Group is currently investigating whether: 1) companies in run-off have a higher risk than other ongoing companies; and 2) the RBC calculation should be modified for these kinds of companies. Lastly, he indicated that findings will be shared with other RBC working groups, as each group may have different risk exposures that require individual group consideration. Mr. Botsko said the Working Group received a comment letter from the National Conference of Insurance Guaranty Funds (NCIGF) during the exposed period. Roger Schmelzer (NCIGF) said the NCIGF supports the efforts of the Working Group currently made on this issue. He also provided the following observations: 1) develop a specific process to identify companies in run-off; 2) require companies in run-off to file annual and quarterly statements up through any rehabilitation period; 3) modify the financial solvency mechanisms to monitor the unique risks for the run-off companies; 4) ensure the annual and quarterly statements should always be available for the public regardless of the status of the company; and 5) review the issue of run-off companies that may have written noncancellable health insurance as these companies may have continuing renewals of these policies. Mr. Botsko said the ad hoc group will review the suggestions and share this information with the different appropriate RBC working groups for further considerations.

Mr. Milquet made a motion, seconded by Mr. Chou, to forward the response to the Restructuring Mechanisms (E) Subgroup. The motion passed unanimously.
4. **Heard a Presentation on P/C RBC Underwriting Risk Factors from the Academy**

Mr. Botsko said during the Working Group’s last meeting on April 27, the American Academy of Actuaries (Academy) provided a brief overview of its report *Update to Property and Casualty Risk-Based Capital Underwriting Factors Experience Through December 31, 2017*. He stated that the Academy presented the impact of the Line 4 risk factors indicated by the 2017 data. It also began a presentation of the significant assumptions underlying the indicated risk factors. Mr. Botsko also said that the Academy plans to continue with further discussion of the significant assumptions and features of the data that affect the results. Allan Kaufman (Academy) provided an overview of the development history, data source and data filtering of the premium and reserve risk factor methodology. He explained the methods and procedures used by the Academy in its analysis. Mr. Kaufman was thorough in his remarks to make sure the members and interested parties were informed enough to help contribute to a robust discussion as they review the report for a detailed discussion during the Working Group’s next meeting. After the presentation, Mr. Botsko encouraged all the interested parties to review the report and provide thoughts to the Working Group during the comment period.

The Working Group agreed to expose the Academy report for a 30-day public comment period ending July 9.

Mr. Botsko said he plans to schedule another meeting in July to further discuss the received comments and other Working Group outstanding items.

Having no further business, the Property and Casualty Risk-Based Capital (E) Working Group adjourned.

W:\National Meetings\2021\Summer\TF\CapAdequacy\PCRBC\Att01_06_09propertyrbwg.doc
The Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met April 27, 2021. The following Working Group members participated: Tom Botsko, Chair (OH); Richard Ford (AL); Wanchin Chou and Susan Andrews (CT); Robert Ridenour (FL); Judy Mottar (IL); Anna Krylova (NM); Halina Smosna and Sak-man Luk (NY); Miriam Fisk (TX); and Randy Milquet (WI).

1. **Adopted Proposal 2021-03-P (Credit Risk Instruction Modification)**

Mr. Botsko said the purpose of this proposal is to provide examples to clarify how the reporting companies should select the designation in the Annual Statement Schedule F, Part 3, Reinsurer Designation Equivalent Rating column if the reporting entities subscribe to one or multiple rating agencies. He also stated that the Working Group received no comments during the exposure period.

Mr. Chou made a motion, seconded by Ms. Mottar, to adopt proposal 2021-03-P (see NAIC Proceedings – Summer 2021, Capital Adequacy (E) Task Force, Attachment One-H). The motion passed unanimously.

2. **Exposed Proposal 2021-05-P (Underwriting Risk Line 1 Factors)**

Mr. Botsko said this proposal provided a routine annual update to the Line 1 premium and reserve industry underwriting factors in the property/casualty (P/C) risk-based capital (RBC) formula. He also stated that the American Academy of Actuaries (Academy) is currently in the process of reviewing the Line 1 calculation methodology; recommendations will be provided in the near future.

The Working Group agreed to expose proposal 2021-05-P for a 30-day public comment period ending May 26.

3. **Exposed a Memorandum to the Restructuring Mechanisms (E) Subgroup**

Mr. Botsko said the Runoff Ad Hoc Group met early this month to discuss the best course of treatment of run-off companies. He stated that a response letter to request for input regarding the definition of run-off companies was drafted. The drafted response indicated that a run-off company should include the following characteristics: 1) no renewing of policies for at least 12 months; and 2) no new direct or assumed business. Mr. Botsko also said the ad hoc group is currently investigating whether: 1) companies in run-off have a higher risk than other ongoing companies; and 2) the RBC calculation should be modified for these kinds of companies. Lastly, he indicated that findings will be shared with other RBC working groups, as each group may have different risk exposures that require individual group consideration.

The Working Group agreed to expose the memorandum to the Restructuring Mechanism (E) Subgroup for a 30-day public comment period ending May 26.

4. **Exposed Proposal 2021-08-P (P/C Bond Factors and Instructions)**

Mr. Botsko said the purpose of this proposal is to modify the Property and Casualty Risk-Based Capital Forecasting and Instructions to: 1) incorporate 20 NAIC designation category bond factors; 2) modify the bond size factor formula; and 3) reclassify hybrid securities in PR006, PR011 and PR015. He also stated that the expansion of 20 NAIC designation categories will provide more robust and accurate results, primarily as it increases the granularity of the formula and reduces the cliffs between the different factors for the different categories. Mr. Luk said while there could be larger percentage changes in RBC ratio by individual companies under the proposed risk factors and bond size factor formula, the impact analysis indicated that the change will only move one company from no action to trend test. Mr. Botsko encouraged all the interested parties to review the materials and provide thoughts to the Working Group during the comment period.

The Working Group agreed to expose proposal 2021-08-P for a 30-day public comment period ending May 26.
5. **Heard a Presentation on P/C RBC Underwriting Risk Factors from the Academy**

David Traugott (Academy) said the Academy report *Update to Property and Casualty Risk-Based Capital Underwriting Factors Experience Through December 31, 2017* (Attachment Five-B1) was based on data from annual statements reporting between 1989 and 2017 and RBC filings between 1997 and 2017. He also said this report is the first of three reports on underwriting risk factors that the Academy described to the Working Group in May 2019. The other two reports, which deal with investment income adjustment factors and the loss/premium concentration factors, will be presented at a later date. In addition, Mr. Traugott stated that the approach in this report is broadly the same as the approach in the 2016 report, with some refinements. Moreover, he indicated that this presentation would focus on results and methodology. First, he compared the risk factors in the 2020 Formula, the risk factors indicated based on Annual statements and other data through 2017 (2017 indications) and the risk factors based on Annual Statement and other data through 2014, as presented in the 2016 Academy Report (2014 indication). He stated that the Authorized Control Level RBC would: 1) increase 2% by comparing the 2014 indication risk charge and the 2020 formula; 2) decrease 0.7% by comparing 2014 indicated factors and 2017 indicated factors; and 3) increase 2.1% by comparing 2017 indicated factors and the 2020 formula. Allan Kaufman (Academy) began an overview of the development history, data source and data filtering of the premium and reserve risk factor methodology. He also said the Academy plans to devote more time to discuss this report in the upcoming Working Group meeting, as the results of this report will affect the investment income adjustment factors analysis.

Mr. Botsko said he plans to schedule another meeting to further discuss this report and other Working Group outstanding items next month.

Having no further business, the Property and Casualty Risk-Based Capital (E) Working Group adjourned.
Report to the
National Association of Insurance Commissioners
Property and Casualty Risk-Based Capital (E) Working Group

Update to
Property and Casualty Risk-Based Capital
Underwriting Factors
Experience Through December 31, 2017

Presented by the American Academy of Actuaries\(^1\)
Property and Casualty Risk-Based Capital Committee

March 2021
(Revised April 21, 2021)

\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policy makers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
American Academy of Actuaries

Property and Casualty Risk-Based Capital Committee

Committee Chairperson (2017 – 2020): Lauren Cavanaugh, MAAA, FCAS
(2020-current): David Traugott

Committee Members
Michael Angelina, MAAA, ACAS, CERA
Marios Argyrou, MAAA, ASA, FCAS
Natalie Atkinson, MAAA, FIA
Wayne Blackburn, MAAA, FCAS
Lesley Bosniack, MAAA, FCAS, CERA
Sandra Callanan, MAAA, FCAS
Wanchin Chou, MAAA, FCAS, CPCU, CSPA
Joseph Cofield, MAAA, FCAS
Smitesh Davé, MAAA, FCAS
Dennis Franciskovich, MAAA, FCAS
Dennis Guenthner, MAAA, FCAS, CERA
Qing He, MAAA, FCAS
Allan Kaufman, MAAA, FCAS
Judy Mottar, MAAA, ACAS
David Shleifer, MAAA, ACAS
David Traugott, MAAA, FCAS
Ron Wilkins, MAAA, FCAS
Jianhui Yu, MAAA, FCAS

Key Contributors: Wayne Blackburn, Lesley Bosniack, Sandra Callanan, Joseph Cofield, Dennis Franciskovich, Qing He, Allan Kaufman, Judy Mottar, David Traugott, Jianhui Yu, SakMan Luk

NAIC support provided by SakMan Luk, Eva Yeung and Jane Barr
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1. INTRODUCTION

The American Academy of Actuaries Property and Casualty Risk-Based Capital Committee (“Committee” or “We”) prepared this Report (“Report”) at the request of the National Association of Insurance Commissioners’ (“NAIC”) Property and Casualty (P&C) Risk-Based Capital (RBC) Working Group (“NAIC Working Group” or “Working Group”).

In this Report, we present indicated Line of Business (“LOB”) Underwriting (“UW”) Risk Factors for the P&C RBC Formula (“RBC Formula” or “Formula”), specifically, RBC Line 4 on pages PR017 and PR018 for the Formula. We refer to these LOB UW Risk Factors as the “Reserve Risk Factor” (“RRF”) and the “Premium Risk Factor” (“PRF”), respectively, or “Risk Factors,” generically.

This is the first in a series of three reports. The results of this review will be input to subsequent Reports 2 and 3 that will address the following:

- Report 2—Investment Income Adjustment (“IIA”)—RBC Line 8 on page PR017 (R4 UW Risk - Reserves) and Line 7 on page PR018 (R5 – UW Risk – Net Written Premium), by LOB.
- Report 3—Loss Concentration Factor (“LCF”) and Premium Concentration Factor (“PCF”)—RBC Line 14 on PR017 and PR018 respectively.

We describe the full scope of this three-part project in a letter to the NAIC Working Group dated May 9, 2019, that is attached as Appendix 15 in this Report. We plan to issue Reports 2 and 3 later this year.

We provide these indicated Risk Factors for the information of the NAIC Working Group. Report 2—Investment Income Adjustment, to be provided later this year, may also be useful in informing NAIC Working Group action related to the indicated UW Risk Factors in this Report.²

This work by the Committee builds on prior American Academy of Actuaries reports on UW Risk Factors, most recently in 2010 and 2016, which we refer to as the 2010 Report and the 2016 Report, respectively. We also use Casualty Actuarial Society (CAS) RBC research prepared by the CAS Dependency and Calibration Working Party (DCWP). We list this American Academy of Actuaries and CAS material in the Reference Section, Appendix 14.

The analysis presented in this Report is based on data evaluated through December 31, 2017. The analysis in the 2016 report was based on data evaluated through December 31, 2014.

² The IIA Report will address the fact that the current IIA’s are based on a 5% interest rate, even though current interest rates are much lower. It is likely that the effect of reflecting lower interest rates will increase the overall risk charges.
2. FINDINGS

Indicated Risk Factors

Using the data and methodology described in this Report, we calculate the indicated Risk Factors. We compare the indicated factors to (a) indicated Risk Factors from the 2016 Report and (b) the Risk Factors in the 2020 RBC Formula in tables below:

- In Tables 1a and 1b we compare the Risk Factors indicated by the current analysis to the Risk Factors indicated in the 2016 Report. This comparison shows us the effects of changes in methodology and additional data for this Report compared to the 2016 Report.

- In Tables 1c-1e we show the effect on RBC values of moving from the Risk Factors in the 2020 RBC Formula to the Risk Factors indicated by this analysis. Appendix 13 provides further details on the effect of that change, and also the effects of “capping” the changes, using the capping rules the NAIC Working Group considered in evaluating the 2016 Report.

Table 1a shows the following information:

- Columns 2 and 5—The factors in the “2020 RBC Formula” column are those used in the 2020 RBC Formula, except that, for catastrophe exposed LOBs, we increase the 2020 Risk Factors to their values before the NAIC catastrophe risk adjustments.

- Columns 3 and 6—The Risk Factors in the “Indicated (2014 Data)” columns are the indicated factors presented in the 2016 Committee Report, using data evaluated through December 31, 2014.

- Columns 4 and 7—The Risk Factors in the “Indicated (2017 Data)” columns are the indicated Risk Factors from this study, using data evaluated through December 31, 2017.

The all-lines average indicated Risk Factors in the analysis are relatively close to the all-lines average indicated Risk Factors from the 2016 analysis. Nonetheless, there are some notable changes in Risk Factors by LOB.

---

3 While we provide this detailed information, as noted in the Introduction, the results of our IAA Report may provide more context for any changes in Line 4 Risk Factors.

4 Beginning in 2016, the RBC Formula includes a new risk component, RCat, covering earthquake and hurricane components of the total premium risk. The indicated PRFs in this Report and in the 2016 Report have been calibrated with data that included earthquake and hurricane losses. Therefore, to avoid double counting of catastrophe risk, the NAIC developed a procedure to reduce the otherwise applicable Risk Factors for the affected LOBs. The factors that reduce the indicated PRFs to an ex-cat basis by LOB are as follows: Homeowners (0.971), CMP (0.980), Special Liability (0.983), Special Property (0.982), and Reinsurance: Nonproportional Assumed Property and Reinsurance: Nonproportional Assumed Financial, collectively called (“Reinsurance Property”) (0.944).

5 The indicated Risk Factors do not reflect the transition rules, often referred to as ‘capping’, that the NAIC requested.

6 The NAIC has adopted a portion of the indicated Risk Factors from the 2016 Report in several steps from 2016 to 2019. The remaining differences between the 2019 Risk Factors and the indicated Risk Factors contained in the 2016 Report are due to NAIC capping for those LOBs that has not yet been removed.

7 These indicated Risk Factors do not reflect any transition rules, often referred to as “capping,” that the NAIC might request.
If the NAIC Working Group decides to update the current factors based on this research, we can provide “capping” alternatives if so requested.

Table 1a
Comparison of Risk Factors
2020 RBC Formula/ 2014 Data / 2017 data

<table>
<thead>
<tr>
<th>Line</th>
<th>PRFs</th>
<th>RRFs</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) H/F</td>
<td>0.964</td>
<td>0.964</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>0.969</td>
<td>0.969</td>
</tr>
<tr>
<td>(3) CA</td>
<td>1.010</td>
<td>1.010</td>
</tr>
<tr>
<td>(4) WC</td>
<td>1.044</td>
<td>1.044</td>
</tr>
<tr>
<td>(5) CMP</td>
<td>0.901</td>
<td>0.901</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>1.668</td>
<td>1.490</td>
</tr>
<tr>
<td>(7) MPL C-M</td>
<td>1.130</td>
<td>1.176</td>
</tr>
<tr>
<td>(8) SL</td>
<td>0.938</td>
<td>0.949</td>
</tr>
<tr>
<td>(9) OL</td>
<td>1.013</td>
<td>1.013</td>
</tr>
<tr>
<td>(11) Spec. Prop.</td>
<td>0.879</td>
<td>0.831</td>
</tr>
<tr>
<td>(12) APD</td>
<td>0.836</td>
<td>0.836</td>
</tr>
<tr>
<td>(10) Fidelity / Surety</td>
<td>0.854</td>
<td>0.680</td>
</tr>
<tr>
<td>(13) Other</td>
<td>0.935</td>
<td>0.935</td>
</tr>
<tr>
<td>(15) International</td>
<td>1.234</td>
<td>1.638</td>
</tr>
<tr>
<td>(16) Reins. Prop. / Fin.</td>
<td>1.239</td>
<td>1.240</td>
</tr>
<tr>
<td>(17) Reins. Liab.</td>
<td>1.323</td>
<td>1.322</td>
</tr>
<tr>
<td>(18) PL</td>
<td>1.263</td>
<td>1.285</td>
</tr>
<tr>
<td>(14) Financial / Mortgage</td>
<td>1.598</td>
<td>2.513</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>0.854</td>
<td>1.028</td>
</tr>
<tr>
<td>Average Risk Factor- all Lines</td>
<td>0.964</td>
<td>0.968</td>
</tr>
<tr>
<td>Average Risk Factor- 10-Yr Lines</td>
<td>0.996</td>
<td>0.996</td>
</tr>
<tr>
<td>Average Risk Factor- 2-Yr Lines</td>
<td>0.880</td>
<td>0.895</td>
</tr>
</tbody>
</table>

Note 1: Average Risk Factors are based on 2017 industry total net written premium and net unpaid loss and loss adjustment expense reserves, by LOB, for PRFs and RRFs, respectively.

Note 2: The company risk charge depends on not only the Risk Factors, above, but also depends on adjustments for company experience, investment income, loss sensitive contracts, company expenses (for premium risk) and a concentration adjustment. The change in Risk Factor is not representative of the change in RBC value for any particular company, as the Risk Factor does not include all elements of the RBC Formula and as distribution of premium/reserves by LOB differs widely among companies. Tables 1c-1e provide further details on the effect of the indicted Risk Factors on overall RBC values.
Note 3: Our indications are based on data from 1989–2017 Annual Statements, Schedule P Parts 1, 2 and 3 for “Ten-Year LOBs” and from 1997–2017 confidential RBC Filings for Two-Year LOBs. The NAIC compiled the data from the RBC Filings so that the available experience reflected 10 years for all LOBs.

Note 4: The shaded lines represent factors which are based on a limited amount of data.

As our data sources and methods somewhat different between Two-Year LOBs and Ten-Year LOBs, the table shows the average indicated Risk Factors for all-lines combined and, also, separately for Two-Year LOBs and Ten-Year LOBs. Ten-Year LOBs are the LOBs for which Schedule P shows 10 accident years (AYs) of data. Two-Year LOBs are those for which Schedule P shows only two AYs of data.

Table 1b, below, supplements Table 1a, showing the premium risk charges assuming industry average expenses and showing the percentage change in Premium Risk Charge percentage (PRC%) and Reserve Risk Charge percentage (RRC%). Note that the percentage change in RBC charge is higher than the change in Risk Factor as a percentage of premium or reserves.

---

8 Electronic data for Part 1 is available for some earlier years, but, for the earlier annual statement years, the LOB definitions in Schedule P were not the same as the current LOB definitions.

9 The Two-Year LOBs include Special Property, Automobile Physical Damage, Fidelity/Surety, Other (Including Credit, Accident and Health), Financial/Mortgage Guaranty, and Warranty.

10 The analysis uses less than $50 billion in 2017 NEP or less than $50 billion in 2017 reserves after filtering, using Annual Statement data for all LOBs.

11 PRC% = PRF + 2017 industry average expense ratio by LOB -100%. RRC% = RRF. Column (4) = column (3)/column (2). Column (7) = column (6)/column (5).
Table 1b
Comparison of Risk Factors
2020 RBC Formula/201 Data / 2017 data

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) H/F</td>
<td>25.4%</td>
<td>24.9%</td>
<td>-1.7%</td>
<td>21.3%</td>
<td>22.3%</td>
<td>4.5%</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>19.7%</td>
<td>20.4%</td>
<td>3.2%</td>
<td>17.9%</td>
<td>20.1%</td>
<td>12.3%</td>
</tr>
<tr>
<td>(3) CA</td>
<td>29.6%</td>
<td>30.8%</td>
<td>4.1%</td>
<td>34.8%</td>
<td>36.1%</td>
<td>3.9%</td>
</tr>
<tr>
<td>(4) WC</td>
<td>30.6%</td>
<td>29.1%</td>
<td>-4.8%</td>
<td>34.4%</td>
<td>33.5%</td>
<td>-2.5%</td>
</tr>
<tr>
<td>(5) CMP</td>
<td>25.7%</td>
<td>25.3%</td>
<td>-1.5%</td>
<td>49.4%</td>
<td>49.9%</td>
<td>1.0%</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>74.4%</td>
<td>73.5%</td>
<td>-1.3%</td>
<td>29.6%</td>
<td>26.5%</td>
<td>-10.3%</td>
</tr>
<tr>
<td>(7) MPL C-M</td>
<td>43.1%</td>
<td>40.4%</td>
<td>-6.3%</td>
<td>8.9%</td>
<td>9.4%</td>
<td>5.5%</td>
</tr>
<tr>
<td>(8) SL</td>
<td>28.7%</td>
<td>29.1%</td>
<td>1.2%</td>
<td>43.1%</td>
<td>41.5%</td>
<td>-3.8%</td>
</tr>
<tr>
<td>(9) OL</td>
<td>31.6%</td>
<td>31.8%</td>
<td>0.4%</td>
<td>53.1%</td>
<td>52.7%</td>
<td>-0.8%</td>
</tr>
<tr>
<td>(11) Spec. Prop.</td>
<td>13.2%</td>
<td>13.2%</td>
<td>0.1%</td>
<td>42.8%</td>
<td>27.8%</td>
<td>-35.2%</td>
</tr>
<tr>
<td>(12) APD</td>
<td>6.8%</td>
<td>6.9%</td>
<td>0.2%</td>
<td>15.5%</td>
<td>13.2%</td>
<td>-14.7%</td>
</tr>
<tr>
<td>(10) Fidelity / Surety</td>
<td>18.0%</td>
<td>16.6%</td>
<td>-8.0%</td>
<td>91.7%</td>
<td>60.0%</td>
<td>-34.5%</td>
</tr>
<tr>
<td>(13) Other</td>
<td>19.1%</td>
<td>18.9%</td>
<td>-0.9%</td>
<td>37.5%</td>
<td>22.5%</td>
<td>-40.0%</td>
</tr>
<tr>
<td>(15) International</td>
<td>107.7%</td>
<td>115.1%</td>
<td>6.9%</td>
<td>69.5%</td>
<td>104.4%</td>
<td>50.2%</td>
</tr>
<tr>
<td>(16) Reins. Prop. / Fin.</td>
<td>50.7%</td>
<td>50.7%</td>
<td>0.0%</td>
<td>41.5%</td>
<td>34.3%</td>
<td>-17.3%</td>
</tr>
<tr>
<td>(17) Reins. Liab.</td>
<td>59.0%</td>
<td>52.0%</td>
<td>-11.9%</td>
<td>65.6%</td>
<td>63.6%</td>
<td>-2.9%</td>
</tr>
<tr>
<td>(18) PL</td>
<td>61.4%</td>
<td>60.0%</td>
<td>-2.4%</td>
<td>134.5%</td>
<td>147.2%</td>
<td>9.5%</td>
</tr>
<tr>
<td>(14) Financial / Mortgage</td>
<td>185.4%</td>
<td>192.9%</td>
<td>4.0%</td>
<td>6.0%</td>
<td>0.1%</td>
<td>-98.2%</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>28.6%</td>
<td>23.3%</td>
<td>-18.6%</td>
<td>31.6%</td>
<td>31.2%</td>
<td>-1.3%</td>
</tr>
</tbody>
</table>

Average Risk Factor- all Lines 23.8% 23.8% -0.1% 38.3% 37.6% -1.9%
Average Risk Factor- 10-Yr Lines 26.9% 26.7% -0.5% 38.7% 39.0% 0.9%
Average Risk Factor- 2-Yr Lines 16.0% 16.3% 1.6% 34.4% 21.8% -36.6%

See Notes 1-4 on Table 1a

Effect of Indicated Risk Factors on RBC by Company
The NAIC has provided the information in Appendix 13, which summarizes the company-by-company changes in RBC values implied by the indicated RBC factors, for all companies with RBC Filings in 2019. These calculations include the effect of all elements of the RBC Formula.

Tables 1c – 1e, below, compare the RBC values based on the indicated Risk Factors with the 2017 data, in this Report, to the RBC values based on the indicated Risk Factors with the 2014 data, in the 2016 Report.

Table 1c shows that, overall, the 2017 indicated Risk Factors produce very little change in UW RBC Values for reserve risk, premium risk, or total Authorized Control Level (ACL) RBC. The average effect is a change of -0.6% for ACL.
Table 1c
Change in RBC Values
Indicated Risk Factors with 2017 Data Compared to Indications with 2014 Data

<table>
<thead>
<tr>
<th>Risk Element</th>
<th>Indicated: 2017 Data vs 2014 Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in Reserve Risk RBC</td>
<td>-1.9%</td>
</tr>
<tr>
<td>Change in Premium Risk RBC</td>
<td>-0.4%</td>
</tr>
<tr>
<td>Change in ACL</td>
<td>-0.7%</td>
</tr>
</tbody>
</table>

Table 1d shows that the changes, by company, are largely confined to the ±5% range.

Table 1d
Distribution of Change in ACL Values

<table>
<thead>
<tr>
<th>% Change in ACL RBC</th>
<th>Indicated: 2017 Data vs 2014 Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Than -50%</td>
<td>0</td>
</tr>
<tr>
<td>-50% to -25%</td>
<td>26</td>
</tr>
<tr>
<td>-25% to -15%</td>
<td>26</td>
</tr>
<tr>
<td>-15% to -5%</td>
<td>173</td>
</tr>
<tr>
<td>-5% to 5%</td>
<td>1,525</td>
</tr>
<tr>
<td>5% to 15%</td>
<td>85</td>
</tr>
<tr>
<td>15% to 25%</td>
<td>2</td>
</tr>
<tr>
<td>25% to 50%</td>
<td>0</td>
</tr>
<tr>
<td>Over 50%</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1,837</td>
</tr>
</tbody>
</table>

Table 1e shows the effect on RBC value by Type of Company.12

The largest change is for the Type of Company “NOC”. The LOBs that predominate for that Type of Company are Fidelity/Surety, Special Liability,13 and Other Liability. The variation in changes by Type of Company are larger for reserve risk than for premium risk. Appendix 13 contains more details on Type of Company and the distribution of LOBs within each Type of Company.

In the next section, we discuss the changes in data and methodology that influence those observations.

12 Each LOB is categorized as being typical of a particular Type of Company, e.g., Private Passenger Automobile Liability is typical of Personal Lines companies. For each company, the category with the largest amount of premium determines the Type for that company. For example, a company with more of its premium in Private Passenger Automobile Liability, Homeowners, or Automobile Physical Damage than in any of the other groups of LOBs is categorized as Personal. Appendix 13, Part 4 provides the complete definition.

13 For example, Boiler and Machinery and Ocean Marine LOBs.
Table 1e
Change in ACL Values by Type of Company
Indicated Risk Factors with 2017 Data Compared to Indications with 2014 Data

<table>
<thead>
<tr>
<th>Type of Company</th>
<th>ACL Value with 2020 Risk Charges ($Billions)</th>
<th>Indicated 2017 vs. Indicated 2014</th>
<th>ACL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reserve Risk Charge</td>
<td>Premium Risk Charge</td>
<td>ACL</td>
</tr>
<tr>
<td>Commercial</td>
<td>64.9</td>
<td>-3.3%</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Med Prof Liab</td>
<td>2.4</td>
<td>-14.9%</td>
<td>-6.9%</td>
</tr>
<tr>
<td>NOC</td>
<td>0.9</td>
<td>-26.9%</td>
<td>-1.7%</td>
</tr>
<tr>
<td>Personal</td>
<td>84.3</td>
<td>4.8%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Reinsurance</td>
<td>8.2</td>
<td>-5.1%</td>
<td>-3.4%</td>
</tr>
<tr>
<td>Workers Comp</td>
<td>10.1</td>
<td>-3.2%</td>
<td>-4.3%</td>
</tr>
<tr>
<td>Total</td>
<td>170.6</td>
<td>-1.9%</td>
<td>-0.4%</td>
</tr>
</tbody>
</table>

NOC = Not otherwise classified.

Elements Driving Differences Between 2017 Indicated Risk Factors and 2014 Indicated Risk Factors

The changes in indicated Risk Factors from the 2016 Report to the current Report result from additional data and from some refinements in methodology. The sections below discuss the factors driving the major changes by Type of Company.

1. Zero Interior Anomaly—RRFs

We find that in the RBC Filings, there are companies that do not complete the interior of loss triangles, perhaps because these values are not required in the RBC calculation. For these companies, in the incurred and paid development triangle of the RBC Filing, all points are zero or blank, other than (a) initial evaluations by AY on the diagonal of the triangle, and (b) current evaluations of each AY, on the last column. We refer to these as “Zero Interior” triangles. Appendix 4, Table A-5b, contains an illustration of a zero interior triangle.

For Two-Year LOBs, in this Report, we remove Zero Interior triangle data from our analysis. That is a change compared to the 2016 Report, and that is the largest source of change in indicated RRFs for Two-Year LOBs. Four of those Two-Year LOBs are typical lines for the Type of Company “NOC” which shows the largest change in reserve risk RBC value as follows: Fidelity/Surety, “Other,” Financial/Mortgage Guaranty, and Warranty.

In the 2016 Report we addressed the potential for zero interior data by excluding Reserve Runoff Ratios (RRR) with absolute value greater than 5. In this report we applied the zero interior filter in addition to excluding RRRs with absolute value greater than 5. Appendix 11, Table A-8a shows the effect of zero interior filter, by LOB.

2. Refined Minor Lines Definition—RRFs

We exclude risk data points where the premium for the LOB represents a small portion of a company’s all lines premium as defined below. We call these data points “Minor Lines.”
For Reserve Risk, the Minor Lines filter compares the NEP for the LOB for a period of years to the corresponding all-lines premium. To the extent the appropriate data are available, we use a rolling Ten-Year period for this calculation. As there are variations in the data available from year-to-year, the “window” varies by LOB. Appendix 5 provides further details on this approach.

The use of Ten-Year “windows” differs from the approach in 2016 Report, where the reserve risk Minor Lines definition was based on all-years premium. With the increase in the number of years of premium in our data set, we determined that a change in procedure should be considered, and we adopted this approach.

This change in methodology reduces RRFs by about 1% overall, but by larger amounts for the reinsurance LOBs, for Financial/Mortgage Guaranty, for Other, and for Special Property LOBs. The change drives much of the change for the reserve risk RBC values for the Reinsurance Type of Company. Appendix 11, Table A-8a shows the effect of the revised minor lines definition, by LOB.

3. Absolute (RRR)>5—RRFs—Two-Year LOBs Based on RBC Data

In the 2016 Report, we excluded RRR values greater than 5 for both Ten-Year LOBs and Two-Year LOBs from Annual Statement and RBC data, respectively, because we were concerned that the ratios reflected data quality issues.

We have reviewed this issue, and for the Two-Year LOBs from confidential RBC data, we continue to exclude data if the absolute value of RRR is greater than 5, as many such values appear to be due to data anomalies. For the Ten-Year LOBs, however, in this review, we use RRR values, regardless of size.

If large RRR values were data errors, then we might expect an impact across all LOBs. However, for Ten-Year LOBs, to the contrary, we find a wide range of impacts, as a percentage of reserves, from a low 0.000 to a high of 0.195. There are nine of thirteen Ten-Year LOBs affected by less than 1% of reserves and only two affected by more than 5% of reserves. As such, we see no need for an all-lines exclusion.

Table A-5a, in Appendix 4, below, shows the effect of removing this filter by LOB. It shows that the weighted average effect on the RRFs for Ten-Year LOBs is an increase of 0.9% of reserves. It shows the Ten-Year LOBs most affected by removing the exclusion are as follows: Products Liability (19% of reserves) and International (20% of reserves). The LOB effects are not apparent in the Type of Company summary because Products Liability is usually a small part of business for a Commercial Type of Company and International is a relatively small LOB.

The change tends to increase the indicated RRF for reinsurance liability, which mitigates the effect of other changes in RRF for that LOB, e.g., the change in the Minor Lines procedure.

4. Other Changes

We describe the nature of the changes in more detail in the remainder of the Report, and we show all the components of change in the following Appendices:
Issues Related to Certain LOBs
Various considerations that might affect the selection of Risk Factors for certain LOBs are as follows:

- **Low Credibility LOBs**—The International, Financial/Mortgage Guaranty, and Warranty LOBs have relatively few data points for our analysis—900, 200, and 100 respectively—after filtering for reserve risk and similar amounts for premium risk. That compares to over 10,000 data points for the Private Passenger Liability, Homeowners, and Workers’ Compensation LOBs. As such, indicated Risk Factors are more subject to variation from year-to-year because of even small changes in methodology and because of random variations in emerging data, than is the case for other LOBs.

- **Financial/Mortgage Guaranty**—There are many single state/monoline companies that provide data in the Annual Statements, but that are exempt from RBC requirement. The data for the single state/monoline mortgage/financial guaranty companies are not included in the data used to develop the indicated Risk Factors in Table 1.14

- **Warranty**—This LOB was separated from the Fidelity/Surety LOB in 2008. Some companies provided a complete history for Accident Year (“AY”) including prior AYs. Other companies provided the separate data only for AYs 2008 and subsequent. As such, RBC data for the Warranty LOB in Annual Statements prior to 2017 is very limited.

- **International**—As noted in the first bullet, the volume of data in this LOB is relatively low. Moreover, proportionally more of the historical experience for this LOB arises from earlier Annual Statements than from more recent Annual Statements. As such, the relevance of indicated Risks Factors for current LOB M business is less certain than for other LOBs.

- **Products**—Asbestos and Environmental claim emergence affects reserve development from each of the over 30 years of Annual Statements in our analysis. It is possible that this ongoing emergence results in over-stated indicated RRFs.15,16

- **Minimum Risk Charges**—For some LOBs, the indicated risk charges will be negative, after the investment income adjustment, for a company with industry average expenses and with average loss ratio/reserve development experience (Medical Professional Claims Made and Financial/Mortgage Guaranty RRFs). Also, for one LOB, the indicated risk charge will be zero or above, but below 5%, (Automobile Physical Damage-PRF). The NAIC Working Group may want to consider the use minimum risk factors.

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14 This RBC Risk Factor analysis does not consider the solvency risk aspects of Statutory Contingency Reserves that might be provided for Financial/Mortgage Guaranty LOBs or the implications of large unearned premium reserves (viewed as a percentage of written premium) for longer duration policies in Warranty, Financial/Mortgage, and health (included in “Other”) LOBs.

15 It is less obvious in the PRF indicated Risk Factors, but asbestos and environmental claim emergence might also affect Reinsurance Liability, Other Liability, and (to a lesser degree) Commercial Multi peril LOBs.

16 To the extent that the NAIC Working Group implements changes in risk factors with caps, as it has done in the past, this risk of over-stated Product Liability RRFs is mitigated.
Effect of 2017 Risk Factors Compared to Risk Factors in 2020 RBC Formula

If the NAIC Working Group were to implement Risk Factor changes based on the indicated Risk Factors, Table 1f, below, shows the percentage change in reserve Risk Charge, premium Risk Charge and ACL that would result, using capped and uncapped scenarios shown.

Table 1f
Change in RBC Values

<p>| 2020 RBC Formula Risk Factors vs. Alternative Capped and Uncapped Indicated risk Factors |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|</p>
<table>
<thead>
<tr>
<th>(1) Risk Factors/Capping</th>
<th>(2) % Change From 2020 Formula</th>
<th>(3) Reserve Risk Charge</th>
<th>(4) Premium Risk Charge</th>
<th>(5) ACL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2020 RBC Formula</td>
<td>Base</td>
<td>Base</td>
<td>Base</td>
</tr>
<tr>
<td>2</td>
<td>2014 Indicated - Uncapped</td>
<td>9.3%</td>
<td>-1.9%</td>
<td>2.8%</td>
</tr>
<tr>
<td>3</td>
<td>2017 Indicated - Uncapped</td>
<td>7.2%</td>
<td>-2.3%</td>
<td>2.1%</td>
</tr>
<tr>
<td>4</td>
<td>2017 Indicated - 5% Min. - Uncapped</td>
<td>7.9%</td>
<td>-2.3%</td>
<td>2.2%</td>
</tr>
<tr>
<td>5</td>
<td>2017 Indicated - 5% Min. - ±10% Max</td>
<td>0.5%</td>
<td>-0.6%</td>
<td>0.0%</td>
</tr>
<tr>
<td>6</td>
<td>2017 Indicated - 5% Min. - ±20% Max</td>
<td>2.1%</td>
<td>-1.5%</td>
<td>0.4%</td>
</tr>
<tr>
<td>7</td>
<td>2017 Indicated - 5% Min. - ±35% Max</td>
<td>3.4%</td>
<td>-2.5%</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

Table 1f shows the following:

- **Row 2**—The change in risk charges that would result from implementing the 2014 indicated Risk Factors in the 2016 Report is not zero, because those factors have been partially, but not fully implemented.

- **Row 3**—The change in Risk Factors that would result from implementing the 2017 indicated Risk Factors are lower than from implementing the 2014 indicated Risk Factors, because, as shown in Table 1c, the 2017 indicated Risk Factors are lower than the 2014 indicated Risk Factors.

- **Row 4**—If we apply a minimum risk charge, after investment income adjustments, of 5%, the change in risk charges is slightly higher than if that were not applied, i.e., 2.2% of ACL rather than 2.1% of ACL.

- **Rows 5-7**—If we apply the 2017 indicated Risk Factors, but capped to produce a maximum change in risk charge by LOB, after investment income adjustment, the changes in ACL are 0.0%, 0.4%, and 0.7% for caps of 10%, 20%, and 35% respectively. The caps are applied to the absolute value of the risk charge change, i.e., no more than 10% upward or 10% downward. The 5% minimum is applied in each of the examples.
3. METHODOLOGY

We determine the indicated Risk Factors as outlined below in Appendices 1-9. In Appendices 10 and 11, we analyze the movement in indicated Risk Factors from the values in the 2016 Report to the values in this Report.

Risk Factor Overview
We describe the basis for the PRF and RRF indications below.

PRF Indications
The PRF for a LOB is a component of the premium risk charge, which reflects the risk that a subsequent year of company premium, net of reinsurance, will produce an adverse UW result.

The indicated PRF for each LOB is derived from loss and loss adjustment expense (“LAE”) ratios, for each LOB/company/year in the selected experience period. We refer to the net earned premium (“NEP”) and the loss ratio (“LR”) for an AY/company/LOB as a premium risk data point.

The indicated PRF is the 87.5th percentile of the LR after the filtering described in the Data Selection section below.

RRF Indications
The RRF for a LOB is a component of the reserve risk charge, which reflects the risk that currently reported reserves for loss and all loss adjustment expense, net of reinsurance, will develop adversely from the initial reserve date to ultimate.17, 18

The indicated RRF for each LOB is derived from RRRs by company/year in the selected experience period. The denominator of that ratio is the company carried loss reserve, for all AYs combined, at the initial reserve date.19 The numerator of the ratio is the increase/decrease in the company estimated incurred losses for all AYs combined from that initial reserve date to the latest available evaluation date. Appendix 12—Examples 1, 2, and 3 illustrate the RRR calculation. We refer to the initial reserve amount and the RRR for an initial reserve date/company/LOB as a reserve risk data point. We refer to premium and reserve risk data points, generically, as risk data points.

The indicated RRF is the 87.5th percentile of the RRRs after the filtering described below.

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17 The development to ultimate is often referred to as a “runoff” time horizon, in contrast to a “one year” time horizon that considers adverse development over a one-year period. This is intended to be the development to ultimate, but implementation of that intention is limited by the available data.

18 The RRF does not measure the adequacy of a company’s carried reserves. The company experience adjustment, not part of this analysis, partially reflects company historical reserve adequacy, relative to the industry.

19 The amounts in this calculation are gross of nontabular discount.
Data
We obtain our data from:

- Annual Statements, Schedule P, Parts 1, 2, and 3, for all LOBs, for years 1989–2017, and
- Confidential RBC Filings, for Two-Year LOBs, for years 1994–2017.

Compared to the 2016 Report, the data available for this Report include three “new” Annual Statement and RBC Filings (2015–2017), and eight “older” Annual Statements (1989–1996). These additional data are desirable because they include more data points, contain more developed data for recent years, reflect a wider range of UW and economic conditions, include more recent data, and provide some data for AY 1988 and subsequent that were not available in the data used for the 2016 Report.

Data Filtering
Consistent with the 2016 Report methodology, our indicated Risk Factors use the data described above and filtering rules itemized below. The filtering rules address the following features of the data:

1. Experience period
2. Pooling
3. Anomalous data, including Zero Interior filter
4. Minor lines
5. Age
6. Size
7. Maturity

In this analysis we refine the use of filters compared to the 2016 Report, as follows:

For both Premium and Reserve Risk:

- Enhanced the size threshold calculation (Appendix 7)
- Age based on “pool” age rather than “oldest company” age (Appendix 6)
- In the 2016 Report we selected the most mature LR and RRR after we consolidated company data into pools, as appropriate, (“Pooling First”). In this Report, we select the most mature LRs and RRRs by company, before consolidation into pools, as appropriate (“Maturity First”). (Appendix 3).

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20 Electronic data for Part 1 is available for some earlier years, but, for the earlier annual statement years, the LOB definitions in Schedule P were not the same as the current LOB definitions.
21 RBC Forms PC111-114 and 121-122 for premium and RBC Forms 211-214, 221-222, and 301-304, for reserves.
22 RBC Filing data compiled by regulators who provide summary results to this Committee.
23 For example, there are companies with 1996 Annual Statements that include data on AY 1988, or reserve year ending December 31, 1988, that did not file Annual Statements after 1996. In this case, the 1988 experience of these companies are not part of the 2016 Report analysis, because data from 1996 and prior Annual Statements were not available.
For Reserve Risk Factors:

- Revise the treatment of RRRs with absolute value greater than 5 for Ten-Year LOBs (Appendix 4)
- Revised definition of “Minor Lines” (Appendix 5)
- Zero Interior filter for reserve risk data for confidential RBC Filings, used for Two-Year LOBs, and from Annual Statement, for all LOBs (Appendix 4)
- Minor lines categorization and LOB-age for RBC RRRs based on Annual Statement data (Appendix 5—Minor Lines and Appendix 6—LOB-age)

We identify the changes with the largest effects, by Type of Company, in the Findings section above.

We outline the nature of these filters, and the impact of the changes, in the sections immediately below, and we further describe them in Appendices 1-9. Except as noted, we applied the same methods in our analysis of Annual Statement data and confidential RBC data.

1. Experience Period (Appendix 2)

In this Report, we use LRs for AYs 1988–2017 and RRRs for initial reserve years ending 1988–2016.\(^{24}\) For Ten-Year LOBs, we obtain this data from Annual Statements. For Two-Year LOBs, we obtain the data from confidential RBC Filings. For the 2016 Report, the data covered LRs and RRRs from AY 1988–2014 and initial reserve years ending December 31, 1988–2013.

**Exclude AYs and Initial Reserve Years Prior to 1988**

For this Report, we have experience for AYs/Reserve Years 1980 to 1987 that was not available for the 2016 Report. Looking at indicated Risk Factors by decade, we find that for nearly all the liability LOBs, this oldest block of years shows the highest indicated PRFs and RRFs.

This pattern may be due to factors that might not be applicable to current conditions. For example, the 1993 Report on Reserve and Underwriting Risk Factors by the American Academy of Actuaries Property/Casualty Risk-Based Capital Task Force (page 4)\(^{25}\) identified four reasons why the experience of the 1980’s might not be suitable for projection of the future. These are:

- **The tort liability explosion, particularly in respect to asbestos and environmental liabilities.**
- **A great deal of naïve capacity, focused especially on general liability and reinsurance lines.**
- **High interest rates, creating intense pressures to engage in cash flow underwriting**
- **High inflation rates**

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\(^{24}\) Note that the most recent AY is 2017, but the most recent initial reserve date is December 2016. The most recent initial reserve year is always one year older than the most recent AY, as for the latest year, the reserve development is zero and not useful for our analysis.

Other considerations include:

- Company loss reserving practices may have improved because of required actuarial opinions and increased regulatory, rating agency and management attention to reserving.
- The adverse experience in these years triggered expansion in the use of claims-made policies, pollution exclusions, asbestos exclusions, and other policy changes.
- Company pricing discipline and pricing methodology may have improved since the 1980’s.

Therefore, in this Report, we do not use the experience prior to 1988, because these early years may not be sufficiently relevant to the present conditions.

2. Pooling (Appendix 3)
We combine risk data points from intercompany pool participants into a single pool-wide risk data point. Two features of the pooling process are new in this Report.

- First, in the 2016 Report we selected the most mature LR and RRR after we consolidated company data into pools, as appropriate, (“Pooling First”). In this Report, we select the most mature LRs and RRRs by company, before consolidation into pools, as appropriate (“Maturity First”). We example the reasons for this change in Appendix 3.
- Second, while we generally apply the filter to the pooled data points, we apply the new zero interior filter before pooling.

3. Anomalous values (Appendix 4)

**Premium Risk**
For PRFs, we exclude risk data points with anomalous values, i.e., negative values for premiums, incurred losses. We exclude zero incurred losses, as these can represent unusual financial transactions or other data anomalies.

**Reserve Risk**
For RRFs, we exclude the entire company/LOB/statement year data triangle, before pooling, if:

- Any calendar year\(^{26}\) has negative cumulative incurred losses, all AYs combined
- Any calendar year has negative total cumulative paid losses, all AYs combined
- Any calendar year has a negative total reserve, all AYs combined
- The interior of the development triangle is entirely zero values

Also, for both Annual Statement and RBC data, we exclude risk data points where the initial reserve is zero. In the Pooling First approach, this can have has the effect of excluding the entire company/LOB/statement year. In the Maturity First approach, even if there is a zero initial reserve at one valuation date, we might construct RRR values from data points in the statement year for other maturities that have non-zero initial reserves.

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\(^{26}\) A calendar year in the Annual Statement or RBC development triangle is the sum of values for all AYs within a column of the data triangle. The test means examining the sum of the incurred losses over all AYs plus the prior year row, for a development column in Schedule P, Part 2, or the corresponding amounts for RBC incurred loss schedules, and similarly for paid losses in Schedule P Part 3.
Absolute (RRR)>5

As discussed in the Findings section, we exclude RBC risk data with absolute values of RRR>5 for Two-Year LOBs. In the 2016 Report, we excluded RRR values greater than 5 for both Ten-Year LOBs and Two-Year LOBs because we were concerned that the ratios reflected data quality issues.

4. Minor Lines (Appendix 5)

We exclude risk data points where the premium for the LOB represents a small portion of a company’s all lines premium as defined below. (‘Minor Lines’)

For premium risk, the Minor Lines filter compares the LOB premium to the all-lines NEP for each AY separately. This is the same method that was used in the 2016 Report. As described in the Findings section above, for Reserve Risk, the Minor Lines filter compares the NEP for the LOB for a period of years—10 years where practical—to the corresponding all-lines premium.

For both reserve risk and premium risk, the threshold boundary for Minor Lines is as follows:

<table>
<thead>
<tr>
<th>LOBs (NAIC Code)</th>
<th>Minor Lines Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>All lines other than those listed below</td>
<td>5.0%</td>
</tr>
<tr>
<td>Other Liability and Products Liability combined</td>
<td>5.0%</td>
</tr>
<tr>
<td>Special Liability, Fidelity/Surety, Warranty</td>
<td>2.5%</td>
</tr>
<tr>
<td>International, Financial/Mortgage Guaranty</td>
<td>No Filter</td>
</tr>
</tbody>
</table>

These thresholds in Table 2 are the same as in the 2016 Report.

We determine the Minor Line status of each reserve risk data point using Annual Statement data. We apply that status to the corresponding RBC reserve risk data point.27

5. Age—Years of LOB NEP > 0 (Appendix 6)

We exclude premium and reserve risk data points where, for a particular company/LOB, there are less than five years28 of NEP greater than zero.

This is the same filter that we used in the 2016 Report, although (1) with additional years of experience, there are some “young” LOBs excluded by this age filter in the 2016 Report that are not excluded in this Report, and (2) in this Report we determined age by pool while in the 2016 Report pool age equaled the age of the oldest company within the pool. This change may have excluded some data points that had been included in the 2016 Report.

6. LOB Size (Appendix 7)

We exclude risk data points where, for a LOB, NEP (or initial reserve) is less than the 15th percentile for the AY or initial reserve year. We smooth the 15th percentile size threshold in one of several ways that we discuss in Appendix 7.

27 This simplifies the calculation effort required of the regulatory working with the confidential RBC data.
28 Consecutive or non-consecutive years.
7. Maturity (Appendix 8)
We exclude the least mature risk data points, as we did in the 2016 Report. We exclude risk data points with maturity less than the number of years shown in Table 3 below.

Table 3—Maturity Filtering
“na” means there is no filter, i.e., use all years regardless of maturity

<table>
<thead>
<tr>
<th>Line</th>
<th>PRF</th>
<th>RRF</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) H/F</td>
<td>na</td>
<td>3</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>na</td>
<td>3</td>
</tr>
<tr>
<td>(3) CA</td>
<td>na</td>
<td>3</td>
</tr>
<tr>
<td>(4) WC</td>
<td>na</td>
<td>4</td>
</tr>
<tr>
<td>(5) CMP</td>
<td>na</td>
<td>5</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>(7) MPL C-M</td>
<td>na</td>
<td>5</td>
</tr>
<tr>
<td>(8) SL</td>
<td>na</td>
<td>3</td>
</tr>
<tr>
<td>(9) OL</td>
<td>na</td>
<td>4</td>
</tr>
<tr>
<td>(11) Spec. Prop.</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>(12) APD</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>(10) Fidelity / Surety</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>(13) Other</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>(15) International</td>
<td>4</td>
<td>na</td>
</tr>
<tr>
<td>(16) Reins. Prop. / Fin.</td>
<td>na</td>
<td>3</td>
</tr>
<tr>
<td>(17) Reins. Liab.</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>(18) PL</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>(14) Financial / Mortgage</td>
<td>4</td>
<td>na</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>5</td>
<td>na</td>
</tr>
</tbody>
</table>

8. Overall Effect of Filtering
Table 4 below shows the volume of NEP/reserve used in the filtered data set compared to the total volume. This table shows that the proposed filtered data set uses most of the NEP and reserve volume available in the data, after removing anomalous data.

Table 4—Data Used in Filtered Data Set^20^ 1988–2017 AYs and Initial Reserve Years

<table>
<thead>
<tr>
<th>Item</th>
<th>PRF</th>
<th>RRF</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Lines</td>
<td>10 Yr Lines</td>
</tr>
<tr>
<td>% Premium/Reserves</td>
<td>92%</td>
<td>93%</td>
</tr>
<tr>
<td>% Risk Data Points</td>
<td>52%</td>
<td>52%</td>
</tr>
</tbody>
</table>

^20^ Data from 1988–2017, reflecting the effect of all filtering (items 1-7).
In the 2016 Report, these ratios had similar values. For premium and reserve amounts, the all-lines ratios were 93% and 80% for premium and reserves, respectively. For number of data points, the ratios were 53% and 43% for premium and reserves, respectively.
9. Safety Level
Consistent with prior Committee reports and NAIC Working Group, decisions, the indicated Risk Factors are based on an 87.5th percentile of reserve risk data points and premium risk data points for Reserve Risk and Premium Risk, respectively, subject to the filtering discussed previously.30

4. OTHER CONSIDERATIONS AND FUTURE RESEARCH

This Report does not address the following issues:

1. Catastrophe Loss Adjustment—The indicated PRFs shown in this Report reflect the inclusion of earthquake and hurricane catastrophe losses. We have not separated the Risk Factors into the non-catastrophe and catastrophe components used in the RBC Formula.

2. Workers’ Compensation Discount—Our scope does not include estimating the effect that unwinding Workers’ Compensation tabular reserves might have on the indicated Risk Factors.

3. Line 3 Company Experience Adjustment—The RBC formula includes an adjustment for the company loss ratio for premium risk (or runoff ratio for reserve risk) in relation to the corresponding industry ratios in pages PR0017 and PR0018, lines 1, 2, and 3. Consistent with the proposed calibration of PRFs and RRFs, the NAIC P&C RBC Working Group should consider changes to the calculation of the industry loss ratio and/or reserve ratio (Line 1 on PR0017 and PR0018) to reflect the filtering of the Risk Factor calibration discussed above. This could include:31
   - Excluding risk data points when premiums (reserves) are below the 15th percentile for that AY/LOB (“Size”).
   - Combining risk data points from intercompany pool participants into a single pool-wide risk data point (“Pooling”).
   - Excluding risk data points where the NEP for the LOB represents a small portion of a company’s total NEP (“Minor Lines”).
   - Excluding LOB/company risk data points if there are less than five years of NEP for that LOB (“Age”).
   - Assess the need for change to reflect that calibration data exclude certain immature risk data points.32

4. The current RBC formula structure—Our indicated Risk Factors assume the current structure of the RBC Formula. For example,33 while indicated UW Risk Factors vary by line of business volume, the Committee provides a single factor for each LOB.

30 In the next report, we plan to further discuss the safety level reflecting both Line 4 safety level and the effect of the investment income offset.
31 We believe the NAIC method of developing the factors excludes anomalous data, i.e., unexpected zero or negative values.
32 Adjustment possibilities include (a) revising own-company calculation to use only the more mature risk data points, or (b) making no adjustment because the company data and industry data are at the same maturity.
33 This is one example. There are other variations in the RBC Formula.
5. As discussed earlier in the report, in the Findings section, for several LOBs, there are particular issues that might affect selected Risk Factors and/or might be the subject of future analysis.

6. The zero interior aspect of the RBC Filing data that we use for our calibration indicates that additional data quality assessment for past data, and/or clarification of RBC Filing requirements, might be useful. Assessment of data quality is problematic because the RBC data is confidential, and not available in detail to this Committee.

7. As we were completing this analysis, we realized that it is possible to obtain two data points from the loss triangles provided for two-year lines of business in the Annual Statement. Because it contains a reserve valued one year prior to two individual accident years provided in the triangle, it is possible to calculate a reserve risk ratio from solely the prior year row and this would provide one additional year of development.

5. APPENDIX 1―DATA

We obtain our data from 1989–2017 Annual Statements, Parts 1, 2, and 3 for all LOBs, and from 1994–2017 confidential RBC Filings for Two-Year LOBs.

Compared to the 2016 Report, the following additional data is available for this Report:


- The eight older Annual Statements (1989–1996) provide data for additional older AYs, and initial reserve dates, i.e.:
  - AYs 1980–1987 and December 31, 1980–1987 initial reserve dates for Ten-Year LOBs, and
  - AY 1988 and December 31, 1987, initial reserve dates for Two-Year LOBs, from Annual Statements.

These additional data are desirable, because they include more data points, contain more developed data for recent years, and reflect the effects of a wider range of UW and economic conditions. Moreover, the Annual Statement Filings for years prior to 1997 provide additional data for initial

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34 This issue does not relate to the quality of RBC Filing data used for RBC calculations. Rather, because our calibrations use RBC Filing data that is not used for RBC Filing calculations, some data submission

35 Electronic data for Part 1 is available for some earlier years, but, for the earlier annual statement years, the LOB definitions in Schedule P were not the same as the current LOB definitions.

36 LRs for AYs 2006–2014 in the 2016 Report were valued at ages 9, 8, …, 1, respectively. In the current report, LRs for AYs 2006–2008 are valued as of 10 years, and LRs for AYs 2009–2014 are valued at ages 9, 8, …, 4, respectively. Reserve development data are similarly more mature.
reserve years ending 1988 and subsequent, for those companies with 1988 and subsequent experience that did not file Annual Statements after 1996.37

**Lines of Business**
Schedule P currently contains information on 22 LOBs.

For the RBC Formula, and in our analysis, those 22 LOBs are combined into 19 LOBs.38 Other Liability Claims-Made is combined with Other Liability: Occurrence, (collectively “Other Liability”) Products Liability: Claims Made is combined with Products Liability: Occurrence, (collectively “Products Liability”) and Reinsurance: Nonproportional Assumed Property is combined with Reinsurance Nonproportional Assumed Financial (collectively “Reinsurance Property”).

**Two-Year and Ten-Year LOBs**
For six of the 19 LOB combinations, Schedule P contains premium and claim information on the most recent two AYs and reserve development information on prior years combined. We refer to these as “Two-Year LOBs.” These six lines are Special Property, Automobile Physical Damage, Fidelity/Surety, Other (Including Credit, Accident and Health), Financial/Mortgage Guaranty, and Warranty.

For the remaining LOBs, Schedule P contains information on the most recent 10 AYs and reserve development on prior years. We refer to these as “Ten-Year LOBs.”

Thus, in our Annual Statement data, for Ten-Year LOBs, we have AY LRAs and RRRs evaluated at maturities up to 10 years, and for Two-Year LOBs, we have AY LRAs and RRRs evaluated at maturities up to two years. The RRRs from Two-Year LOBs cover the development of only the most recent two calendar years, for all accident years, including those prior to the most recent two accident years.

**Premium and Reserve Risk Data**
For the analysis of premium risk, for each LOB, we obtain (a) earned premium net of reinsurance, (b) incurred loss and loss adjustment expenses net of reinsurance, and (c) the related LR, for each LOB, AY, company, and annual statement year.

For the analysis of reserve risk, we obtain (a) loss and defense and cost containment expense (“DCCE”) reserves at each year end, for all AYs combined, net of reinsurance (b) the increase/decrease in reserve estimate to the latest available maturity, for all AYs combined, net of reinsurance, and (c) the ratio of (a) and (b) that we call the RRR.39

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37 For example, there are companies with 1996 Annual Statements that include data on AY 1988, or reserve year ending December 31, 1988, that did not file Annual Statements after 1996. In this case, the 1988 experience of these companies are not part of the 2016 Report analysis, because data from 1996 and prior Annual Statements were not available.

38 The LOB definitions had a major revision in the 1989 Annual Statement. There have been some changes in LOB definitions in the years from 1989 to present. As needed, in the section below, we note those that affect analysis.

39 All values gross of non-tabular discount. Reserves and payments are net of salvage and subrogation, as reported in the Annual Statement.
Note that the calibration is based on runoff of loss + DCCE, but the resulting Risk Factor is applied to loss + all LAE. This assumes that development for adjusting and other expenses follows the same pattern as loss + DCCE.

Appendix 12, Examples 1, 2, and 3 below illustrate how we calculate RRRs for Ten-Year LOBs and Two-Year LOBs, from Annual Statement data and RRRs for Two-Year LOBs from RBC Filings.

Confidential Information in RBC Filings
The RBC Filings provide incurred loss and DCCE development draw from Schedule P Part 2, for all LOBs, and paid loss and DCCE development drawn from Schedule P Part 3, for Two-Year LOBs.

The differences between Annual Statement data and confidential RBC Filing data for reserve risk, for Two-Year LOBs, include the following:

- Annual Statement Schedule P Parts 2 and 3 contains the latest two calendar years of development data. For example, the 2017 Annual Statement shows the incurred and paid values for the following:
  - AY 2017 evaluated at December 31, 2017,
  - AY 2016 evaluated at December 31, 2016, and December 31, 2016,
  - The reserve at December 31, 2015, for accident years 2015 and prior and the change in incurred and paid values for AYs 2015 and prior (combined) in calendar year 2016 and in calendar year 2017.

- RBC data includes up to 10 individual AYs of development, over 10 calendar years, but it does not include any development information on AYs prior to those 10. Because RBC data does not include development information on AYs prior to year 10, the most mature runoff ratio from RBC data includes only one AY, i.e., the most mature AY, which provides maturities from one to 10.

Thus, for the most mature RRRs from Annual Statement data we have two calendar years of development for all AYs, while for RBC data we have up to 10 calendar years of development, but for only one AY. Neither type of data is as complete as the development history available for Ten-Year LOBs from the Annual Statement, which provides ten calendar years of development for all AYs.

AY Indicated Risk Factors—Annual Statement Data Compared to RBC Data
For Two-Year LOBs, we have data from Annual Statements and from RBC Filings. We calculate indicated PRFs and RRFs from each source.

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40 RBC Forms PC111-114 and 121-122 for premium and RBC Forms 211-214, 221-222, and 301-304, for reserves.
Table A-1 below shows the differences between PRF indications using Annual Statement data and PRFs indications using RBC Filing data, and the differences between RRF indications using Annual Statement data and RRF indications using RBC Filing data.

<table>
<thead>
<tr>
<th>LOB</th>
<th>Indicated PRFs</th>
<th>Indicated RRFs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RBC</td>
<td>A/S</td>
</tr>
<tr>
<td>(1) Spec. Prop.</td>
<td>0.831</td>
<td>0.836</td>
</tr>
<tr>
<td>(12) APD</td>
<td>0.837</td>
<td>0.847</td>
</tr>
<tr>
<td>(10) Fidelity / Surety</td>
<td>0.666</td>
<td>0.704</td>
</tr>
<tr>
<td>(13) Other</td>
<td>0.933</td>
<td>0.953</td>
</tr>
<tr>
<td>(14) Financial / Mortgage</td>
<td>2.588</td>
<td>1.929</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>0.975</td>
<td>0.902</td>
</tr>
<tr>
<td>(11) Spec. Prop.</td>
<td>0.278</td>
<td>0.238</td>
</tr>
<tr>
<td>(12) APD</td>
<td>0.132</td>
<td>0.163</td>
</tr>
<tr>
<td>(10) Fidelity / Surety</td>
<td>0.600</td>
<td>0.311</td>
</tr>
<tr>
<td>(13) Other</td>
<td>0.225</td>
<td>0.175</td>
</tr>
<tr>
<td>(14) Financial / Mortgage</td>
<td>0.001</td>
<td>0.274</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>0.312</td>
<td>0.349</td>
</tr>
</tbody>
</table>

In interpreting the differences indicated Risk Factors between the Annual Statement data and RBC data, we note the following, with respect to both PRFs and RRFs:

- Warranty—This LOB was separated from the Fidelity/Surety LOB in 2008. Some companies provided a complete history for all AYs, including AYs prior to 2008. Other companies provided the separate data only for AYs 2008 and subsequent. As such, only Annual Statement 2017 and RBC Filing 2017 contains complete development and reserve runoff data, and, overall, there are too few points, i.e., under 100, to provide reliable indicated Risk Factors. Hence, variations between Annual Statement and RBC indicated Risk Factors are not surprising.
- Financial/Mortgage Guaranty—There are many single state/monoline companies that provide data in the Annual Statements, but who are exempt from RBC requirement. As they do not make RBC Filings, the experience for the single state/monoline mortgage/financial guaranty companies is not included in the data used to develop the indicated Risk Factors in Table 1. Hence there is substantially more data in the Annual Statement data than the RBC data, and differences between Annual Statement and RBC indicated Risk Factors are not surprising.

With respect to PRFs, for the other four Two-Year LOBs, the RBC data produces lower indicated Risk Factors. We interpret this to be the effect of favorable AY LR development that is reflected in the 10-year development in the RBC Filing data but is not reflected in the two-year development in the Annual Statement data.

With respect to RRFs, the direction of the differences between the RRFs based on Annual Statement data and RRFs based on RBC data vary by LOB, and we note the following:

- The RBC data includes both favorable and unfavorable reserve development that may not reflected in the two-calendar year window reflected in the Annual Statement data.
  - For Automobile Physical Damage, it appears that the balance of favorable and unfavorable produces a lower RRF from the RBC data than from the Annual Statement data.
  - For Fidelity and Surety, it appears that adverse economic environments in the 1999–2002 period and the 2008–2009 period generate adverse development on initial reserves established at year-ends prior to those dates, but not reflected for several years after those periods.

- RBC reserve risk data includes fewer data points for all the Two-Year LOBs, and the differences are proportionally larger for some LOBs than for others. As the company-by-company RBC data is confidential, and not available to us, we have not explored that in detail.

6. APPENDIX 2—EXPERIENCE PERIOD

We have Annual Statements premium risk data for AYs 1980–2017, for most Ten-Year LOBs and 1985–2017 from RBC Filings for most Two-Year LOBs.

We have RRRs for the same starting dates, but ending in 2016. Because Annual Statement LOB definitions change over time, there are fewer years of experience for the Medical Professional Liability, Warranty, and Financial/Mortgage Guaranty LOBs. Table A-2, below, shows the LRss and RRRs available to us by year.

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41 The most recent initial reserve year is always one year older than the most recent AY, as, for the latest year, we only have an initial estimate and no information on subsequent development.
Table A-2
LR and RRR Years From Available Data

<table>
<thead>
<tr>
<th>Source</th>
<th>Net Earned Premium and Loss Ratio Years:</th>
<th>Initial Reserve and Reserve Runoff Ratios for Years Ending Dec. 31:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Statements (Statement Years 1989-2017)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Statements Exceptions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MPL Claims Made, MPL Occurrence (Note 1)</td>
<td>1984-2017</td>
<td>1984-2016</td>
</tr>
<tr>
<td>Financial/Mortgage (Note 2)</td>
<td>1993-2017</td>
<td>1993-2016</td>
</tr>
<tr>
<td>Confidential RBC Filings (Filing Years 1994-2017)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most Two-Year LOBs (Note 4)</td>
<td>1985-2017</td>
<td>1988-2016</td>
</tr>
</tbody>
</table>

Note 1: Earliest Annual Statement or RBC Filing for the MPL LOBs – 1993
Note 2: Earliest Annual Statement for the Financial/Mortgage LOB – 1994
Note 3: Earliest Annual Statement or RBC Filing for Warranty LOB – 2008, when the Warranty LOB was separated from the Fidelity/Surety LOB. RBC Filings for some companies show the new Warranty LOB for AYs 2008 and subsequent only, while some companies show RBC data for prior AYs as well.
Note 4: We did not use data from RBC filing years 1994-1996, as data for those years was collected for information purposes only, and might be subject to learning-curve errors.

Treatment of 1980–1987 AYs/RRRs
The current data set includes 1980–1987 AYs and RRRs that were not available for prior Committee reports, nor for the DCWP for its work.

Table A-3 below shows the indicated Risk Factors by decade, 1980–1989, 1990–1999, 2000–2009, and 2010–2017. We see that, for nearly all the liability LOBs, the oldest block of years, 1980–1989, shows the highest indicated PRFs and RRFs.

Table A-4, below, shows that including the oldest years (1980–1987) in the indicated Risk Factors produces significantly higher indicated RRFs and a somewhat higher PRFs, compared to the indicated Risk Factors excluding the oldest years. RRFs increase by more than 20% for many of the larger volume lines.

Therefore, for the reasons we discuss above, in the “1. Experience Period” subsection in the Methodology section, we believe the experience prior to 1988 may not be applicable to current conditions, and we do not include it in our indicated Risk Factors.

We plan to revisit this assumption when we review Investment Income Adjustments in our next report, where we will consider the effect of interest rate changes on risk charges over the entire period.
### Table A-3

**Comparison of Risk Factors—**

**Current Indicated (2017 Data) AY/RRF 10-Year Experience Ranges**

<table>
<thead>
<tr>
<th>Line</th>
<th>80-89</th>
<th>90-99</th>
<th>00-09</th>
<th>10-17 (2)</th>
<th>80-89</th>
<th>90-99</th>
<th>00-09</th>
<th>10-16 (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) H/F</td>
<td>0.918</td>
<td>0.999</td>
<td>0.946</td>
<td>0.909</td>
<td>0.398</td>
<td>0.195</td>
<td>0.272</td>
<td>0.200</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>1.074</td>
<td>0.969</td>
<td>0.955</td>
<td>0.999</td>
<td>0.396</td>
<td>0.165</td>
<td>0.195</td>
<td>0.246</td>
</tr>
<tr>
<td>(3) CA</td>
<td>1.193</td>
<td>1.069</td>
<td>0.958</td>
<td>1.017</td>
<td>0.589</td>
<td>0.349</td>
<td>0.359</td>
<td>0.423</td>
</tr>
<tr>
<td>(4) WC</td>
<td>1.198</td>
<td>1.041</td>
<td>1.042</td>
<td>0.928</td>
<td>0.536</td>
<td>0.293</td>
<td>0.382</td>
<td>0.134</td>
</tr>
<tr>
<td>(5) CMP</td>
<td>1.020</td>
<td>0.951</td>
<td>0.848</td>
<td>0.857</td>
<td>0.973</td>
<td>0.553</td>
<td>0.456</td>
<td>0.366</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>1.777</td>
<td>1.634</td>
<td>1.379</td>
<td>1.254</td>
<td>0.981</td>
<td>0.246</td>
<td>0.361</td>
<td>0.138</td>
</tr>
<tr>
<td>(7) MPL C-M</td>
<td>1.035</td>
<td>1.368</td>
<td>1.084</td>
<td>1.023</td>
<td>0.242</td>
<td>0.133</td>
<td>0.081</td>
<td>0.116</td>
</tr>
<tr>
<td>(8) SL</td>
<td>1.145</td>
<td>0.996</td>
<td>0.892</td>
<td>0.882</td>
<td>0.651</td>
<td>0.680</td>
<td>0.277</td>
<td>0.102</td>
</tr>
<tr>
<td>(9) OL</td>
<td>1.634</td>
<td>1.076</td>
<td>1.016</td>
<td>0.930</td>
<td>1.612</td>
<td>0.619</td>
<td>0.521</td>
<td>0.261</td>
</tr>
<tr>
<td>(10) Spec. Prop.</td>
<td>0.722</td>
<td>0.858</td>
<td>0.797</td>
<td>0.840</td>
<td>0.252</td>
<td>0.305</td>
<td>0.246</td>
<td>0.282</td>
</tr>
<tr>
<td>(11) Fidelity / Surety</td>
<td>0.773</td>
<td>0.847</td>
<td>0.817</td>
<td>0.857</td>
<td>0.045</td>
<td>0.119</td>
<td>0.164</td>
<td>0.146</td>
</tr>
<tr>
<td>(12) Other</td>
<td>0.673</td>
<td>0.666</td>
<td>0.760</td>
<td>0.543</td>
<td>0.373</td>
<td>0.915</td>
<td>0.560</td>
<td>0.264</td>
</tr>
<tr>
<td>(13) Other</td>
<td>0.905</td>
<td>0.947</td>
<td>0.932</td>
<td>0.903</td>
<td>0.132</td>
<td>0.239</td>
<td>0.272</td>
<td>0.119</td>
</tr>
<tr>
<td>(15) International</td>
<td>1.708</td>
<td>1.623</td>
<td>1.675</td>
<td>1.630</td>
<td>2.489</td>
<td>2.141</td>
<td>0.460</td>
<td>0.273</td>
</tr>
<tr>
<td>(16) Reins. Prop. / Fin.</td>
<td>1.363</td>
<td>1.235</td>
<td>1.268</td>
<td>1.127</td>
<td>0.732</td>
<td>0.416</td>
<td>0.314</td>
<td>0.000</td>
</tr>
<tr>
<td>(17) Reins. Liab.</td>
<td>1.785</td>
<td>1.328</td>
<td>1.359</td>
<td>0.903</td>
<td>1.023</td>
<td>0.658</td>
<td>0.729</td>
<td>0.060</td>
</tr>
<tr>
<td>(18) PL</td>
<td>1.496</td>
<td>1.378</td>
<td>1.290</td>
<td>1.067</td>
<td>2.490</td>
<td>1.532</td>
<td>1.701</td>
<td>0.701</td>
</tr>
<tr>
<td>(14) Financial / Mortgage</td>
<td>2.726</td>
<td>2.530</td>
<td>2.506</td>
<td>2.000</td>
<td>0.059</td>
<td>0.000</td>
<td>0.000</td>
<td>0.006</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>0.663</td>
<td>0.937</td>
<td>0.900</td>
<td>0.113</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
</tbody>
</table>

**Average Risk Factor— all Lines**

- PRF: 1.056 0.991 0.950 0.925 0.780 0.389 0.392 0.223
- RRF: 1.143 1.023 0.979 0.941 0.835 0.400 0.409 0.277

**Average Risk Factor— 10-Yr Lines**

- PRF: 0.834 0.907 0.877 0.884 0.163 0.267 0.212 0.182
- RRF: 0.905 0.947 0.932 0.903 0.132 0.239 0.272 0.119

**Average Risk Factor— 2-Yr Lines**

- PRF: 0.905 0.932 0.903 0.857 0.045 0.119 0.164 0.146
- RRF: 0.673 0.666 0.760 0.543 0.373 0.915 0.560 0.264

**Notes:**


2. For PRFs and RRFs the 2010–2016/2017 have limited credibility because the maturity filter excludes up to five of the latest 10 years, and because the remaining data points are less mature than the data points for any other decade.

3. Average risk factors weighted with Annual Statement premium for all LOBs, including LOBs calibrated with RBC data.

### Table A-4
Comparison of Risk Factors by Experience Period
Including/Excluding 1980–1987

<table>
<thead>
<tr>
<th>Line</th>
<th>PRF 88-17</th>
<th>PRF 80-17</th>
<th>RRF 88-16</th>
<th>RRF 80-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) H/F</td>
<td>0.960</td>
<td>0.951</td>
<td>0.223</td>
<td>0.273</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>0.975</td>
<td>1.001</td>
<td>0.201</td>
<td>0.244</td>
</tr>
<tr>
<td>(3) CA</td>
<td>1.022</td>
<td>1.073</td>
<td>0.361</td>
<td>0.417</td>
</tr>
<tr>
<td>(4) WC</td>
<td>1.030</td>
<td>1.067</td>
<td>0.335</td>
<td>0.376</td>
</tr>
<tr>
<td>(5) CMP</td>
<td>0.897</td>
<td>0.928</td>
<td>0.499</td>
<td>0.627</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>1.480</td>
<td>1.556</td>
<td>0.265</td>
<td>0.350</td>
</tr>
<tr>
<td>(7) MPL C-M</td>
<td>1.149</td>
<td>1.150</td>
<td>0.094</td>
<td>0.109</td>
</tr>
<tr>
<td>(8) SL</td>
<td>0.952</td>
<td>1.006</td>
<td>0.415</td>
<td>0.477</td>
</tr>
<tr>
<td>(9) OL</td>
<td>1.014</td>
<td>1.137</td>
<td>0.527</td>
<td>0.821</td>
</tr>
<tr>
<td>(11) Spec. Prop.</td>
<td>0.831</td>
<td>0.822</td>
<td>0.278</td>
<td>0.278</td>
</tr>
<tr>
<td>(12) APD</td>
<td>0.837</td>
<td>0.834</td>
<td>0.132</td>
<td>0.132</td>
</tr>
<tr>
<td>(10) Fidelity / Surety</td>
<td>0.666</td>
<td>0.676</td>
<td>0.600</td>
<td>0.600</td>
</tr>
<tr>
<td>(13) Other</td>
<td>0.933</td>
<td>0.933</td>
<td>0.225</td>
<td>0.225</td>
</tr>
<tr>
<td>(15) International</td>
<td>1.712</td>
<td>1.679</td>
<td>1.044</td>
<td>1.479</td>
</tr>
<tr>
<td>(16) Reins. Prop. / Fin.</td>
<td>1.240</td>
<td>1.240</td>
<td>0.343</td>
<td>0.348</td>
</tr>
<tr>
<td>(17) Reins. Liab.</td>
<td>1.252</td>
<td>1.493</td>
<td>0.636</td>
<td>0.636</td>
</tr>
<tr>
<td>(18) PL</td>
<td>1.270</td>
<td>1.360</td>
<td>1.472</td>
<td>1.691</td>
</tr>
<tr>
<td>(14) Financial / Mortgage</td>
<td>2.588</td>
<td>2.588</td>
<td>0.001</td>
<td>0.001</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>0.975</td>
<td>0.975</td>
<td>0.312</td>
<td>0.312</td>
</tr>
<tr>
<td>Average Risk Factor- all Lines</td>
<td>0.967</td>
<td>0.992</td>
<td>0.376</td>
<td>0.471</td>
</tr>
<tr>
<td>Average Risk Factor- 10-Yr Lines</td>
<td>0.995</td>
<td>1.030</td>
<td>0.390</td>
<td>0.494</td>
</tr>
<tr>
<td>Average Risk Factor- 2-Yr Lines</td>
<td>0.897</td>
<td>0.894</td>
<td>0.218</td>
<td>0.218</td>
</tr>
</tbody>
</table>

See notes to Table A-3.

### 7. APPENDIX 3—POOLING METHODOLOGY

#### Pool Mapping
In determining the indicated UW Risk Factors, we combine the data from intercompany pool participants into a single pool-wide risk data point. Alternatively, if we were to treat these interrelated risk data points as independent, the same loss ratio value (or reserve runoff ratio) would appear multiple times, reducing the apparent variability in the LR (or RRR) across companies, and distorting the indicated 87.5th percentile LR/RRR value.42

42 See DCWP Report 6 pages 10-12, 16, and 77-80 for more details.

[https://www.casact.org/pubs/forum/13fforum/01-Report-6-RBC.pdf](https://www.casact.org/pubs/forum/13fforum/01-Report-6-RBC.pdf)
We identify intercompany pools by annual statement year using the following information, to the extent available, for each company and annual statement year:\footnote{The pool is defined separately for each statement year. For example, if two companies are in an intercompany pool for annual statement year 2013, then all data points from that annual statement year will be pooled. If the same two companies are no longer subject to intercompany pooling in 2014, the data points will not be pooled.}{43}

- NAIC group code from 2010, 2014, and 2017 analyses to identify member companies,
- Schedule P Intercompany Pooling Participation Percentage (Schedule P Part I Column 34),
- Schedule F Part 9 Note, and
- Notes to Financial Statements, Note 26\footnote{Currently Note 26. This information was in different Notes at different years in the past.}{44} (on Intercompany Pooling Arrangements).

Our current analysis includes 1984–1996 and 2015–2017 Annual Statements, which were not part of prior Academy or DCWP analysis. For the early years, 1984–1996, as we do not have the NAIC group assignments by company, we identify pool members as companies with identical or similar loss ratios across companies in combination with the oldest known NAIC group code. For the most recent years, 2015–2017, we had the 2017 NAIC group code to guide us. For 1997–2014 we make a few changes to the pool mapping based on an improved perspective on pooling, arising from the longer history of Annual Statements available to us.

Note that due to the limitations of the data and information available, our methodology is approximate, and might not necessarily identify all intercompany pooling arrangements and/or may combine some companies that are not actually pooled.\footnote{The pooling structure can also affect “LOB age” as we measure age based on number of years of NEP>0 for the pooled data.}{45} Group identification becomes more approximate for older annual statement years. However, we believe that the elimination of multiple identical records from the data set through this adjustment, even with the approximations, improves the quality of the Risk Factor analysis.

Selection of Most Mature Data Point—Maturity First vis-à-vis Pooling First

We have multiple evaluations of each initial reserve date-RRR and AY-LR for a given LOB/company. We remove data triangles that we classify as anomalous (see Appendix 4). Then, for each LOB, for each AY/Initial reserve year, before pooling, we determine the Annual Statement that had the most mature evaluation of the AY/initial reserve year. We calculate the LR/RRR from that Annual Statement. We pooled the resulting LRs/RRRs, using the pool associated with the annual statement year from which we calculated the LR/RRR. We refer to this approach as “Maturity First.”

In prior reviews, after removing company data triangles that we classified as anomalous, we then pooled Annual Statements, where appropriate, based on the annual statement year from which the data was derived.\footnote{This change is the latest in a series of refinements to the pooling calculation in the course of studies over the past 10 years, as described below.}{46} After pooling, for each LOB, we determined the most recent annual statement
year for each company or pool. We obtained up to 10 LRs or RRRs from that Annual Statement. We used earlier Annual Statements to obtain one LR/RRR using the most mature AY for LR and both the most mature AY and prior AYs for RRRs. We refer to this approach as “Pooling First.”

In the normal course, the Maturity First and Pooling First methods are the same. However, we find that there are companies where the most mature reading for an LR/RRR for a LOB does not appear in the expected Annual Statement. That might be because of new pool assignments, perhaps because the company was sold, the company ceased filing Annual Statements, reinsurance transactions reduced the LR/RRR data to zero, or for other reasons.

For a company subject to pooling, with the Pooling First approach, changes in pool assignment during the experience period can result in using of the same company data multiple times. Consider two companies, A and B, each with two statements (2016 and 2017) with data for each of the 10 AYs and for the prior years combined. Also suppose that A and B became part of Pool X in 2017. In the Pooling First approach, the 2017 statements for A and B are combined into a single statement for Pool X. We calculate 30 LRs (27 RRRs) for each LOB: 10 LRs (9 RRRs) for each of A, plus 10 LRs (9 RRRs) for B from statement year 2016, plus 10 LRs (9 RRRs) for Pool X from statement year 2017.

In the Maturity First approach, prior to pooling, we calculate 10 LRs (9 RRRs) for each of Companies A and B (for AYs 2008–2017, and for initial reserve years 2008–2016) from the 2017 Annual Statement and one LR/RRR from the 2016 Annual Statement (for LR/RRR 2007). These values are then pooled, resulting in 12 AY LRs (11 RRRs). The 20 LRs (18 RRRs) from the 2017 Annual Statement from Company A and Company B are pooled into Pool X and the remaining two LRs/RRRs from the 2016 Annual Statement remain unpooled. Hence, the total number of data points in the final dataset is reduced from 30/27 in the Pooling First Approach to 12/11 in the current Maturity First Approach.

The difference arises because, in the Pooling First approach, Pool X is considered a new company which results in some duplication of LR/RRRs. Hence, as expected, using the Maturity First approach somewhat reduces the number of data points.

8. APPENDIX 4—ANOMALOUS DATA

We describe the anomalous data treatment in the Methodology Section. In this Appendix we show Tables supporting the discussion of Absolute (RRR)>5 and Zero Interior anomalous data filters.

Prior to 2010, the pooling issue was identified, but there was no adjustment. DCWP introduced a pooling adjustment. The pooling adjustment assumed the pooling status was constant over the 1997–2010 Annual Statements available for its work. Based on that assumption, Pooling First or Maturity First were equivalent. The 2016 Report, with a longer Annual Statement history, examined the pooling history in more detail and reflected the changes in pooling from annual statement year to annual statement year. However, that analysis continued to calculate based on Pooling First approach. In this Report, with a still longer history of Annual Statements, we revised the Pooling First approach and modified the calculation as described.
**Absolute (RRR)>5**

Table A-5a, below, shows the effect, by LOB, of removing the Absolute (RRR)>5 filter. Table A-5a shows that the weighted average effect on the RRFs for Ten-Year LOBs is an increase of 2.4% of reserves, in RRFs, and there are important variations by LOB within the Ten-Year LOBs. The effect on indicated RRRs is most apparent in International (23% of reserves) and Products Liability (15% of reserves).

**Table A-5a**

<table>
<thead>
<tr>
<th>Line</th>
<th>RRR - Exclude if over 500%</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>(1) H/F</td>
<td>0.221</td>
<td>0.223</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>0.200</td>
<td>0.201</td>
</tr>
<tr>
<td>(3) CA</td>
<td>0.361</td>
<td>0.361</td>
</tr>
<tr>
<td>(4) WC</td>
<td>0.334</td>
<td>0.335</td>
</tr>
<tr>
<td>(5) CMP</td>
<td>0.494</td>
<td>0.499</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>0.259</td>
<td>0.265</td>
</tr>
<tr>
<td>(7) MPL C-M</td>
<td>0.090</td>
<td>0.094</td>
</tr>
<tr>
<td>(8) SL</td>
<td>0.386</td>
<td>0.415</td>
</tr>
<tr>
<td>(9) OL</td>
<td>0.520</td>
<td>0.527</td>
</tr>
<tr>
<td>(15) International</td>
<td>0.850</td>
<td>1.044</td>
</tr>
<tr>
<td>(16) Reins. Prop. / Fin.</td>
<td>0.342</td>
<td>0.343</td>
</tr>
<tr>
<td>(17) Reins. Liab.</td>
<td>0.598</td>
<td>0.636</td>
</tr>
<tr>
<td>(18) PL</td>
<td>1.280</td>
<td>1.472</td>
</tr>
<tr>
<td>Average Risk Factor- 10-Yr Lines</td>
<td>0.381</td>
<td>0.390</td>
</tr>
</tbody>
</table>

**“Zero Interior” Reserve Risk Data Anomalies**

As noted in the Methodology section, in our current review we exclude a LOB/Statement year if the interior of the development triangle is zero. Table A-5b below is an illustration of such data. We also observe some cases where some of, but not the entire interior of the data triangle has unexpected zero values.
With data of this type, we can calculate RRRs for individual AYs, for example, the 10-year development, for AY 2008. However, we cannot calculate RRRs for any full initial reserve year.

In the 2016 Report, we addressed this data anomaly in two ways. First, wherever possible we used the RRR based on development of the single most mature AY, row 2 that is not affected by the zero interior values. Second, we limited the impact of zero values by excluding data points where the absolute value of the RRR was greater than 500%.

In this Report, we exclude any data point where the entire interior is blank, which partly address the need for the Absolute (RRR)>500% limitation. However, we continue to exclude any data point with RRR >500%. We believe our current process has improved the identification of valid RBC data. However, there may be further steps we and/or NAIC could take to improve the data further, in future reviews.47

The Zero Interior issue predominately relates to RBC data for Two-Year LOBs, which are discussed above. There are also a small number of companies with Ten-Year LOB Annual Statement data that present zero interiors, typically showing non-zero values in the latest diagonal but having zero/blank data for all other values, including zero/blank in the latest evaluation column. We exclude that Ten-Year LOB data.

9. APPENDIX 5—MINOR LINES

We exclude risk data points where the volume for a LOB represents a small portion of a company’s volume as defined below (“Minor Lines”). The DWCP research48 reported, and the 2016 Report agreed, that “For certain [specialty] LOBs failure to exclude the Minor Lines risk data points

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47 As the detailed data is confidential, there are limits on the extent to which this Committee can address this issue alone.
48 DCWP Reports 6 and 7.
appears to result in PRFs that are not representative of the risks for companies writing the bulk of the industry LOB premium.”

For premium risk, similar to the 2016 Report, the Minor Lines filter calculation compares the LOB NEP to the all-lines NEP for each AY separately.

For reserve risk, the Minor Lines filter compares the LOB NEP to the all-lines NEP for a range of years, usually 10 years ending at the initial reserve date. Because the Annual Statement LOB definitions vary over time, a 10-year range is not possible for all LOBs for all initial reserve data. Hence, our approach varies somewhat by LOB. Table A-6 shows our approach for all years.

<table>
<thead>
<tr>
<th>Line</th>
<th>Initial Reserve Years Ending:</th>
<th>Net Earned Premium from the following AYs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Lines</td>
<td>1998-2016</td>
<td>Rolling 10-year window ending at the initial reserve date</td>
</tr>
<tr>
<td></td>
<td>1980-1987</td>
<td>Fifteen years, 1980-1994 (Notes 1, 2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Data unavailable for Two-Year LOBs.</td>
</tr>
<tr>
<td>MPL Occ and CM</td>
<td>1984-1987</td>
<td>Eleven years 1984-1994 (Note 2)</td>
</tr>
<tr>
<td></td>
<td>1988-1997</td>
<td>See Most LOBs</td>
</tr>
<tr>
<td></td>
<td>1998-2016</td>
<td>See Most LOBs</td>
</tr>
<tr>
<td>Warranty</td>
<td>2003-2016</td>
<td>Rolling 10-year window ending at the initial reserve date</td>
</tr>
<tr>
<td>Warranty</td>
<td>2007-2016</td>
<td>Ten Years, 2007-2016 (Note 3)</td>
</tr>
</tbody>
</table>

Note 1: We use a relatively long period because, in the early part of this time period, the all-lines total does not include Two-Year LOBs and overstates the ratio of LOB premium to all-lines premium.

Note 2: This table shows the methods we would apply to initial reserve years 1980-1987, but for the reasons discussed previously, we do not use those initial reserve dates in our indicated Risk Factors.

Note 3: These are the only years of available data for the Warranty LOB.

This Minor Lines approach differs from the approach in the 2016 Report, where the reserve risk Minor Lines definition was based on all-years premium. With the increase in the number of years of premium in our data set, we adopt the approach described above.

The thresholds for the LOB Minor Lines filters for both PRFs and RRFs are the same as those we used in the 2016 Report, and are as follows:

- Apply 5.0% filter for most lines with exceptions described below.
- Apply no Minor Lines exclusion for the International and Financial/Mortgage Guaranty lines of business due to the low volume in these lines.

49 DCWP Report 6, Page 5.
50 This is determined after pooling, so changes in pooling can affect Minor Line status.
- Apply 2.5% filter for the Special Liability, Fidelity/Surety, and Warranty lines of business, because a 5% filter for either PRFs or RRFs would exclude most premiums or initial reserves.\(^{51}\)
- Exclude risk data points where the combined Other Liability and Products Liability NEP is less than 5.0% of total NEP to avoid exclusion of too much Products Liability volume.\(^{52}\)

For RRFs, which require multiple years of premium data, we determine Minor Line status using Annual Statement data, and we apply that categorization to the RBC data. To the extent that the LOB/Company/Initial Reserve Date in the RBC data do not have a corresponding data point in the Annual Statement data,\(^{53}\) the data point is treated as a Minor Line. For PRFs, which require a single year of data, we determine Minor Line by comparing the RBC NEP by LOB/company/year to the all-lines total NEP from the Annual Statement data.

We find that the change in Minor Lines definition, from the all-year basis to the 10-year basis, decreases the indicated RRFs for nearly all LOBs. That result is consistent with (a) Minor Lines tend to have higher RRRs than non-Minor Lines, and (b) the new method better distinguishes between Minor Lines data and non-Minor Lines data.

10. APPENDIX 6—YEARS OF LOB NEP > 0 (“LOB Age” or “Age”)

The 2016 Report\(^{54}\) concluded that for most LOBs, PRFs and RRFs are smallest for companies with the longest experience period for a particular LOB. The 2016 Report presented an analysis of Risk Factors, by LOB by Age. The analysis in the 2016 report shows that the differential in Risk Factors by Age is most pronounced when comparing Risk Factors with a filter of Age equal to 5+ years\(^{55}\) when compared to companies with age less than 5 years. In addition, few risk data points are removed with a filter that removes Ages less than 5.

In this Report we calculate the age of the pool as the number of years of NEP>0 for the pool. In the 2016 Report, we calculated age as the maximum of the number of years of NEP>0 for any of the companies in the pool. This change somewhat reduces the number of data points after filtering.

11. APPENDIX 7—LOB-SIZE THRESHOLDS

Our indicated Risk Factors exclude risk data points with small premium/reserve LOB size, defined as the 15\textsuperscript{th} percentile of size. We exclude the risk data points with small size because the experience

\(^{51}\) In addition to the other considerations, for Warranty, a 2.5% filter was chosen due limited volume of warranty experience.
\(^{52}\) Correlation between NEP for PL and OL lines, for baseline PRF data with no Minor Lines exclusion, was 0.66.
\(^{53}\) Such mismatches can occur because, there are pooling changes by Annual Statement year and the data point might derive from one Annual Statement year in the RBC data and a different Annual Statement year in the Two-Year Annual Statement data.
\(^{54}\) This conclusion is consistent with the conclusion in DCWP, in Report 6, Section 7 and DCWP Report 7, Section 7.
\(^{55}\) Consecutive or nonconsecutive years.
of these companies/pools is not representative of the experience derived from the majority of risk data points.\textsuperscript{56} We apply the size threshold analysis to the data after filtering for Minor Lines and Age, as described in the earlier Appendices.

We consider four smoothing approaches to calculating the 15\textsuperscript{th} percentile, as follows: (1) 15\textsuperscript{th} percentile by year without adjustment, (2) smoothed 15\textsuperscript{th} percentile by year, (3) detrended 15\textsuperscript{th} percentile by year, and (4) all-year 15\textsuperscript{th} percentile.

\textbf{Raw and Smoothed 15\textsuperscript{th} Percentile by Year}
In method 1, we select the 15\textsuperscript{th} percentile by each LOB and accident/reserve year, for each company/pool as appropriate.

In method 2, to remove large discontinuities by year, we limit each point to be within 10\% of the prior and subsequent years. For the first accident/reserve year (1988), we limit each point to be within 10\% of the three-year average (1989–1991) and the subsequent year (1989). For the last accident/reserve year (2017/2016), we limit each point to be within 10\% of the three-year average (2014–2016/2013–2015) and the prior year (2016/2015).

\textbf{Detrended 15\textsuperscript{th} Percentile by Year}
We developed the third approach listed above in response to a suggestion for future research in the 2016 Report. For some LOBs, the 15\textsuperscript{th} percentile size varies randomly up and down so much that even the smoothed 15\textsuperscript{th} percentile had large variations in size threshold from year to year. To address that feature, we use regression to calculate the annual trend in the 15\textsuperscript{th} percentile company size by year. We use this trend to adjust the LOB premium for each company for each year to a common date, 1999 for premium and 1998 for reserves. We call the result of that calculation the “Adjusted LOB Size.”

We then determine the all-year LOB 15\textsuperscript{th} percentile of the Adjusted LOB Size values across all data points. We use the regression trend rate to detrend the all-year LOB 15\textsuperscript{th} percentile to the historical level for each year to determine the smoothed LOB 15\textsuperscript{th} percentile by year.

\textbf{Selected LOB Size Approaches}
For all RRF calculations and for PRF calculations with Annual Statement data, we select the smoothed 15\textsuperscript{th} percentile method for Homeowners, Private Passenger Auto Liability, Workers’ Compensation, Special Property, and Auto Physical Damage. For Warranty, we select the all-year overall 15\textsuperscript{th} percentile. For the other 13 LOBs, we select the detrended 15\textsuperscript{th} percentile method.

For PRF calculations with RBC data we select the smoothed 15\textsuperscript{th} percentile method for five of the six Two-Year LOBs, and for Warranty, we select the all-year overall 15\textsuperscript{th} percentile.

\textsuperscript{56} DCWP Reports 6 and 7 shows the extent to which indicated Risk Factors vary by LOB-size.
12. APPENDIX 8—MATURITY

The 2016 Report found that Risk Factors based on data grouped by age of development can increase as the age of development increases; the effect varies by LOB but is especially pronounced for LOBs such as WC and MPL-Occurrence.

The 2016 Report considered: (a) ways to adjust risk data points so that they reflected a 10 years maturity; and (b) the alternative of excluding risk data points that are not sufficiently mature. The 2016 Report used method (b). Our indicated Risk Factors are based on the same approach that was used in the 2016 Report.

Table 3, in the Methodology section, shows the maturity filters we use.

13. APPENDIX 9—ORDER OF POOLING, ANOMALIES, AND OTHER FILTERS

In this section we summarize the order in which we apply the filtering rules discussed above.

**PRF Analysis from Annual Statement Data**
1. Exclude AY/LOB/Company data points with negative premium or with zero or negative incurred loss amounts
2. Calculate LRs for each AY/company/LOB remaining in the data
3. Identify the data point with greatest maturity for each AY/company/LOB
4. Apply Pooling rules to combine AY/company/LOB data points, where appropriate
5. For each AY/company-pool/LOB data point we determine, and apply filters, for the following, on a pool basis:
   a. Minor Line status
   b. LOB Age
6. With the pool data, after the prior filtering, calculate size threshold by LOB/AY and identify whether the company size exceeds that threshold.
7. Apply Maturity filter.

**RRF Analysis from Annual Statement or RBC Data**
1. Exclude all company Annual Statement triangles with negative calendar year values or zero interior values. Also exclude potential data points with zero calendar reserves prior to the current valuation year of each Annual Statement.
2. Calculate RRRs for each initial reserve year/company/LOB from the remaining data.
3. Identify the RRR with the greatest maturity for each initial reserve year/company/LOB.
4. Apply pooling rules to company initial reserve year/company/LOB data points, where appropriate.

5. For each RRR/company-pool/LOB data point, we determine and apply filters, for the following, on pool basis:
   a. Minor Line status
   b. LOB Age

6. With the pool data, after the prior filtering, calculate size threshold by LOB/initial reserve year and identify whether the company size exceeds that threshold.

7. Apply Maturity filter.

For Two-Year LOBs, for indicated PRFs from RBC data, we determine age, maturity, and size thresholds from RBC data. We determine Minor Line status using RBC data by LOB combined with Annual Statement for all lines combined.

For Two-Year LOBs, for indicated RRFs from RBC data, we determine size thresholds from RBC data. We determine age and Minor Line status, which require matching premium information, from Annual Statement premium data. There is no maturity filter applicable to RRFs for Two-Year LOBs.

For pooled data risk data points, for both Two-Year and Ten-Year LOBs, we determine age and maturity on a pooled basis, rather than using maximum or average values by company. We also determine Minor Lines status on a pooled basis.

**14. APPENDIX 10—ANALYSIS OF CHANGE IN PRFs 2014 TO 2017 FOR TEN-YEAR LOBs**

In this section we show our analysis of the change in PRFs, from the results of the 2016 Report to the results in this Report, for Ten-Year LOBs. In this analysis of change, for each LOB, we begin with the results in the 2016 Report. We then calculate a series of indicated PRFs, each step applies additional changes in methodology/data from the 2016 Report to this Report. The change in indicated PRFs between steps constitutes our measure of the effect of the methodology/data change.

We believe this provides useful information on the relative effects of each change. However, the effects interact, so that if we calculate effects in a different order, then we might measure a different effect for each change. Hence, the changes should be interpreted as informative, but not definitive.

For Two-Year LOBs, developed from confidential RBC data, we did not have the detail data from the 2016 Report needed to perform a change analysis.57

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57 We note that changes are small for the larger LOBs and that when the number of data points is small—e.g., Financial/Mortgage and Warranty—the movements from year to year are not unexpected.
In the subsections below we identify which of the methodology/data changes, each of which was discussed earlier in the report, is placed in each of the categories.

**Data and Maturity First**
This category covers the following:

- As we now have older Annual Statements, we have data points for AYs and initial reserve years 1988 and subsequent that were not included in our 2016 Report.
- As we discussed in the Appendix 3—Pooling Methodology, we now select the most mature data points and then combine individual companies into pools, rather than performing the calculation in the reverse order.
- Finally, with respect to data, in the normal course of an analysis update, there are changes in the NAIC database, which contains company reports as of the date that the information was extracted. In our current work, we use data extracted from the NAIC database as of the first quarter of 2019, which updates our entire data set. The 2016 Report used data extracted in 2015–2016.

**Filters**
This category covers the following:

- We implemented some changes in the way we calculate the Size filtering (Appendix 7).
- While we apply the same five-year age filter, as we have added older and newer AYs to our database, some companies that were “new” (age under five years) in the 2016 Report are not “new” in this Report.
- We based age on the pool age. In the 2016 Report age equaled the maximum age of any company in the pool. As a result, we may have excluded some data points that were included in the 2016 Report.

**Development and Recent Years**
As in every re-evaluation, there are changes due to increasing maturity of data for AYs and initial reserve years that have not yet reached maximum maturity available in our data and the addition of new AYs and initial reserve years.

**Effect of Changes**
Table A-7a—PRFs, below, shows the effect of these factors, by LOB. Table A-7b, below, shows the changes in the number of data points after each step of the analysis.

---

58 For example, we see more data from Annual Statement years and RBC years 2013 and 2014, in the 2017 data than in the 2014 data. We understand this to be because Annual Statements and RBC Filings for some companies were not included in the NAIC data when the 2014 data was downloaded.
### Table A-7a—PRFs—Analysis of Change

Indicated Risk Factors based on 2014 data to indications based on 2017 data

<table>
<thead>
<tr>
<th>Line</th>
<th>2014 Indicated PRF</th>
<th>Change as a Percentage of Premium, Due to:</th>
<th>2017 Indicated PRF</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data, Maturity</td>
<td>First</td>
<td>Filter</td>
</tr>
<tr>
<td>(1) H/F</td>
<td>0.964</td>
<td>0.2%</td>
<td>0.1%</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>0.969</td>
<td>0.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>(3) CA</td>
<td>1.010</td>
<td>0.6%</td>
<td>0.1%</td>
</tr>
<tr>
<td>(4) WC</td>
<td>1.044</td>
<td>0.3%</td>
<td>0.1%</td>
</tr>
<tr>
<td>(5) CMP</td>
<td>0.901</td>
<td>0.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>1.490</td>
<td>2.6%</td>
<td>-3.2%</td>
</tr>
<tr>
<td>(7) MPL C-M</td>
<td>1.176</td>
<td>-0.1%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>(8) SL</td>
<td>0.949</td>
<td>0.3%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>(9) OL</td>
<td>1.013</td>
<td>0.5%</td>
<td>0.1%</td>
</tr>
<tr>
<td>(11) Spec. Prop.</td>
<td>0.831</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>(12) APD</td>
<td>0.836</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>(10) Fidelity / Surety</td>
<td>0.680</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>(13) Other</td>
<td>0.935</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>(15) International</td>
<td>1.658</td>
<td>7.4%</td>
<td>0.0%</td>
</tr>
<tr>
<td>(16) Reins. Prop. / Fin.</td>
<td>1.240</td>
<td>-1.2%</td>
<td>1.3%</td>
</tr>
<tr>
<td>(17) Reins. Liab.</td>
<td>1.322</td>
<td>-3.7%</td>
<td>-3.5%</td>
</tr>
<tr>
<td>(18) PL</td>
<td>1.285</td>
<td>-0.3%</td>
<td>-2.0%</td>
</tr>
<tr>
<td>(14) Financial / Mortgage</td>
<td>2.513</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>1.028</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Average Risk Factor - All Lines | 0.968 | N/A | N/A | N/A | N/A | 0.0% | 0.967 |
Average Risk Factor - 10-Yr Lines | 0.996 | 0.3% | 0.0% | 0.1% | -0.6% | -0.1% | 0.995 |
Average Risk Factor - 2-Yr Lines | 0.895 | N/A | N/A | N/A | N/A | 0.3% | 0.897 |
### Table A-7b—PRFs—Analysis of Change

#### Number of Filtered Data Points

<table>
<thead>
<tr>
<th>Line</th>
<th>2014 Indicated PRF</th>
<th>Data, Maturity Filter Development</th>
<th>Recent Years</th>
<th>Total Change</th>
<th>2017 Indicated PRF</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) H/F</td>
<td>11,256</td>
<td>563 (9)</td>
<td>-</td>
<td>-1,070</td>
<td>12,898</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>10,904</td>
<td>556 (35)</td>
<td>-</td>
<td>-835</td>
<td>12,620</td>
</tr>
<tr>
<td>(3) CA</td>
<td>7,589</td>
<td>472 (20)</td>
<td>-</td>
<td>-631</td>
<td>8,872</td>
</tr>
<tr>
<td>(4) WC</td>
<td>7,931</td>
<td>416 (45)</td>
<td>-</td>
<td>-677</td>
<td>8,979</td>
</tr>
<tr>
<td>(5) CMP</td>
<td>8,791</td>
<td>652 (109)</td>
<td>-</td>
<td>-731</td>
<td>10,065</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>1,112</td>
<td>31 (135)</td>
<td>-</td>
<td>-166</td>
<td>1,278</td>
</tr>
<tr>
<td>(7) MPL C-M</td>
<td>3,281</td>
<td>121 (86)</td>
<td>-</td>
<td>-446</td>
<td>3,934</td>
</tr>
<tr>
<td>(8) SL</td>
<td>2,145</td>
<td>138 (34)</td>
<td>-</td>
<td>-126</td>
<td>2,375</td>
</tr>
<tr>
<td>(9) OL</td>
<td>10,951</td>
<td>585 (65)</td>
<td>-</td>
<td>-991</td>
<td>12,462</td>
</tr>
<tr>
<td>(11) Spec. Prop.</td>
<td>10,908</td>
<td>N/A N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>12,165</td>
</tr>
<tr>
<td>(12) APD</td>
<td>12,040</td>
<td>N/A N/A</td>
<td>N/A</td>
<td>1,807</td>
<td>13,847</td>
</tr>
<tr>
<td>(10) Fidelity / Surety</td>
<td>2,370</td>
<td>N/A N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>2,530</td>
</tr>
<tr>
<td>(13) Other</td>
<td>2,268</td>
<td>N/A N/A</td>
<td>N/A</td>
<td>430</td>
<td>2,698</td>
</tr>
<tr>
<td>(15) International</td>
<td>410</td>
<td>47 61</td>
<td>-</td>
<td>-</td>
<td>108</td>
</tr>
<tr>
<td>(16) Reins. Prop. / Fin.</td>
<td>1,182</td>
<td>89 (2)</td>
<td>-</td>
<td>88</td>
<td>1,357</td>
</tr>
<tr>
<td>(17) Reins. Liab.</td>
<td>1,189</td>
<td>137 87</td>
<td>-</td>
<td>-</td>
<td>1,413</td>
</tr>
<tr>
<td>(18) PL</td>
<td>3,341</td>
<td>265 254</td>
<td>-</td>
<td>-419</td>
<td>3,760</td>
</tr>
<tr>
<td>(14) Financial / Mortgage</td>
<td>245</td>
<td>N/A N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>239</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>83</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>134</td>
</tr>
</tbody>
</table>

**Notes:** Recent Years for MPL Occ., International, Reins. Liab., and PL are zero because the maturity filter excludes accident years 2015-2017 in the analysis of change.

For all Ten-Year LOBs combined, the change in indicated PRFs from 2014 to 2017 is relatively small, -0.1% of premium.

However, there are some LOBs with larger changes in indicated Risk Factors. The two Ten-Year LOBs with indicated PRF changes greater than ±5% of premium are the following:

- International PRF is increased due to the data changes.
- Reinsurance Liability PRF is reduced due to both data changes and the filter changes.
- Financial/Mortgage and Warranty LOB PRF changes by more than 5% of premium, but these are lines with limited data and the therefore more subject to variation in indicated Risk Factors due to random effects of new information and/or even small changes in methodology.
15. APPENDIX 11—ANALYSIS OF CHANGE IN RRFs 2014 TO 2017

In this section we show our analysis of the change in RRFs, for Ten-Year LOBs and Two-Year\textsuperscript{59} LOBs, comparing from the results of the 2016 Report to the results in this Report. We described the approach in Appendix 10, above.

We categorize the changes in indicated RRFs, from those in the 2016 Report to those in this Report, as follows:

1. New Minor Lines approach for reserves described in Appendix 5 (“Minor Line Filter”).
2. Other Filters including Age, LOB Size, and Maturity (“Other Filters”).
3. Updates in NAIC database\textsuperscript{60} (“New data”) and increased maturity of initial reserve years 1998-2013 (“New Data (< 2014), Development”).
5. New quality control test to remove triangles whose entire interior is blank, Zero Interior filter.
6. Calculate RRR values by company, and select the most mature company data point, before pooling (“Maturity First”).
7. Allow $|RRR|>500\%$ for Ten-Year LOBs (“Allow $|RRR|>500\%$”).

Table A-8a—RRFs shows the effects of each of these factors, by LOB. Table A-8b, below, shows the changes in the number of data points after each step of the analysis.

\textsuperscript{59} We were able to analyze the drivers of change in RRFs from RBC data, as the regulator working with our committee recreated, under our direction, the 2016 analysis, which enabled us to analyze the drivers of change for both Ten-Year and Two-Year LOBs.

\textsuperscript{60} As expected, we see additional data for Annual Statement Years 2013 and 2014. Also, for LOB “Other,” in addition to the expected changes due to updates, we observed a significant reduction in the number of data points in the 2001 Annual Statement Year. That might have been an error in the prior analysis.
### Table A-8a—RRFs—Analysis of Change

#### Indicated Risk Factors based on 2014 data to indications based on 2017 data

<table>
<thead>
<tr>
<th>Line</th>
<th>2014 Indicated RRF</th>
<th>Change as a Percentage of Reserves, Due to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Minor Line Filter</td>
<td>New Data (&lt; 2014), Development</td>
</tr>
<tr>
<td>(1) H/F</td>
<td>0.213</td>
<td>-0.4%</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>0.179</td>
<td>0.3%</td>
</tr>
<tr>
<td>(3) CA</td>
<td>0.348</td>
<td>-1.1%</td>
</tr>
<tr>
<td>(4) WC</td>
<td>0.344</td>
<td>-0.5%</td>
</tr>
<tr>
<td>(5) CMP</td>
<td>0.494</td>
<td>-1.1%</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>0.296</td>
<td>-1.0%</td>
</tr>
<tr>
<td>(7) MPL C-M</td>
<td>0.089</td>
<td>0.0%</td>
</tr>
<tr>
<td>(8) SL</td>
<td>0.431</td>
<td>-0.5%</td>
</tr>
<tr>
<td>(9) OL</td>
<td>0.531</td>
<td>-3.3%</td>
</tr>
<tr>
<td>(11) Spec. Prop.</td>
<td>0.428</td>
<td>-4.1%</td>
</tr>
<tr>
<td>(12) APD</td>
<td>0.155</td>
<td>0.9%</td>
</tr>
<tr>
<td>(10) Fidelity / Surety</td>
<td>0.917</td>
<td>-1.7%</td>
</tr>
<tr>
<td>(13) Other</td>
<td>0.375</td>
<td>-5.7%</td>
</tr>
<tr>
<td>(15) International</td>
<td>0.695</td>
<td>-0.6%</td>
</tr>
<tr>
<td>(16) Reins. Prop. / Fin.</td>
<td>0.415</td>
<td>-6.6%</td>
</tr>
<tr>
<td>(17) Reins. Liab.</td>
<td>0.656</td>
<td>-4.7%</td>
</tr>
<tr>
<td>(18) PL</td>
<td>1.345</td>
<td>-3.9%</td>
</tr>
<tr>
<td>(14) Financial / Mortgage</td>
<td>0.060</td>
<td>-3.7%</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>0.316</td>
<td>33.2%</td>
</tr>
<tr>
<td>Average Risk Factor - All Lines</td>
<td>0.383</td>
<td>-1.1%</td>
</tr>
<tr>
<td>Average Risk Factor - 10-Yr Lines</td>
<td>0.387</td>
<td>-1.0%</td>
</tr>
<tr>
<td>Average Risk Factor - 2-Yr Lines</td>
<td>0.344</td>
<td>-3.2%</td>
</tr>
</tbody>
</table>
Table A-8b—RRFs—Analysis of Change

<table>
<thead>
<tr>
<th>Number of Filtered Data Points</th>
<th>Change in Number of Filtered Data Points Resulting From:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line</td>
<td>2014 Indicated RRF</td>
</tr>
<tr>
<td>(1) H/F</td>
<td>11,258</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>11,620</td>
</tr>
<tr>
<td>(3) CA</td>
<td>8,232</td>
</tr>
<tr>
<td>(4) WC</td>
<td>8,087</td>
</tr>
<tr>
<td>(5) CMP</td>
<td>8,322</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>1,721</td>
</tr>
<tr>
<td>(7) MPL C-M</td>
<td>2,493</td>
</tr>
<tr>
<td>(8) SL</td>
<td>2,215</td>
</tr>
<tr>
<td>(9) OL</td>
<td>10,568</td>
</tr>
<tr>
<td>(11) Spec. Prop.</td>
<td>8,499</td>
</tr>
<tr>
<td>(12) APD</td>
<td>6,620</td>
</tr>
<tr>
<td>(10) Fidelity / Surety</td>
<td>1,971</td>
</tr>
<tr>
<td>(13) Other</td>
<td>1,756</td>
</tr>
<tr>
<td>(15) International</td>
<td>580</td>
</tr>
<tr>
<td>(16) Reins. Prop. / Fin.</td>
<td>1,222</td>
</tr>
<tr>
<td>(17) Reins. Liab.</td>
<td>1,348</td>
</tr>
<tr>
<td>(18) PL</td>
<td>4,196</td>
</tr>
<tr>
<td>(14) Financial / Mortgage</td>
<td>258</td>
</tr>
<tr>
<td>(19) Warranty</td>
<td>69</td>
</tr>
<tr>
<td>Average Risk Factor - All Lines</td>
<td>90,585</td>
</tr>
<tr>
<td>Average Risk Factor - 10-Yr Lines</td>
<td>71,412</td>
</tr>
<tr>
<td>Average Risk Factor - 2-Yr Lines</td>
<td>19,173</td>
</tr>
</tbody>
</table>

Notes:

1. Recent Years for CMP and MPL C-M are zero due because the maturity filter excludes initial reserve years 2014–2016 in the analysis of change.
2. The effect shown in this column is the net result of several filters. First, prior to the impact of other filters, applying the zero interior filter caused data points to reduce in all lines. However, some number of RRRs from RBC triangles with zero interiors, have already been removed due to RRR>5 filter, so the net decrease in number of RRRs is less than the decrease due to the zero interior filter alone. Moreover, when we remove the RBC triangles with zero interior values, then to the extent that there are RBC triangles from later, less mature, valuations, unaffected by zero interior values, we use those triangles. The combined effect of those factors can produce an increase in RRRs.

For all Ten-Year LOBs combined, the change in indicated RRFs from 2014 to 2017 is 0.4% of reserves. However, there some Ten-Year LOBs with larger changes in indicated Risk Factors. The three LOBs with indicated RRF changes greater than ±5% of reserves are the following:

- The International indicated RRF increased by 34.9% overall due to Other Filters (company age) and allowing RRRs greater than 500%. International is one of the three smallest lines of business both in terms of company data points included in the analysis and reserve volume. Its sensitivity to the changes is not surprising.
- The Reinsurance Prop./Fin. indicated RRF decreased 7.2% of reserves, due primarily to changes in the Minor Line filter and the addition of recent years.
- The Products Liability indicated RRF increased 12.8% of reserves due primarily to the impact of allowing RRRs greater than 500%.
For all Two-Year LOBs combined, the change in indicated RRFs from 2014 to 2017 is more significant than the Ten-Year LOBs, at -12.6%. This was driven by the new zero interior filter. With the exception of automobile physical damage, all of the Two-Year LOBs had changes greater than ±5% of reserves.

16. APPENDIX 12—EXAMPLES

Example 1: Reserve Runoff Ratio—Ten-Year LOBs—Annual Statement Data

In this section, we show how the RRRs are calculated from Annual Statement data for Ten-Year LOBs.

To illustrate the runoff ratio calculation based on Annual Statement data, consider the following simulated example, Company XYZ’s Schedule P, Part 2 and 3 for a particular LOB for Annual Statement Year 2017.

<table>
<thead>
<tr>
<th>Table A-9a</th>
<th>Simulated Company XYZ Schedule P—Part 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>INCURRED NET LOSSES AND DEFENSE AND COST CONTAINMENT EXPENSES REPORTED AT YEAR END ($000 OMITTED)</td>
<td>2008</td>
</tr>
<tr>
<td>Years in Which Losses Were Incurred</td>
<td>Development</td>
</tr>
<tr>
<td>1 Prior</td>
<td>730</td>
</tr>
<tr>
<td>2</td>
<td>4,890</td>
</tr>
<tr>
<td>3</td>
<td>XXX</td>
</tr>
<tr>
<td>4</td>
<td>2010</td>
</tr>
<tr>
<td>5</td>
<td>2011</td>
</tr>
<tr>
<td>6</td>
<td>2012</td>
</tr>
<tr>
<td>7</td>
<td>2013</td>
</tr>
<tr>
<td>8</td>
<td>2014</td>
</tr>
<tr>
<td>9</td>
<td>2015</td>
</tr>
<tr>
<td>10</td>
<td>2016</td>
</tr>
<tr>
<td>11</td>
<td>2017</td>
</tr>
<tr>
<td>12 Total</td>
<td>-110</td>
</tr>
</tbody>
</table>

We calculate nine RRRs from these data. The most mature is the RRR for the 2008 initial reserve year. The numerator of the Reserve Runoff Ratio is the incurred development for 2008 and prior AYs, combined, from the 2008 evaluation year to the 2017 evaluation year. These data come from Schedule P, Part 2 and we calculate this from the numbers in bold above as follows:

\[
(440 + 3,620) - (730 + 4,890) = -1,560
\]
The denominator of this ratio is the carried loss reserves at the 2008 evaluation date. We calculate this for all AYs combined using Schedule P, Parts 2 and 3, from the cells that are shaded above as follows:

\[(730 + 4,890) – (0 + 2,100) = 3,520\]

The value for Prior AYs in calendar year 2008 is zero because the Prior rows in Parts 2 and 3 of Schedule P are the amounts excluding the amounts paid through December 31, 2008, on AYs 2008 and prior.

The reserve runoff ratio is then simply the numerator divided by the denominator:

\[-1,560 ÷ 3,520 = -44.3\%\]

The reserve runoff ratios for reserve years 2009 through 2016 are calculated in the same manner. For initial reserve year 2009, the numerator of the RRR, Part 2, columns 2 and 12, is

\[(440+3,620+3,660) - (510+3,750+5,010) = -1,550\]

The denominator of the RRR, from Parts 2 and 3, column 2, is \((510+3,750+5,010) - (390+3,360+1,540) = 3,980\). The RRR is -38.9%.

**Example 2: Reserve Runoff Ratio—Two-Year LOBs—Annual Statement Data**

While our indicated RRFs for Two-Years LOBs is based on data from confidential RBC Filings, for comparison purposes, we also calculate indicated RRFs based on Annual Statement data. The RRR calculation for Two-Year LOBs from Annual Statement data is similar to the calculation for Ten-Year LOBs, but the calculation includes only two AY and the prior year data. The
following example from a 2017 Annual Statement illustrates the runoff ratio calculation based on Annual Statement data for sample Company XYZ Schedule P, Part 2 and 3.

**Table A10a**

<table>
<thead>
<tr>
<th>Simulated Company XYZ Schedule P—Part 2—Two-Year LOBs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INCURED NET LOSSES AND DEFENSE AND COST CONTAINMENT EXPENSES REPORTED AT YEAR END ($000 OMITTED)</strong></td>
</tr>
<tr>
<td><strong>Years in Which Losses Were Incurred</strong></td>
</tr>
<tr>
<td>1 Prior</td>
</tr>
<tr>
<td>2 2016</td>
</tr>
<tr>
<td>3 2017</td>
</tr>
<tr>
<td>4 Total</td>
</tr>
</tbody>
</table>

**Table A10b**

<table>
<thead>
<tr>
<th>Simulated Company XYZ Schedule P—Part 3—Two-Year LOBs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CUMULATIVE PAID NET LOSSES AND DEFENSE AND COST CONTAINMENT EXPENSES REPORTED AT YEAR END ($000 OMITTED)</strong></td>
</tr>
<tr>
<td><strong>Years in Which Losses Were Incurred</strong></td>
</tr>
<tr>
<td>1 Prior</td>
</tr>
<tr>
<td>2 2016</td>
</tr>
<tr>
<td>3 2017</td>
</tr>
</tbody>
</table>

We calculate only one runoff ratio from these data, the runoff ratio for the 2016 reserve year. For this ratio, the numerator of the Reserve Runoff Ratio is the incurred development for 2016 and prior AYs, combined, from 2016 evaluation year to the 2017 evaluation year. These data come from Schedule P, Part 2 and we calculate this as follows:

\[(18,326 + 24,070) – (17,703 + 23,314) = 1,379\]

The denominator is the carried loss reserves at the 2016 evaluation date. We calculate this for all AYs combined using Schedule P, Parts 2 and 3, as follows:

\[(17,703 + 23,314) - (9,253 + 4,060) = 27,704\]

The reserve runoff ratio is then simply the numerator divided by the denominator:

\[1,379 ÷ 27,704 = 5.0\%\]

**Example 3: Reserve Runoff Ratio—Two-Year LOBs—RBC Data**

The tables below shows an example of RBC data. This data is the RBC data that is consistent with the Two-Year Annual Statement data shown in Example 2, above.
**Table A11a**
Simulated Company XYZ RBC Equivalent of Schedule P—Part 2—Two-Year LOBs

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Prior</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>2 2008</td>
<td>1,875</td>
<td>1,808</td>
<td>1,678</td>
<td>1,498</td>
<td>1,463</td>
<td>1,338</td>
<td>1,193</td>
<td>1,182</td>
<td>1,216</td>
<td>1,231</td>
</tr>
<tr>
<td>3 2009</td>
<td>1,926</td>
<td>1,827</td>
<td>1,481</td>
<td>1,388</td>
<td>1,446</td>
<td>1,276</td>
<td>1,290</td>
<td>1,304</td>
<td>1,304</td>
<td>1,304</td>
</tr>
<tr>
<td>4 2010</td>
<td>3,378</td>
<td>3,567</td>
<td>3,100</td>
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**Table A11b**
Simulated Company XYZ RBC Equivalent of Schedule P—Part 3—Two-Year LOBs

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<td>11 2017</td>
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The RBC data differs from the Annual Statement data in that there is no data in the Prior row.

We calculate RRRs using the most mature runoff data available. Often that was age 10, corresponding to 2008 and prior. One feature of that calculation is that the runoff contains only one AY.

For example, the runoff for initial reserve year 2008 would be calculated as follows:

Incurred Movement = 1,231 – 1,875 = -645, using the “2008 row”.
The initial reserve = 1,875 – 92 = 1,783
The runoff ratio equals -645 ÷ 1,783 = -36.1%

Because there is no prior row, this constitutes the development of 2008 only.
## 17. APPENDIX 13—IMPACT OF ALTERNATIVE RISK FACTORS

Part 1: Change in P&C RBC Charges by Type of Company: R4 Alone, R5 Alone, and Total ACL

### Notes

- Amounts in Billions. Excluding Zero and Negative Size Companies
- “NOC,” standing for Not Otherwise Classified, means companies whose major line is one of the following: Special Liability, Fidelity/Surety, “Other,” International, Financial/Mortgage Guaranty, Warranty.
- Risk factors for “2014 Data” and “2017 Data” for catastrophe exposed LOBs, are reduced to reflect the fact that catastrophe risk is incorporated separately in the RBC Formula. We apply the multiplicative adjustment used by the NAIC. See footnote 4.

### Table 1: Change in P&C RBC Charges by Type of Company: R4 Alone, R5 Alone, and Total ACL

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<th>NOC</th>
<th>Personal</th>
<th>Reinsurer</th>
<th>Jorkers Com</th>
<th>Total</th>
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<td>7.2%</td>
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<tr>
<td>Indicated (2017 Mn 5%)</td>
<td>86.2</td>
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<td>0.8</td>
<td>29.1</td>
<td>3.1</td>
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<td>0.6</td>
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<td>124.1</td>
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<th>NOC</th>
<th>Personal</th>
<th>Reinsurer</th>
<th>Jorkers Com</th>
<th>Total</th>
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<td>74.4</td>
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<td>-1.9%</td>
<td>-1.9%</td>
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<td>-2.3%</td>
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<tr>
<td>Indicated (2017 Mn 5%)</td>
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<td>1.4</td>
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<td>32.2</td>
<td>0.8</td>
<td>5.2</td>
<td>72.6</td>
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<td>-4.4%</td>
<td>-18.0%</td>
<td>0.5%</td>
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<td>-4.2%</td>
<td>-2.3%</td>
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<td>32.4</td>
<td>0.7</td>
<td>5.2</td>
<td>73.9</td>
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<td>0.9%</td>
<td>-2.0%</td>
<td>-4.2%</td>
<td>-0.6%</td>
</tr>
<tr>
<td>Indicated (2017 Max chg 20%)</td>
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<td>5.2</td>
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<td>-1.5%</td>
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<td>Indicated (2017 Max chg 35%)</td>
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<td>0.7</td>
<td>5.2</td>
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<th>Personal</th>
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<td>10.5</td>
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<td>0.6%</td>
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<td>2.8%</td>
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<td>Indicated (2017 Uncapped)</td>
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<td>Indicated (2017 Max chg 10%)</td>
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<tr>
<td>Indicated (2017 Max chg 20%)</td>
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<td>8.1</td>
<td>10.0</td>
<td>171.3</td>
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<td>-1.3%</td>
<td>0.4%</td>
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<td>8.1</td>
<td>10.1</td>
<td>171.9</td>
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Part 2: Change in P&C RBC Charges by % Size in Change in RBC Value:

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<th>2020 to 2017 Min 5%</th>
<th>2020 to 2017 Max Chg 10%</th>
<th>2020 to 2017 Max Chg 20%</th>
<th>2020 to 2017 Max Chg 35%</th>
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<tr>
<td>Less Than -50%</td>
<td>168</td>
<td>133</td>
<td>1</td>
<td>1</td>
<td>7</td>
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<tr>
<td>-50% to -25%</td>
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<td>10</td>
<td>144</td>
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<td>2</td>
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<td>-15% to -5%</td>
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<td>643</td>
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<th>2020 to 2017 Max Chg 20%</th>
<th>2020 to 2017 Max Chg 35%</th>
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</thead>
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<td>3</td>
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<td>275</td>
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<tr>
<td>-5% to 5%</td>
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<td>1481</td>
<td>1386</td>
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<tr>
<td>5% to 15%</td>
<td>117</td>
<td>117</td>
<td>118</td>
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</tr>
<tr>
<td>15% to 25%</td>
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</tr>
<tr>
<td>25% to 50%</td>
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<td>11</td>
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<tr>
<td>Over 50%</td>
<td>10</td>
<td>10</td>
<td>7</td>
<td>8</td>
</tr>
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<td>Total</td>
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<table>
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<tr>
<th>% Changes in ACL RBC</th>
<th>2020 to 2017 Min 5%</th>
<th>2020 to 2017 Max Chg 10%</th>
<th>2020 to 2017 Max Chg 20%</th>
<th>2020 to 2017 Max Chg 35%</th>
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<tr>
<td>Less Than -50%</td>
<td>26</td>
<td>12</td>
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<td>-50% to -25%</td>
<td>78</td>
<td>78</td>
<td>0</td>
<td>3</td>
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<tr>
<td>-25% to -15%</td>
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<td>55</td>
<td>1</td>
<td>36</td>
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<td>-15% to -5%</td>
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<td>149</td>
<td>157</td>
<td>204</td>
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<td>-5% to 5%</td>
<td>1161</td>
<td>1164</td>
<td>1586</td>
<td>1416</td>
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<tr>
<td>5% to 15%</td>
<td>242</td>
<td>244</td>
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<td>166</td>
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<td>15% to 25%</td>
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<td>25% to 50%</td>
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<tr>
<td>Over 50%</td>
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<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1837</td>
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<td>1837</td>
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</table>
### Part 3: Change in P&C RBC Charges by Size of Company: R4 Alone, R5 Alone, and Total ACL

#### P&C RBC - Comparison of R4 by Company Size (L&LAE + NWP)

<table>
<thead>
<tr>
<th>R4 Company Size</th>
<th>zero or less</th>
<th>0% - 30%</th>
<th>10% - 20%</th>
<th>30% - 40%</th>
<th>40% - 50%</th>
<th>50% - 60%</th>
<th>60% - 70%</th>
<th>70% - 80%</th>
<th>80% - 90%</th>
<th>90% - 100%</th>
<th>Total</th>
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<tr>
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<td>78.4</td>
<td>85.1</td>
<td>55.2</td>
<td>712.7</td>
<td>2,030.2</td>
<td>4,566.6</td>
<td>12,271.0</td>
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<td>123,561.5</td>
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<tr>
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<td>82.3</td>
<td>50.4</td>
<td>706.3</td>
<td>2,024.3</td>
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<td>12,172.9</td>
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<td>123,585.9</td>
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<td>11.6%</td>
<td>9.8%</td>
<td>-2.6%</td>
<td>-2.5%</td>
<td>3.7%</td>
<td>5.9%</td>
<td>2.9%</td>
<td>8.0%</td>
<td>10.5%</td>
<td>9.4%</td>
<td>9.3%</td>
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<tr>
<td>Indicated (2017 Uncapped)</td>
<td>398.5</td>
<td>18.3</td>
<td>67.3</td>
<td>73.2</td>
<td>55.5</td>
<td>713.4</td>
<td>2,042.6</td>
<td>4,588.7</td>
<td>13,253.5</td>
<td>107,353.4</td>
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<td>-3.5%</td>
<td>-0.4%</td>
<td>0.1%</td>
<td>0.5%</td>
<td>3.3%</td>
<td>4.3%</td>
<td>4.1%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Indicated (2013 Min 5%)</td>
<td>387.6</td>
<td>20.0</td>
<td>70.8</td>
<td>79.6</td>
<td>57.7</td>
<td>745.0</td>
<td>1,144.0</td>
<td>2,539.7</td>
<td>4,884.9</td>
<td>13,375.8</td>
<td>107,767.0</td>
</tr>
<tr>
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<td>15.1%</td>
<td>3.8%</td>
<td>-4.8%</td>
<td>-4.9%</td>
<td>6.3%</td>
<td>4.5%</td>
<td>2.1%</td>
<td>5.1%</td>
<td>7.0%</td>
<td>8.0%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Indicated (2017 Max Chg 10%)</td>
<td>164.1</td>
<td>19.2</td>
<td>73.8</td>
<td>81.7</td>
<td>39.3</td>
<td>713.7</td>
<td>1,124.5</td>
<td>2,440.3</td>
<td>4,595.5</td>
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<td>102,237.1</td>
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<td>-0.7%</td>
<td>-1.0%</td>
<td>1.6%</td>
<td>0.1%</td>
<td>0.4%</td>
<td>0.4%</td>
<td>0.6%</td>
<td>0.3%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Indicated (2017 Max Chg 20%)</td>
<td>175.4</td>
<td>19.5</td>
<td>72.9</td>
<td>80.6</td>
<td>38.2</td>
<td>719.8</td>
<td>1,135.1</td>
<td>2,464.6</td>
<td>4,652.4</td>
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<td>103,895.5</td>
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<tr>
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<td>9.9%</td>
<td>0.8%</td>
<td>-2.0%</td>
<td>-1.6%</td>
<td>2.2%</td>
<td>1.0%</td>
<td>1.2%</td>
<td>1.4%</td>
<td>1.9%</td>
<td>1.9%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Indicated (2017 Max Chg 35%)</td>
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<td>19.5</td>
<td>72.0</td>
<td>80.3</td>
<td>36.7</td>
<td>724.8</td>
<td>1,136.0</td>
<td>2,482.5</td>
<td>4,696.6</td>
<td>12,700.1</td>
<td>105,236.3</td>
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<tr>
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<td>0.8%</td>
<td>-3.1%</td>
<td>-2.8%</td>
<td>3.3%</td>
<td>1.7%</td>
<td>1.4%</td>
<td>2.2%</td>
<td>2.8%</td>
<td>3.5%</td>
<td>3.4%</td>
</tr>
</tbody>
</table>

#### P&C RBC - Comparison of R5 by Company Size (L&LAE + NWP)

<table>
<thead>
<tr>
<th>R5 Company Size</th>
<th>zero or less</th>
<th>0% - 30%</th>
<th>10% - 20%</th>
<th>30% - 40%</th>
<th>40% - 50%</th>
<th>50% - 60%</th>
<th>60% - 70%</th>
<th>70% - 80%</th>
<th>80% - 90%</th>
<th>90% - 100%</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020 RBC Formula</td>
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<td>107.0</td>
<td>143.6</td>
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<td>472.5</td>
<td>698.5</td>
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<td>1,962.0</td>
<td>3,717.3</td>
<td>8,526.7</td>
<td>57,992.3</td>
</tr>
<tr>
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<td>106.5</td>
<td>137.3</td>
<td>255.8</td>
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<td>686.5</td>
<td>1,049.7</td>
<td>1,893.3</td>
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</tr>
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<td>-0.8%</td>
<td>-4.4%</td>
<td>-4.2%</td>
<td>-3.3%</td>
<td>-1.6%</td>
<td>-4.3%</td>
<td>-3.5%</td>
<td>-3.0%</td>
<td>-2.7%</td>
<td>-1.6%</td>
</tr>
<tr>
<td>Indicated (2017 Uncapped)</td>
<td>371.8</td>
<td>106.3</td>
<td>156.0</td>
<td>252.5</td>
<td>451.5</td>
<td>677.9</td>
<td>1,017.8</td>
<td>1,800.1</td>
<td>3,577.7</td>
<td>8,195.4</td>
<td>56,347.9</td>
</tr>
<tr>
<td>Percentage change</td>
<td>0.8%</td>
<td>-0.7%</td>
<td>-5.3%</td>
<td>-5.6%</td>
<td>-4.3%</td>
<td>-2.9%</td>
<td>-5.4%</td>
<td>-4.7%</td>
<td>-3.8%</td>
<td>-3.9%</td>
<td>-1.8%</td>
</tr>
<tr>
<td>Indicated (2017 Min 5%)</td>
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<td>106.3</td>
<td>156.0</td>
<td>252.5</td>
<td>451.5</td>
<td>677.9</td>
<td>1,017.8</td>
<td>1,800.1</td>
<td>3,577.7</td>
<td>8,195.4</td>
<td>56,347.9</td>
</tr>
<tr>
<td>Percentage change</td>
<td>0.8%</td>
<td>-0.7%</td>
<td>-5.3%</td>
<td>-5.6%</td>
<td>-4.3%</td>
<td>-2.9%</td>
<td>-5.4%</td>
<td>-4.7%</td>
<td>-3.8%</td>
<td>-3.9%</td>
<td>-1.8%</td>
</tr>
<tr>
<td>Indicated (2017 Max Chg 10%)</td>
<td>372.7</td>
<td>107.0</td>
<td>142.1</td>
<td>243.6</td>
<td>466.8</td>
<td>693.0</td>
<td>1,080.2</td>
<td>1,940.2</td>
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<td>8,414.1</td>
<td>57,165.8</td>
</tr>
<tr>
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<td>-0.6%</td>
<td>-1.0%</td>
<td>-1.0%</td>
<td>1.6%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.4%</td>
<td>0.4%</td>
<td>0.3%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Indicated (2017 Max Chg 20%)</td>
<td>372.4</td>
<td>106.8</td>
<td>140.3</td>
<td>246.0</td>
<td>462.7</td>
<td>688.1</td>
<td>1,065.4</td>
<td>1,932.8</td>
<td>3,636.4</td>
<td>8,320.3</td>
<td>56,674.6</td>
</tr>
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<td>-0.2%</td>
<td>-2.3%</td>
<td>-2.3%</td>
<td>-2.6%</td>
<td>-1.4%</td>
<td>-2.9%</td>
<td>-2.2%</td>
<td>-2.6%</td>
<td>-2.4%</td>
<td>-1.3%</td>
</tr>
<tr>
<td>Indicated (2017 Max Chg 35%)</td>
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<td>106.5</td>
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<td>455.5</td>
<td>681.5</td>
<td>1,047.7</td>
<td>1,888.8</td>
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<td>8,206.3</td>
<td>56,163.8</td>
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<td>-0.5%</td>
<td>-4.0%</td>
<td>-3.9%</td>
<td>-3.3%</td>
<td>-2.4%</td>
<td>-4.5%</td>
<td>-3.7%</td>
<td>-3.8%</td>
<td>-2.1%</td>
<td>-2.5%</td>
</tr>
</tbody>
</table>
Part 4: Type of Company Definition
For each company, the company is assigned to one of six categories—Personal Lines, Commercial Lines, Medical Professional Liability, Reinsurance, Workers’ Compensation, or Other—by determining the amount of premium plus reserves (net written premium, plus net loss and LAE unpaid) for each of the six categories (using the table shown below), and then determining the category with the highest amount of premium plus reserves.

<table>
<thead>
<tr>
<th>Schedule P Line</th>
<th>Category</th>
<th>Schedule P Line</th>
<th>Category</th>
</tr>
</thead>
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<tr>
<td>(1) H/F</td>
<td>Personal Lines</td>
<td>(12) APD</td>
<td>Personal Lines</td>
</tr>
<tr>
<td>(2) PPA</td>
<td>Personal Lines</td>
<td>(10) Fidelity / Surety</td>
<td>Other</td>
</tr>
<tr>
<td>(3) CA</td>
<td>Commercial Lines</td>
<td>(13) Other</td>
<td>Other</td>
</tr>
<tr>
<td>(4) WC</td>
<td>Workers Compensation</td>
<td>(15) International</td>
<td>Other</td>
</tr>
<tr>
<td>(5) CMP</td>
<td>Commercial Lines</td>
<td>(16) Reins. Prop. / Fin.</td>
<td>Reinsurance</td>
</tr>
<tr>
<td>(6) MPL Occ.</td>
<td>Medical Malpractice</td>
<td>(17) Reins. Liab.</td>
<td>Reinsurance</td>
</tr>
<tr>
<td>(7) MPL C-M</td>
<td>Medical Malpractice</td>
<td>(18) Product Liab.</td>
<td>Commercial Lines</td>
</tr>
<tr>
<td>(8) SL</td>
<td>Other</td>
<td>(14) Financial / Mortgage</td>
<td>Other</td>
</tr>
<tr>
<td>(9) OL</td>
<td>Commercial Lines</td>
<td>(19) Warranty</td>
<td>Other</td>
</tr>
</tbody>
</table>

Part 5: LOB Share With Each Type of Company
The table below shows the proportion of NWP+Loss and LAE reserve by LOB within each of the type of company categories.

<table>
<thead>
<tr>
<th>LOB/Category</th>
<th>Commercial</th>
<th>Med Mal</th>
<th>NOC</th>
<th>Personal</th>
<th>Reinsurer</th>
<th>Workers Comp</th>
<th>Total</th>
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<td>0%</td>
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<td>0%</td>
<td>45%</td>
<td>2%</td>
<td>4%</td>
<td>22%</td>
</tr>
<tr>
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<td>0%</td>
<td>3%</td>
<td>2%</td>
<td>4%</td>
<td>5%</td>
</tr>
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<td>0%</td>
<td>2%</td>
<td>2%</td>
<td>73%</td>
<td>15%</td>
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<td>0%</td>
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<td>6%</td>
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<td>0%</td>
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<td>0%</td>
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<td>0%</td>
<td>1%</td>
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<td>8%</td>
<td>6%</td>
<td>16%</td>
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<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
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<td>6%</td>
<td>1%</td>
<td>5%</td>
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<tr>
<td>APD</td>
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<td>0%</td>
<td>18%</td>
<td>1%</td>
<td>2%</td>
<td>9%</td>
</tr>
<tr>
<td>Other</td>
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<td>13%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Fin/Mortgage</td>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<td>INTL</td>
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<td>0%</td>
<td>0%</td>
<td>3%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Rein (Prop and)</td>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Rein (LiAI)</td>
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<td>49%</td>
<td>1%</td>
<td>3%</td>
</tr>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>WAR</td>
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<td>0%</td>
<td>4%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<td>14,841,788</td>
<td>119,683,083</td>
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We see that the main LOBs within the category NOC are Fidelity/Surety, Other Liability and Special Liability, and we see that the Medical Professional Type of Company is predominantly Medical Professional Liability Claims Made.
18. APPENDIX 14—REFERENCES


19. APPENDIX 15—May 2019 Letter to NAIC
May 8, 2019

Tom Botsko, Chair
Property and Casualty Risk-Based Capital Working Group
National Association of Insurance Commissioners
(via email to Eva Yeung)

Dear Tom:

The American Academy of Actuaries\(^1\) Property and Casualty Risk-Based Capital (RBC) Committee plans to support the National Association of Insurance Commissioners’ efforts to update the calibration of factors used to calculate underwriting (UW) risk. This letter describes our plans. We appreciate this opportunity to describe those plans and solicit input from the NAIC Property and Casualty RBC Working Group.

1. Overview

We plan to analyze the following:

- Investment Income Adjustment (IIA)—RBC Line 8 on page PR017 (R4 Reserve risk) and Line 7 on page PR018 (R5 Premium risk), by Line of Business (LOB);

- Loss Concentration Factor (LCF) and Premium Concentration Factor (PCF)—RBC Line 14 on PR017 and PR018 respectively, which are used to calculate diversification credit in the RBC Formula; and

- LOB UW risk factors—RBC Line 4 on PR017 and PR018. We will use the results of this review as a starting point for the IIA and LCF/PCF analysis. This review will include the use of data not available to this Academy committee at the time the 2016 Academy Report\(^2\) was provided.

\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policy makers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

APPENDIX 15 – May 2019 Letter to the NAIC

The remainder of this letter provides more details regarding our proposed analyses.

2. IIA Analysis (Line 8/7)

The IIA reduces the amount of UW risk charge to recognize that future investment income will be available to offset the cost of adverse UW (premium risk) or reserve development (reserve risk).

Evaluation approach

The IIAs are based on a 5% per annum interest rate assumption, which is not consistent with recent experience.

We will consider two ways to update the IIAs. First, the Line 4 risk factor and the IIA on Lines 8/7 are currently calibrated as independent parameters. We use the term Nominal Value Approach (NVA) to describe an approach that does not consider possible interactions between interest rates underlying the IIA and loss experience underlying the Line 4 risk factors.

Implementing NVA requires changing the IIAs to reflect changing interest rates over time. We will consider how that might be done in a manner that provides reasonable stability but remains responsive to current conditions.

Second, we note that there are reasons to expect that loss ratios (LRs) and reserve runoff ratios (RRRs) are higher when interest rates are higher. An alternative to NVA, which considers a possible interaction between UW risk and interest rates, is to calibrate UW risk factors (Line 4) using data discounted to present value based on historical interest rates. Risk factors and IIAs can be developed from that analysis. We refer to that alternative as the Present Value Approach (PVA).

With PVA, we would establish the combined effect of the underwriting risk factors (Line 4) and the IIA (Line 8/7). We would produce a single indicated risk factor that reflects both UW risk, Line 4, and IIA, Lines 8/7. If desired, for consistency with the current format of the RBC Formula, that combined risk factor can be split into its two components. However, future changes in interest rates will not necessarily require changes in the IIA values.

We plan to prepare indicated risk factors for IIAs based on both NVA and PVA.

Interaction with UW risk safety level

Consistent with prior calibrations, UW risk factor Line 4 calibrations prepared for the NAIC in the 2016 Report are based on an 87.5th percentile safety level. We understand
the 87.5th percentile is used because it appeared to be consistent with the UW risk safety level selected when the RBC Formula was first calibrated in the early 1990s.

The 5% interest rate was also selected in the initial RBC calibration in the early 1990s. At that time actual interest rates were higher than 5%. Therefore, the initial IIA calibration can be viewed as including an implicit interest rate safety margin—that being the difference between actual interest rates at the time and the 5% interest rate selected.

In the IIA analysis, we will use interest rates with and without the kind of implicit safety margin that was part of the RBC calibration in the early 1990s. In using interest rates with no implicit safety margin, we will consider the extent to which the UW risk safety level should be increased to a value above 87.5%, to reflect the combination of the current 87.5th percentile on UW risk and any implicit interest rate safety margin. We will provide the NAIC with alternative treatments on this issue.

3. LCF/PCF Analysis (Line 14)

The LCF/PCF uses the ratio of the reserve/premium amount for the company’s largest RBC LOB to the company’s all-lines total reserve/premium amount. This ratio is used to measure the spread of business by LOB, commonly called diversification. We refer to that ratio as the Company Line of Business Maximum% (CoMaxLine%).

The LCF/PCF equals CoMaxLine% times 0.3 plus 0.7. This produces a discount for diversification, up to a maximum somewhat less than 30%.

Evaluation of 30% Maximum Diversification Credit

The proposed work will review the extent to which the 30% maximum should be revised based on experience.

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4 The maximum credit would be 30% if the number of LOBs were infinite. If premium/reserves were divided equally among the 19 LOBs, CoMaxLine% is 1/19, 5.26%, and the maximum credit is 28.4%.
Evaluation of other approaches

There are alternatives to the CoMaxLine% Approach in the RBC formula. One alternative approach is to use the largest LOB risk amount, rather than the largest reserve/premium amount. We refer to this as the CoMaxLine%-Risk approach. 5,6

Another alternative approach to evaluating diversification could be based on the Herfendahl-Hirschman Index (HHI). HHI is widely used by economists to measure concentration. The HHI index considers the relative proportions of all LOBs (largest, second-largest, third-largest, etc.) 7, whereas the CoMaxLine% approach only considers the relative proportion of the largest LOB.

We will evaluate these alternatives.

4. Update to UW factors

The UW factors presented in the 2016 Report are based on data for Annual Statement years 1997–2014. For this work, the NAIC has provided data for Annual Statement years 1984–2017. We plan to update UW factors to include the additional new years (2015–2017), and we will potentially use data from Annual Statement years prior to 1997 for specific LOBs.

Our indicated risk factors will include the effect of catastrophe events, net of reinsurance. We expect that the NAIC will continue to apply its current catastrophe adjustment

5 As an example of the difference between the risk maximum and the premium/reserve (volume) maximum, consider a hypothetical company that had $1 million of private passenger liability premium and $1 million of occurrence medical malpractice premium.

The private passenger automobile risk premium charge is about 15% and malpractice occurrence premium risk charge is about 60%, producing $150,000 of automobile premium risk, $600,000 of medical malpractice premium risk, and $750,000 in total premium risk (before diversification).

Using the CoMaxLine% approach in the RBC Formula, the CoMaxLine% is 0.50, and the credit for spread of business is 15%, half of the 30% maximum credit.

Based on risk, the maximum risk is the $600,000 for occurrence medical malpractice and the CoMaxLine%-Risk is 0.80 (600,000/750,000). The CoMaxLine%-Risk is much higher than CoMaxLine% because from the risk perspective the company is much less diversified. Measured this way, the credit for spread of business is reduced to 6%.

6 Using risk by LOB suggests the use of expenses by LOB. Expenses by LOB for the current year are in the Insurance Expense Exhibit, which is not filed until a month after the Annual Statement is filed. We will test options that use data that is available when the Annual Statement is filed, e.g., current year total expenses allocated by LOB based on prior year expenses by LOB, prior year expense by LOB with no adjustment to the current year, and current year company-wide expenses that does not vary by LOB.

7 HHI equals the sum of the squares of the relative proportions of each LOB compared to the total.

For example, if there is only one LOB, HHI is 1.0, as is the case for the CoMaxLine%. With two lines split 50% and 50% HHI and the CoMaxLine% are still the same, both 0.5.

With two lines split 25% and 75% HHI is 0.25^2 plus 0.75^2 or 0.625 compared to the CoMaxLine% of 0.750, i.e., HHI shows more diversification. With three lines split 50%, 25% and 25% HHI is 0.50^2 plus 0.25^2 plus 0.25^2 or 0.375, more diversification than the CoMaxLine% of 0.5.

The HHI is sometimes applied to only the n-th largest segments, e.g., the degree of diversification among the top five or 10 LOBs.

8 Annual Statements 1989 and subsequent for reserve risk data.
process to any updated UW risk factors it may choose to implement based on the results of our analysis.⁹

5. Timeline

NAIC staff have provided us with much of the necessary data. We greatly appreciate that assistance, without which this project would not be possible.

We are currently reviewing the data and organizing it for our analyses.

We will provide a timeline and milestones at future meetings and calls.

6. Directional Impacts of These Analyses on RBC Formula Values

While we currently have no results, based on the nature of the changes, we expect that:

- The IIA revision will indicate an increase in amount of UW risk charges for all companies; and
- The LCF/PCF analysis will generally indicate a decrease in amount of UW risk charges for diversified companies.

We expect to provide possible transition rules for implementation, consistent with past practice and/or if such rules appear warranted by features in the data.

Also, as we have in the past, we will ask NAIC to do an impact review of indicated changes.

* * * *

We appreciate this opportunity to assist the NAIC.

Regards,

Lauren Cavanaugh
Chairperson
Academy Property & Casualty
Risk-Based Capital Committee

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⁹ The Academy P&C RBC Committee would be happy to discuss how we might assist the NAIC in calibration of the risk factors on a net-of-catastrophe basis, but we believe that should be a separate project, after we complete the projects we describe in this letter.
The Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met July 15, 2021. The following Subgroup members participated: Wanchin Chou, Chair, and Susan Andrews (CT); Robert Ridenour, Vice Chair (FL); Susan Bernard, Lynne Wehmueller, and Kathryn Taras (CA); Judy Mottar (IL); Gordon Hay (NE); Anna Krylova (NM); Halina Smosna and Gloria Huberman (NY); Tom Botsko (OH); Andrew Schallhorn (OK); and Miriam Fisk, Monica Avila, and Rebecca Armon (TX).

1. **Adopted its June 1 and April 26 Minutes**

The Subgroup met June 1 and April 26. During these meetings, the Subgroup took the following action: 1) forwarded the response to the Climate and Resiliency (EX) Task Force request for proposed changes to the property/casualty (P/C) risk-based capital (RBC) catastrophe component; 2) heard updates from its Catastrophe Model Technical Review Ad Hoc Group; and 3) discussed the possibility of allowing additional third-party models or adjustments to the vendor models.

Mr. Botsko made a motion, seconded by Ms. Krylova, to adopt the Subgroup’s June 1 (Attachment Five-C1) and April 26 minutes (Attachment Five-C2). The motion passed unanimously.

2. **Adopted its 2021 Working Agenda**

Mr. Chou summarized the changes of the 2021 working agenda, which included the following substantial changes: 1) changing the completion date of the “evaluate the possibility of allowing additional third-party models or adjustments to the vendor models to calculate the cat model losses” item to year-end 2022 or later; and 2) deleting the “remove the embedded 3% operational risk component contained in the reinsurance contingent credit risk factor of Rcat” item from the working agenda. He also provided a brief update on items 9 and 19.

Mr. Schallhorn made a motion, seconded by Mr. Ridenour, to adopt the Subgroup’s 2021 working agenda (see NAIC Proceedings – Summer 2021, Capital Adequacy (E) Task Force, Attachment Seven). The motion passed unanimously.

3. **Heard an Update from its Catastrophe Model Technical Review Ad Hoc Group**

Ms. Smosna said the ad hoc group met June 7 to discuss additional questions for AIR Worldwide and June 28 to review some technical questions with AIR Worldwide on its wildfire model. She said the ad hoc group gained a better understanding on: 1) event generation; 2) spread model; 3) damage estimation; and 4) insured loss calculation. Mr. Chou stated that there were 54 technical questions discussed with AIR Worldwide in May and June, and he indicated that the ad hoc group will meet next month with Risk Management Solutions (RMS) to review/discuss some technical questions. He also discussed further steps to develop the proper charge for wildfire.

4. **Heard a Presentation from AIR Worldwide Regarding the Wildfire Model**

Dr. Jeff Amthor (AIR Worldwide) provided a brief overview on wildfire in the western U.S. and stochastic wildfire modeling for risk assessment. He said most of the wildfires are caused by humans and lightning. He also stated that climate change is likely increasing the area burned. During the stochastic wildfire modeling for risk assessment section, he briefly mentioned: 1) large stochastic fire catalogs used to provide a robust view of possibilities and probabilities; 2) wildfire modeling begins with ignition; 3) physically based processes for simulating fire spread; and 4) key modeling challenges.

Mr. Chou encouraged all the interested parties to review this presentation. Thoughts and ideas on developing the wildfire charge are welcome in the upcoming meeting to complete this project effectively.

Having no further business, the Catastrophe Risk (E) Subgroup adjourned.
The Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met June 1, 2021. The following Subgroup members participated: Wanchin Chou, Chair (CT); Robert Ridenour, Vice Chair (FL); Laura Clements, Giovanni Muzzarelli, and Lynne Wehmueller (CA); Judy Mottar (IL); Gordon Hay (NE); Anna Krylova (NM); Halina Smosna and Sak-man Luk (NY); Tom Botsko (OH); Andrew Schallhorn (OK); and Miriam Fisk, Rebecca Armon and Monica Avila (TX).

1. **Forwarded the Response to a Request for Proposed Changes to the P/C RBC Catastrophe Component**

Mr. Chou said the Subgroup exposed the response to a request for proposed changes to the catastrophe risk component for a 30-day public comment period during its April 26 meeting. He stated that the Subgroup received no comments during the exposure period. Mr. Chou said the purpose of this response is to inform the Climate and Resiliency (EX) Task Force that due to the limited resources of the Subgroup, it is currently only focusing on developing the risk charge for the wildfire peril. However, the Subgroup plans to discuss the additional peril like flood when the models become more mature and with better underlined statistic in the future.

Ms. Clements made a motion, seconded by Ms. Mottar, to forward the response to the Climate and Resiliency (EX) Task Force. The motion passed unanimously.

2. **Heard an Update from its Catastrophe Model Technical Review Ad Hoc Group**

Ms. Wehmueller said the ad hoc group met on May 10 to: 1) discuss data input and financial impact questions and responses; 2) review questions for model assumptions; and 3) discuss a referral letter from the Subgroup. She stated that some of the responses from AIR to the wildfire model questions posed by the ad hoc group were quite comprehensive and explanatory, while others were limited and require follow-up. Ms. Wehmueller also said the questions posed by the ad hoc group covered all components of the wildfire model generation, including hazard, vulnerability and financial modules, as well as some general questions about the model inputs, updates, model strengths and opportunities for improvement. She said the ad hoc group noticed that a reference document of data sources for the model inputs provided by AIR indicated different data inputs were based on different time periods and levels of resolution. In addition, Ms. Wehmueller said the Subgroup and its ad hoc group will need to work with the NAIC Legal department to establish a data use agreement between them and AIR. Moreover, she stated that Mr. Chou urged the ad hoc group members to review the AIR wildfire model documentation and provide additional technical question for AIR during the last ad hoc group meeting. Lastly, she said Mr. Chou asked every member of the ad hoc group to review and provide comments for the response to a request for proposed changes to the property/casualty (P/C) risk-based capital (RBC) catastrophe component.

Mr. Chou said the data use agreement has been set up; it allows the ad hoc group to share data via closed meetings. He also stated that additional questions provided by the ad hoc group members were received last week. Mr. Chou said he plans to discuss and finalize all the question by the upcoming ad hoc group meeting to ensure AIR has enough time to respond by the Subgroup’s next meeting.

3. **Discussed the Possibility of Allowing Additional Third-Party Models or Adjustments to the Vendor Models**

Mr. Chou said the Subgroup discussed the working agenda item to evaluate the possibility of allowing additional third-party models or adjustments to the vendor models to calculate the catastrophe model losses during the last virtual meeting. He stated that the Subgroup discussed the possibility of modifying the PR027 catastrophe risk instructions to accommodate the three different kinds of catastrophe (CAT) models that deviate from the vendor models: 1) internal CAT models; 2) vendor CAT models with adjustments or different weight; and 3) derivative models based on the vendor models. Mr. Chou asked the Subgroup members and interested parties to discuss: 1) the appropriateness to categorize the internal CAT models and derivative models based on the vendor models as internal models and vendor CAT models with adjustments or different weight as a modified vendor models; and 2) modifying the PR027 instructions based on the discussion. Mr. Botsko commented that the Subgroup should consider the following issues while discussing this item: 1) resource limitation from the state to review the internal models; and 2) how to validate the immature models. Ralph Blanchard (Travelers) asked the Subgroup to review...
the current treatment of the second category—vendor CAT models with adjustments or different weight consistent with the current instructions. Scott Williamson (Reinsurance Association of America—RAA) said he thinks that the current PR027 instruction has addressed the treatment of the second category of the model. However, he asked the Subgroup to consider: 1) how to handle the proprietary type of models; and 2) developing a process for approving proprietary models. Mr. Chou said this is a complicated subject and that the Subgroup will take time to discuss during upcoming meetings.

Mr. Chou said the Subgroup will schedule another meeting in July to continue discussing all the outstanding issues.

Having no further business, the Catastrophe Risk (E) Subgroup adjourned.
The Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met April 26, 2021. The following Subgroup members participated: Wanchin Chou, Chair, and Susan Andrews (CT); Robert Ridenour, Vice Chair (FL); Laura Clements, Giovanni Muzzarelli, Mitra Sanandajifar and Lynne Wehmueller (CA); Judy Mottar (IL); Gordon Hay (NE); Anna Krylova (NM); Gloria Huberman, Halina Smosna and Sak-man Luk (NY); Tom Botsko (OH); Andrew Schallhorn (OK), Will Davis (SC); and Miriam Fisk and Monica Avila (TX).

1. Exposed the Response to a Request for Proposed Changes to the P/C RBC Catastrophe Component

Mr. Chou said the Subgroup received a referral letter from the Climate and Resiliency (EX) Task Force on March 15. He said the Task Force recommended the Subgroup to consider: 1) expanding the current catastrophe framework to include other perils such as wildfire, flood and/or convection storms that may experience a greater tail risk under projected climate-related trends; 2) implementing two perils in the risk-based capital (RBC) framework by year-end 2022 if possible; 3) revising the current criteria for all commercial modelers that are allowed to be used; and 4) ensuring all modeling information is documented and made available to NAIC staff and lead state regulators.

Mr. Chou said a response to the referral letter was drafted earlier. It stated that the Subgroup is focusing on developing the risk charge for the wildfire peril only due to the limited resources and modeling information for other perils. He said the Subgroup plans to discuss the additional perils such as flood when the model becomes more mature with better underlying statistics in the near future. Mr. Chou also indicated that the Subgroup is only the assessor, not the reviewer of the model. However, he said the Subgroup will take the appropriate time and steps to understand the models and assign an appropriate charge to each additional peril. Mr. Chou asked all the interested parties to review the draft response and submit comments during the exposure period. Any received comments will be discussed during an upcoming meeting.

The Subgroup agreed to expose the response to a request for proposed changes to the property/casualty (P/C) RBC catastrophe component for a 30-day public comment period ending May 25.

2. Heard an Update from its Catastrophe Model Technical Review Ad Hoc Group

Mr. Chou said an ad hoc group to conduct a more in-depth review on different wildfire models was established earlier this month. He emphasized that the goal of this ad hoc group is not trying to approve the models. Rather, it is to perform a more in-depth technical study of different model assumptions, limitations and impact analysis in the upcoming months and ultimately provide a proper risk charge recommendation to the Subgroup for consideration. Ms. Smosna said the ad hoc group met for the first time early this month to discuss: 1) the development history of the current earthquake and hurricane risk charges; and 2) the possibility of developing an action plan to achieve phase 2 through phase 4 of wildfire model review phases. She also stated that the ad hoc group thinks that gaining some understanding on Florida’s catastrophe modeling approval process will be a good starting point to address this issue.

Mr. Ridenour said the Florida Commission on Hurricane Loss Projection Methodology (Florida Commission) establishes standards for model review every two years. Its hurricane loss projection methodology is based on certain switches being applied and a specific version of the model. He also stated that the Florida Commission approval process is only used in Florida; it is not something approved for NAIC purposes. Mr. Chou finally said that the ad hoc group will meet once a month until a proper wildfire charge is developed. He encouraged all interested parties to submit comments or questions to the ad hoc group for further discussion.

3. Discussed the Possibility of Allowing Additional Third-Party Models or Adjustments to the Vendor Models

Mr. Chou said the working agenda item to evaluate the possibility of allowing additional third-party models or adjustments to the vendor models to calculate the catastrophe model losses was created in December 2019. He stated that the Subgroup discussed three different kinds of catastrophe (CAT) models that deviate from the vendor models: 1) internal CAT models; 2) vendor CAT models with adjustments or different weight; and 3) derivative models based on the vendor models at the Spring National Meeting.
Scott Williamson (Reinsurance Association of America—RAA) commented that the Subgroup should consider developing a basic approval process if the Subgroup decided to rely on models in order to ensure the use of models are consistent and comparable across companies. Ralph Blanchard (Travelers) said Subgroup decided earlier that a company should use the same data, modeling and assumptions that the insurer uses in its own internal catastrophe risk management process. Mr. Chou said unlike earthquake and hurricane models, wildfire models do not have consistent assumptions and switches. The Subgroup will need to take the appropriate time and steps to understand them. Mr. Chou said that valuable information will be able to assist the Subgroup on developing the instructions in the future. He then encouraged all the interested parties to provide input on revising the RBC catastrophe risk charge instructions on PR027.

Mr. Chou said the Subgroup will schedule another meeting in May to continue discussing all the outstanding issues.

Having no further business, the Catastrophe Risk (E) Subgroup adjourned.
What RBC Pages Should Be Submitted?
For year-end 2021 property/casualty (P/C) risk-based capital (RBC), hard copies of Pages PR001—PR035, as well as Pages PR038 and PR039, should be submitted to any state that requests a hard copy. Beginning with the year-end 2011 RBC, a hard copy was not required to be submitted to the NAIC, but a portable document format (PDF) file representing the hard copy filing is part of the electronic filing with the NAIC.

Accident and Health Business
Affordable Care Act (ACA) Sensitivity Test
The Capital Adequacy (E) Task Force adopted proposal 2020-02-CA to delete the ACA Fee Sensitivity Test from the RBC formula during its Nov. 19, 2020, meeting.

Incentives—Managed Care Credit
As a result of the adoption of proposal 2021-02-CA by the Capital Adequacy (E) Task Force during its April 29, 2021, meeting, the term “incentives” was incorporated into the managed care instructions and blanks as “Bonuses/Incentives.”

Investment Income Adjustment to Underwriting Risk Factors
As a result of the adoption of proposal 2021-04-CA by the Capital Adequacy (E) Task Force during its June 30, 2021, meeting, a 0.5% investment income adjustment was incorporated into the Underwriting Risk factors for comprehensive medical, Medicare supplement, and dental and vision.

The revised factors are:

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Catastrophe Risk
PR027 Interrogatories
As a result of the adoption of proposal 2020-08-CR by the Capital Adequacy (E) Task Force during its March 23, 2021, meeting, the PR027 interrogatories instructions were modified to clarify how insurers with no gross exposure to earthquake or hurricane should complete the interrogatories.

Remove Operational Risk Factor
The Capital Adequacy (E) Task Force adopted proposal 2020-11-CR to remove the embedded 3% operational risk component contained in the reinsurance contingent credit risk of Rcat component from the P/C RBC formula during its March 23, 2021, meeting.

In This Issue:
- What RBC Pages Should be Submitted /1
- Accident and Health Business /1
- Affordable Care Act Sensitivity Test /1
- Incentives—Managed Care Credit /1
- Investment Income Adjustment to UW Risk Factors /1
- Catastrophe Risk /1
- PR027 Interrogatories /1
- Remove Operational Risk Factor /1
- Credit Risk /2
- Receivable For Securities /2
- Bonds /2
- Bond Designation Structure /2
- Bond Factors /2
- New Industry Average Risk Factors /3
- RBC Forecasting and Instructions /4
Credit Risk

As a result of the adoption of proposal 2021-03-P by the Capital Adequacy (E) Task Force during its April 29, 2021, meeting, several examples were added to clarify how the reporting companies should select the designation in the Annual Statement Part 3, Reinsurer Designation Equivalent Rating column if the reporting entities subscribe to one or multiple rating agencies.

Bonds

Bond Designation Structure

The Capital Adequacy (E) Task Force adopted proposal 2020-10-CA to modify the bond structure for the 20 designation categories for bonds into the P/C RBC formula during its March 23, 2021, meeting. The structure for the 20 bond designation categories was modified for the Bonds page (PR006), Asset Concentration page (PR011), and Off-Balance Sheet Security Lending Collateral and Schedule DL, Part 1 Assets page (PR015).

Receivable for Securities

As a result of the adoption of proposal 2021-07-CA by the Capital Adequacy (E) Task Force during its June 30 meeting, the factor for the Receivables for Securities (Line (1), Page PR009) was updated from 0.025 to 0.020.

Bond Factors

During its June 30, 2021 meeting, the Capital Adequacy (E) Task Force adopted proposal 2021-08-P that: 1) revised factors for the 20 bond designation categories; 2) modified the bond size factor formula; 3) reclassified hybrid securities in PR006, PR007, PR011, and PR015; and 4) modified the instructions to incorporate references for the bonds. The factors for the 20 bond designation categories were incorporated in the Bond page (PR006), the Asset Concentration page (PR011), and Off-Balance Sheet Security Lending Collateral, and Schedule DL, Part 1 Assets page (PR015).

20 Bond Designation Factors:

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Bond Size Factors:

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<td>Over 500</td>
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New Industry Average Risk Factors - Annual Update

During its June 30 meeting, the Capital Adequacy (E) Task Force adopted the annual update of industry average development factors:

### PR017 Underwriting Risk - Reserves

Line (1), Industry Average Development Factors

<table>
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<th>Col.</th>
<th>Line of Business</th>
<th>2021 Factor</th>
<th>2020 Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>H/F</td>
<td>0.998</td>
<td>0.993</td>
</tr>
<tr>
<td>(2)</td>
<td>PPA</td>
<td>1.025</td>
<td>1.035</td>
</tr>
<tr>
<td>(3)</td>
<td>CA</td>
<td>1.083</td>
<td>1.078</td>
</tr>
<tr>
<td>(4)</td>
<td>WC</td>
<td>0.912</td>
<td>0.916</td>
</tr>
<tr>
<td>(5)</td>
<td>CMP</td>
<td>0.999</td>
<td>1.016</td>
</tr>
<tr>
<td>(6)</td>
<td>MPL Occurrence</td>
<td>0.874</td>
<td>0.861</td>
</tr>
<tr>
<td>(7)</td>
<td>MPL Claims Made</td>
<td>0.973</td>
<td>0.940</td>
</tr>
<tr>
<td>(8)</td>
<td>SL</td>
<td>0.976</td>
<td>0.963</td>
</tr>
<tr>
<td>(9)</td>
<td>OL</td>
<td>0.964</td>
<td>0.968</td>
</tr>
<tr>
<td>(10)</td>
<td>Fidelity/Surety</td>
<td>0.915</td>
<td>0.907</td>
</tr>
<tr>
<td>(11)</td>
<td>Special Property</td>
<td>0.978</td>
<td>0.977</td>
</tr>
<tr>
<td>(12)</td>
<td>Auto Physical Damage</td>
<td>0.989</td>
<td>0.993</td>
</tr>
<tr>
<td>(13)</td>
<td>Other (Credit A&amp;H)</td>
<td>0.965</td>
<td>0.971</td>
</tr>
<tr>
<td>(14)</td>
<td>Financial/Mortgage Guaranty</td>
<td>0.723</td>
<td>0.682</td>
</tr>
<tr>
<td>(15)</td>
<td>INTL</td>
<td>1.104</td>
<td>1.162</td>
</tr>
<tr>
<td>(16)</td>
<td>REIN. P&amp;F Lines</td>
<td>0.893</td>
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<tr>
<td>(17)</td>
<td>REIN. Liability</td>
<td>0.989</td>
<td>0.985</td>
</tr>
<tr>
<td>(18)</td>
<td>PL</td>
<td>0.879</td>
<td>0.900</td>
</tr>
<tr>
<td>(19)</td>
<td>Warranty</td>
<td>1.007</td>
<td>1.013</td>
</tr>
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</table>

### PR018 Underwriting Risk - Net Written Premiums

Line (1), Industry Average Loss and Expense Ratios

<table>
<thead>
<tr>
<th>Col.</th>
<th>Line of Business</th>
<th>2021 Factor</th>
<th>2020 Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)*</td>
<td>H/F</td>
<td>0.681</td>
<td>0.678</td>
</tr>
<tr>
<td>(2)</td>
<td>PPA</td>
<td>0.795</td>
<td>0.810</td>
</tr>
<tr>
<td>(3)</td>
<td>CA</td>
<td>0.761</td>
<td>0.759</td>
</tr>
<tr>
<td>(4)</td>
<td>WC</td>
<td>0.682</td>
<td>0.705</td>
</tr>
<tr>
<td>(5)*</td>
<td>CMP</td>
<td>0.673</td>
<td>0.672</td>
</tr>
<tr>
<td>(6)</td>
<td>MPL Occurrence</td>
<td>0.731</td>
<td>0.726</td>
</tr>
<tr>
<td>(7)</td>
<td>MPL Claims Made</td>
<td>0.821</td>
<td>0.797</td>
</tr>
<tr>
<td>(8)*</td>
<td>SL</td>
<td>0.593</td>
<td>0.603</td>
</tr>
<tr>
<td>(9)</td>
<td>OL</td>
<td>0.635</td>
<td>0.639</td>
</tr>
<tr>
<td>(10)</td>
<td>Fidelity/Surety</td>
<td>0.394</td>
<td>0.384</td>
</tr>
<tr>
<td>(11)*</td>
<td>Special Property</td>
<td>0.559</td>
<td>0.553</td>
</tr>
<tr>
<td>(12)</td>
<td>Auto Physical Damage</td>
<td>0.726</td>
<td>0.732</td>
</tr>
<tr>
<td>(13)</td>
<td>Other (Credit A&amp;H)</td>
<td>0.693</td>
<td>0.684</td>
</tr>
<tr>
<td>(14)</td>
<td>Financial/Mortgage Guaranty</td>
<td>0.252</td>
<td>0.513</td>
</tr>
<tr>
<td>(15)*</td>
<td>INTL</td>
<td>0.769</td>
<td>0.758</td>
</tr>
<tr>
<td>(16)*</td>
<td>REIN. P&amp;F Lines</td>
<td>0.558</td>
<td>0.534</td>
</tr>
<tr>
<td>(17)*</td>
<td>REIN. Liability</td>
<td>0.713</td>
<td>0.708</td>
</tr>
<tr>
<td>(18)</td>
<td>PL</td>
<td>0.617</td>
<td>0.645</td>
</tr>
<tr>
<td>(19)</td>
<td>Warranty</td>
<td>0.681</td>
<td>0.691</td>
</tr>
</tbody>
</table>

* Cat Lines
RBC Forecasting and Instructions
The P/C RBC forecasting spreadsheet calculates RBC using the same formula presented in the 2021 NAIC Property & Casualty Risk-Based Capital Report Including Overview & Instructions for Companies. The entire RBC publication, including the Forecasting spreadsheet, is available to download from NAIC Account Manager through the NAIC Publications Department. The User Guide is no longer included in the RBC publications.

WARNING: The RBC forecasting spreadsheet CANNOT be used to meet the year-end RBC electronic filing requirement. RBC filing software from an annual financial statement software vendor should be used to create the electronic filing. If the forecasting worksheet is sent instead of an electronic filing, it will not be accepted, and the RBC will not have been filed.
**Capital Adequacy (E) Task Force**

**RBC Proposal Form**

<table>
<thead>
<tr>
<th>DATE: 3-17-21</th>
<th>FOR NAIC USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTACT PERSON: Crystal Brown</td>
<td></td>
</tr>
<tr>
<td>TELEPHONE: 816-783-8146</td>
<td></td>
</tr>
<tr>
<td>EMAIL ADDRESS: <a href="mailto:cbrown@naic.org">cbrown@naic.org</a></td>
<td></td>
</tr>
<tr>
<td>ON BEHALF OF: Health RBC (E) Working Group</td>
<td></td>
</tr>
<tr>
<td>NAME: Steve Drutz</td>
<td></td>
</tr>
<tr>
<td>TITLE: Chief Financial Analyst/Chair</td>
<td></td>
</tr>
<tr>
<td>AFFILIATION: WA Office of Insurance Commissioner</td>
<td></td>
</tr>
<tr>
<td>ADDRESS: PO Box 40255</td>
<td></td>
</tr>
<tr>
<td>Olympia, WA 98504-0255</td>
<td></td>
</tr>
</tbody>
</table>

**IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED**

- [x] Health RBC Blanks
- [x] Property/Casualty RBC Blanks
- [x] Life and Fraternal RBC Instructions
- [x] Health RBC Instructions
- [x] Property/Casualty RBC Instructions
- [x] Life and Fraternal RBC Blanks
- [ ] OTHER ____________________________

**DESCRIPTION OF CHANGE(S)**

Incorporate investment income into the Underwriting Risk – Experience Fluctuation Risk factors for columns 1-3. The base underwriting factors would be adjusted for Comprehensive Medical, Medicare Supplement and Dental and Vision.

**MODIFICATION FOR ROUNDING:** All ratios in Columns 1, 2 and 3 on pages XR013, LR020 and PR020 will be adjusted to round to the fourth decimal place.

Lines that will be adjusted include:
- XR013 – 12, 13, and 15
- LR020 – 9, 10.3 and 12
- PR020 – 9, 10.3 and 12

**REASON OR JUSTIFICATION FOR CHANGE **

Incorporated investment income into Columns 1-3 on the Underwriting Risk – Experience Fluctuation Risk page. The American Academy of Actuaries provided recommended factors to the Working Group. The Academy found that due to no claims lag in Stand-Alone Medicare Part D coverage, the investment income adjustment would be negligible, and the RBC factors would not be impacted.

The Working Group will continue to work with the Academy to look at the potential to incorporate an investment income adjustment to the factors for the other health lines of business for 2022 or later.
MODIFICATION FOR ROUNDING: The UW Risk Fluctuation Factors on pages XR013, LR020 and PR020 were adjusted and adopted for 2021 reporting to go to the fourth decimal place. Due to the NAIC system constraints, the number of decimal places a ratio is displayed is determined by the column settings. Therefore, if one factor/ratio goes to four decimal places, all factors or ratios in that column must display at 4 decimal places.

As a result, the following lines will be impacted and need to be updated to round to four decimal places.

Lines that will be adjusted include:
XR013 – 12, 13, and 15. Lines 12 and 13 are formula based calculations which could result in slight differences to the amount. Line 15 is a direct pull from page XR018 and only goes to 3 decimal places so it would end in “0”
LR020 – 9, 10.3 and 12. Lines 9 and 10.3 are formula based calculations which could result in slight differences to the amount. Line 12 is a direct pull from page LR022 and only goes to 3 decimal places so it would end in “0”
PR020 – 9, 10.3 and 12. Lines 9 and 10.3 are formula based calculations which could result in slight differences to the amount. Line 12 is a direct pull from page PR022 and only goes to 3 decimal places so it would end in “0”

Additional Staff Comments:
These changes will also need to be incorporated into the Life and P/C formula.
3-17-21 cgb The Working Group exposed the proposal for 30-days with comments due back on April 16, 2021.
4-23-21 cgb Two comment letters were received during the comment period from UHG and AHIP/BCBSA. The WG discussed the comments and agreed to refer the proposal to the Capital Adequacy (E) Task Force with the 0.5% investment yield for exposure for all lines of business.
04-27-21 cgb The American Academy of Actuaries provided an updated letter that included the factors to two-digit rounding for each tier. A copy of the letter is included in the proposal.
4-29-21 cgb The TF exposed the proposal until 5/21/21.

** This section must be completed on all forms. Revised 2-2019
## UNDERWRITING RISK

### Experience Fluctuation Risk

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<tbody>
<tr>
<td>Premium</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Title XVIII-Medicare</td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>0</td>
</tr>
<tr>
<td>Title XIX-Medicare</td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>0</td>
</tr>
<tr>
<td>Other Health Risk Revenue</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>0</td>
</tr>
<tr>
<td>Medicaid Pass-Through Payments Reported as Premium</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Underwriting Risk Revenue = (Lines 1) + (2) + (3) + (4) - (5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Incurred Claims</td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>0</td>
</tr>
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<td>Medical Liabilities</td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>0</td>
</tr>
<tr>
<td>Fee-For-Service Offset</td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>0</td>
</tr>
<tr>
<td>Underwriting Risk Incurred Claims = Lines (9) - (10)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Underwriting Risk Claims Ratio = For Column (1) through (5), Lines (11)(6)</td>
<td>0.0000</td>
<td>0.0000</td>
<td>0.0000</td>
<td>0.0000</td>
<td>0.0000</td>
<td>0.0000</td>
<td>XXX</td>
</tr>
<tr>
<td>Underwriting Risk Factor*</td>
<td>0.1493</td>
<td>0.1043</td>
<td>0.1195</td>
<td>0.251</td>
<td>0.130</td>
<td>0.130</td>
<td>XXX</td>
</tr>
<tr>
<td>Base Underwriting Risk RBC = Lines (6) x (12) x (13)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Managed Care Discount Factor</td>
<td>1.0000</td>
<td>1.0000</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>0</td>
</tr>
<tr>
<td>Maximum Per-Individual Risk after Reinsurance*</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

The formulas in Column 2 & 3 for Line 12 would be updated in a like manner. The cell is formatted to display four decimal places.

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Underwriting Risk Incurred Claims - (Lines (10), Line (11)) for Columns (1) through (5), Column (6), Line (14)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

The line 15 amount pulls in from page XR018, therefore, only the formatting of the cell will change to display four decimal places.

### TIERED RBC FACTORS *

<table>
<thead>
<tr>
<th>Comprehensive Medical</th>
<th>Medicare Supplement</th>
<th>Dental &amp; Vision</th>
<th>Stand-Alone Medicare Part D Coverage</th>
<th>Other Health</th>
<th>Other Non-Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - $3 Million</td>
<td>0.1493</td>
<td>0.1043</td>
<td>0.1195</td>
<td>0.251</td>
<td>0.130</td>
</tr>
<tr>
<td>$3 - $25 Million</td>
<td>0.1493</td>
<td>0.0663</td>
<td>0.0755</td>
<td>0.251</td>
<td>0.130</td>
</tr>
<tr>
<td>Over $25 Million</td>
<td>0.0893</td>
<td>0.0663</td>
<td>0.0755</td>
<td>0.151</td>
<td>0.130</td>
</tr>
</tbody>
</table>

### ALTERNATE RISK CHARGE***

The Line (15) Alternate Risk Charge is calculated as follows:

- **LESSER OF:**
  - 1,500,000 or 2 x Maximum Individual Risk
  - 50,000 or 2 x Maximum Individual Risk
  - 50,000 or 2 x Maximum Individual Risk
  - 150,000 or 6 x Maximum Individual Risk
  - 50,000 or 2 x Maximum Individual Risk

† The Annual Statement Sources are found on page XR014

* This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental/Vision managed care discount factor.

*** Limited to the largest of the applicable alternate risk adjustments, prorated if necessary.
## UNDERWRITING RISK - Experience Fluctuation Risk

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>(1) Comprehensive Medical</th>
<th>(2) Medicare Supplement</th>
<th>(3) Dental &amp; Vision</th>
<th>(4) Stand-Alone Medicare Part D Coverage</th>
<th>(5) Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1.1) Premium – Individual</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(1.2) Premium – Group</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(1.3) Premium – Total = Line (1.1) + Line (1.2)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(2) Title XVIII-Medicare†</td>
<td>XXX</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(3) Title XIX-Medicare§</td>
<td>XXX</td>
<td>XXX</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(4) Other Health Risk Rev</td>
<td>$0</td>
<td>XXX</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(5) Underwriting Risk Claims Ratio = Net Incurred Claims / Line (1.3)</td>
<td>$0</td>
<td>XXX</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(6) Net Incurred Claims</td>
<td>$0</td>
<td>XXX</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(7) Fee-for-Service</td>
<td>$0</td>
<td>XXX</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(8) Underwriting Risk Incurred Claims = Line (6) – Line (7)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(9) Underwriting Risk Claims Ratio = Line (8) / Line (5)</td>
<td>0.0000</td>
<td>0.0000</td>
<td>0.0000</td>
<td>0.0000</td>
<td>0.0000</td>
</tr>
<tr>
<td>(10.1) Underwriting Risk Factor for Initial Amounts</td>
<td>0.0000</td>
<td>0.0000</td>
<td>0.0000</td>
<td>0.0000</td>
<td>0.0000</td>
</tr>
<tr>
<td>(10.2) Underwriting Risk Factor for Excess of Initial Amounts</td>
<td>0.0000</td>
<td>0.0000</td>
<td>0.0000</td>
<td>0.0000</td>
<td>0.0000</td>
</tr>
<tr>
<td>(10.3) Underwriting Risk Factor</td>
<td>0.0000</td>
<td>0.0000</td>
<td>0.0000</td>
<td>0.0000</td>
<td>0.0000</td>
</tr>
<tr>
<td>(11) Base Underwriting Risk RBC = Line (5) x Line (5) x Line (10.3)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(12) Managed Care Discount Factor = LB022 Line (47)</td>
<td>1.0000</td>
<td>1.0000</td>
<td>1.0000</td>
<td>1.0000</td>
<td>1.0000</td>
</tr>
<tr>
<td>(13) Base RBC After Managed Care Discount = Line (11) x Line (12)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(14) RBC † = if (D14&gt;0, ROUND(D15<em>MAX(0,MIN(D14,2500000000))+D20</em>MAX(0,D14-2500000000))/D14,0)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(15) Maximum</td>
<td>$1,500,000 or 2 x Maximum Individual Risk</td>
<td>$50,000 or 2 x Maximum Individual Risk</td>
<td>$50,000 or 2 x Maximum Individual Risk</td>
<td>$150,000 or 6 x Maximum Individual Risk</td>
<td>$0</td>
</tr>
<tr>
<td>(16) Alternate Risk Charge</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(17) Net Alternate Risk Charged</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(18) Net Underwriting Risk RBC (Maximum of Line (14))</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

† Source is company records unless already included in premiums.
‡ For Comprehensive Medical the Initial Premium Amount is $25,000,000 or the amount in Line (1.3) if smaller. For Medicare Supplement and Dental & Vision, the Initial Premium Amount is $3,000,000 or the amount in Line (1.3) if smaller. For Stand-Alone Medicare Part D the Initial Premium Amount is $25,000,000 or the amount in Line (1.3) if smaller.
§ Formula applies only to Column (1), for all other columns Line (14) should equal Line (13).
* The Line (16) Alternate Risk Charge is calculated as follows:

\[
\text{LESHER OF} \begin{cases} 
1,500,000 \\
2 \times \text{Maximum Individual Risk}
\end{cases}
\]

\[
\begin{array}{c|c|c|c|c|c}
\text{Columns} & 1 & 2 & 3 & 4 & \text{Maximum of Columns} \\
\hline
(1), (2), (3) & 20 & 20 & 20 & 20 & 20 \\
(4) & 20 & 20 & 20 & 20 & 20 \\
\hline
\end{array}
\]

£ Applicable only if Line (16) for a column equals Line (16) for Column (5), otherwise zero.

The formulas in Column 2 & 3 for Line 9 would be updated in a like manner. The cell is formatted to display four decimal places.

The factors in Lines 10.1 and 10.2 Columns 1-3 are hard coded.

The line 12 amount pulls from page LR022, therefore, only the formatting of the cell will change to display four decimal places.

The formulas in Column 2 & 3 for Line 10.3 would be updated in a like manner. The cell is formatted to display four decimal places.
UNDERWRITING RISK - PREMIUM RISK FOR COMPREHENSIVE MEDICAL, MEDICARE SUPPLEMENT AND DENTAL & VISION PR020

(Experience Fluctuation Risk in Life RBC Formula)

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Comprehensive Medical</th>
<th>Medicare Supplement</th>
<th>Dental &amp; Vision</th>
<th>Stand-Alone Medicare</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1.1) Premium - Individual</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<tr>
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<td>XXX</td>
<td>XXX</td>
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<td>0</td>
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<tr>
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<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>(7) Fee-For-Service Claims</td>
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<td>0</td>
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<td>0</td>
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<tr>
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<td>0</td>
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<td>0</td>
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<td>(20.9) Composite Underwriting Risk Factor</td>
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<tr>
<td>(21) Base Underwriting Risk RBC = Line (5) x Line (9) x Line (10.3)</td>
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<td>(22) Managed Care Discount Factor = PR021 Line (12)</td>
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<tr>
<td>(23) Base RBC After Managed Care Discount = Line (21) x Line (12)</td>
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<td>(24) RBC After Reinsurance</td>
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<td>(25) Maximum Individual Risk After Reinsurance †</td>
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<td>0</td>
<td>0</td>
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<tr>
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<td>0</td>
<td>0</td>
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</tr>
</tbody>
</table>

The formulas in Column 2 & 3 for Line 9 would be updated in a like manner. The cell is formatted to display four decimal places.

The factors in Lines 10.1 and 10.2 Columns 1-3 are hard coded.

The line 12 amount pulls in from page PR022, therefore, only the formatting of the cell will change to display four decimal places.

The formulas in Column 2 & 3 for Line 13 would be updated in a like manner. The cell is formatted to display four decimal places.

Source is company records unless already included in premium.

† For Comprehensive Medical the Initial Premium Amount is $25,000,000 or the amount in Line (3) if smaller. For Medicare Supplement and Dental & Vision the Initial Premium Amount is $3,000,000 or the amount in Line (3) if smaller.

‡ For Stand-Alone Medicare the Initial Premium Amount is $25,000,000 or the amount in Line (3) if smaller.

§ The line (14) Alternate Risk Charge is calculated as follows:

\[ \min(1,500,000, 2 \times \text{maximum individual risk}, 2 \times \text{maximum individual risk}, 2 \times \text{maximum individual risk}) \times 1.11 \times 0.0893 \]

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<tr>
<th>Line</th>
<th>2021</th>
<th>2020</th>
<th>2019</th>
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<tbody>
<tr>
<td>A&amp;H Experience Exhibit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;H Net Written Premiums</td>
<td>PREMWRTNCS</td>
<td>PREMWRTNCS</td>
<td>PREMWRTNCS</td>
</tr>
<tr>
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<td>0</td>
</tr>
<tr>
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<td>0.00%</td>
<td>0.00%</td>
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<tr>
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<td>Comprehensive Medical</td>
<td>Medicare Supplement</td>
<td>Dental &amp; Vision</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------</td>
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<tr>
<td>Premium</td>
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<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Title XVIII-Medicare</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Title XIX-Medicaid</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Other Health Risk Revenue</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Underwriting Risk Revenue</td>
<td>Lines (1) + (2) + (3) + (4) - (5)</td>
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<td>XXX</td>
</tr>
<tr>
<td>Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Premium</td>
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<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Underwriting Risk Incurred Claims</td>
<td>Lines (9) - (10)</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Underwriting Risk Claims Ratio</td>
<td>Lines (11) / (6)</td>
<td>1.000</td>
<td>XXX</td>
</tr>
<tr>
<td>Underwriting Risk Factor*</td>
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<tr>
<td>Base Underwriting Risk RBC Factor</td>
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**TIERED RBC FACTORS**

<table>
<thead>
<tr>
<th>Tier</th>
<th>Comprehensive Medical</th>
<th>Medical</th>
<th>Dental &amp; Vision</th>
<th>Medicare Part D Coverage</th>
<th>Other Non-Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - $3 Million</td>
<td>0.1493</td>
<td>0.1043</td>
<td>0.1195</td>
<td>0.130</td>
<td>0.130</td>
</tr>
<tr>
<td>$3 - $25 Million</td>
<td>0.1493</td>
<td>0.0663</td>
<td>0.0755</td>
<td>0.130</td>
<td>0.130</td>
</tr>
<tr>
<td>Over $25 Million</td>
<td>0.0893</td>
<td>0.0663</td>
<td>0.0755</td>
<td>0.151</td>
<td>0.130</td>
</tr>
</tbody>
</table>

**ALTERNATE RISK CHARGE**

<table>
<thead>
<tr>
<th>Tier</th>
<th>Comprehensive Medical</th>
<th>Medical</th>
<th>Dental &amp; Vision</th>
<th>Medicare Part D Coverage</th>
<th>Other Non-Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - $3 Million</td>
<td>0.0984</td>
<td>0.0984</td>
<td>0.0984</td>
<td>0.130</td>
<td>0.130</td>
</tr>
<tr>
<td>$3 - $25 Million</td>
<td>0.0984</td>
<td>0.0984</td>
<td>0.0984</td>
<td>0.130</td>
<td>0.130</td>
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<tr>
<td>Over $25 Million</td>
<td>0.0984</td>
<td>0.0984</td>
<td>0.0984</td>
<td>0.151</td>
<td>0.130</td>
</tr>
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</table>

**LESSEE OF**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Maximum</th>
<th>Minimum</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 x Maximum Individual Risk</td>
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<td>500,000</td>
</tr>
</tbody>
</table>

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UNDERWRITING RISK - PREMIUM RISK FOR COMPREHENSIVE MEDICAL, MEDICARE SUPPLEMENT AND DENTAL & VISION  PR020

(Experience Fluctuation Risk in Life RBC Formula)

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Comprehensive Medical</th>
<th>Medicare Supplement</th>
<th>Dental &amp; Vision</th>
<th>Stand-Alone Medicare Part D Coverage</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1.1) Premium – Individual</td>
<td>Statement Value</td>
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<td>0</td>
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<td>(1.2) Premium – Group</td>
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<td>0</td>
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<tr>
<td>(1.3) Premium – Total = Line (1.1) + Line (1.2)</td>
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<tr>
<td>(2) Title XVIII-Medicare†</td>
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<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>(3) Title XIX-Medicaid†</td>
<td>0</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>(4) Other Health Risk Revenue†</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(5) Underwriting Risk Revenue = Lines (1.3) + (2) + (3) + (4)</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td></td>
</tr>
<tr>
<td>(6) Net Incurred Claims</td>
<td>0</td>
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<td>0</td>
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</tr>
<tr>
<td>(7) Fee-for-Service Offset†</td>
<td>0</td>
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<td>0</td>
<td></td>
</tr>
<tr>
<td>(8) Underwriting Risk Incurred Claims = Line (6) – Line (7)</td>
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<td>0</td>
<td></td>
</tr>
<tr>
<td>(9) Underwriting Risk Claims Ratio = Line (8) / Line (5)</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td></td>
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<tr>
<td>(10.1) Underwriting Risk Factor for Initial Amounts Of Premium‡</td>
<td>0.1493</td>
<td>0.1043</td>
<td>0.1195</td>
<td>0.251</td>
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<tr>
<td>(10.2) Underwriting Risk Factor for Excess of Initial Amount‡</td>
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<td>0.0663</td>
<td>0.0760</td>
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<tr>
<td>(10.3) Composite Underwriting Risk Factor</td>
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<td>0.000</td>
<td>0.000</td>
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<tr>
<td>(11) Base Underwriting Risk RBC = Line (5) x Line (9) x Line (10.3)</td>
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<td>0</td>
<td></td>
</tr>
<tr>
<td>(12) Managed Care Discount Factor = PR021 Line (12)</td>
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<td>(13) Base RBC After Managed Care Discount = Line (11) x Line (12)</td>
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</tr>
<tr>
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<td>0</td>
<td></td>
</tr>
<tr>
<td>(15) Maximum Per-Individual Risk After Reinsurance†</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>(16) Alternate Risk Charge*</td>
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<td>0</td>
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</tr>
<tr>
<td>(17) Net Alternate Risk Charge£</td>
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<td>0</td>
<td></td>
</tr>
<tr>
<td>(18) Net Underwriting Risk RBC (Maximum of Line (14) or Line (15)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Source is company records unless already included in premiums.
† For Comprehensive Medical the Initial Premium Amount is $25,000,000 or the amount in Line (1.3) if smaller. For Medicare Supplement and Dental & Vision the Initial Premium Amount is $3,000,000 or the amount in Line (1.3) if smaller. For Stand-Alone Medicare Part D the Initial Premium Amount is $25,000,000 or the amount in Line (1.3) if smaller.
‡ Formula applies only to Column (1), for all other columns Line (14) should equal Line (13).
§ The Line (16) Alternate Risk Charge is calculated as follows:

<table>
<thead>
<tr>
<th>LESSER OF:</th>
<th>$1,500,000</th>
<th>$500,000</th>
<th>$500,000</th>
<th>$150,000</th>
<th>Maximum of Columns</th>
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<td>2 x Maximum Individual Risk</td>
<td>2 x Maximum Individual Risk</td>
<td>6 x Maximum Individual Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) $500,000 or 2 Maximum Individual Risk</td>
<td>2 x Maximum Individual Risk</td>
<td>6 x Maximum Individual Risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) $500,000 or 2 Maximum Individual Risk</td>
<td>6 x Maximum Individual Risk</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) $150,000 or 6 x Maximum Individual Risk</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

£ Applicable only if Line (16) for a column equals Line (16) for Column (5), otherwise zero.

Denotes items that must be manually entered on the filing software.
# UNDERWRITING RISK

## Experience Fluctuation Risk

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>(1) Premium – Individual</th>
<th>(2) Premium – Group</th>
<th>(3) Total = Line (1.1) + Line (1.2)</th>
<th>(4) Title XVIII-Medicare†</th>
<th>(5) Title XIX-Medicaid†</th>
<th>(6) Other Health Risk Revenue†</th>
<th>(7) Underwriting Risk Revenue = Lines (1.3) + (2) + (3) + (4)</th>
<th>(8) Net Incurred Claims</th>
<th>(9) Underwriting Risk Incurred Claims = Line (6) – Line (7)</th>
<th>(10) Underwriting Risk Claims Ratio = Line (8) / Line (5)</th>
</tr>
</thead>
<tbody>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>XXX</td>
<td>XXX</td>
<td>$0</td>
<td>$0</td>
<td>0.000</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>XXX</td>
<td>XXX</td>
<td>$0</td>
<td>$0</td>
<td>0.000</td>
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<td>Supplement</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>XXX</td>
<td>XXX</td>
<td>$0</td>
<td>$0</td>
<td>0.000</td>
</tr>
<tr>
<td>Dental &amp; Vision</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>XXX</td>
<td>XXX</td>
<td>$0</td>
<td>$0</td>
<td>0.000</td>
</tr>
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<td>Stand-Alone Medicare Part D</td>
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<td>$0</td>
<td>XXX</td>
<td>XXX</td>
<td>$0</td>
<td>$0</td>
<td>0.000</td>
</tr>
</tbody>
</table>

## Calculations

- **Line (10.1)** Underwriting Risk Factor for Initial Amounts Of Premium‡
  - Comprehensive Medical: 0.1493
  - Medicare: 0.1043
  - Supplement: 0.1195
  - Dental & Vision: 0.251

- **Line (10.2)** Underwriting Risk Factor for Excess of Initial Amount‡
  - Comprehensive Medical: 0.0893
  - Medicare: 0.0663
  - Supplement: 0.0755
  - Dental & Vision: 0.151

- **Line (10.3)** Composite Underwriting Risk Factor
  - 0.000

- **Line (11)** Base Underwriting Risk RBC = Line (5) x Line (9) x Line (10.3)
  - $0

- **Line (12)** Managed Care Discount Factor = LR022 Line (17)
  - 0.000

- **Line (13)** Base RBC After Managed Care Discount = Line (11) x Line (12)
  - $0

- **Line (14)** RBC Adjustment For Individual = \[\frac{(\text{Line}(1.1) \times 1.2 + \text{Line}(1.2))}{\text{Line}(1.3)}\] x Line (13)\$
  - $0

- **Line (15)** Maximum Per-Individual Risk After Reinsurance†
  - $0

- **Line (16)** Net Underwriting Risk RBC (Maximum of Line (14) or Line (15))
  - $0

- **Line (17)** Net Underwriting Risk Incurred Claims = Line (6) – Line (7)
  - $0

- **Line (18)** Net Underwriting Risk Claims Ratio = Line (8) / Line (5)
  - 0.000

- **Line (19)** Underwriting Risk Factor for Initial Amounts Of Premium‡
  - Comprehensive Medical: 0.1493
  - Medicare: 0.1043
  - Supplement: 0.1195
  - Dental & Vision: 0.251

- **Line (20)** Underwriting Risk Factor for Excess of Initial Amount‡
  - Comprehensive Medical: 0.0893
  - Medicare: 0.0663
  - Supplement: 0.0755
  - Dental & Vision: 0.151

- **Line (21)** Composite Underwriting Risk Factor
  - 0.000

- **Line (22)** Net Underwriting Risk RBC (Maximum of Line (14) or Line (15))
  - $0

### Source
- For Comprehensive Medical the Initial Premium Amount is $25,000,000 or the amount in Line (1.3) if smaller. For Medicare Supplement and Dental & Vision, the Initial Premium Amount is $3,000,000 or the amount in Line (1.3) if smaller. For Stand-Alone Medicare Part D the Initial Premium Amount is $25,000,000 or the amount in Line (1.3) if smaller.

### Notes
- Formula applies only to Column (1), for all other columns Line (14) should equal Line (13).
- The Line (16) Alternate Risk Charge is calculated as follows:

<table>
<thead>
<tr>
<th>LESSER OF:</th>
<th>$1,500,000</th>
<th>$50,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Risk</td>
<td>2 x Maximum</td>
<td>2 x Maximum</td>
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<tr>
<td>Risk Incurred</td>
<td>Individual Risk</td>
<td>Individual Risk</td>
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  \[\text{Maximum of Columns (1), (2), (3) and (4)}\]

- Applicable only if Line (16) for a column equals Line (16) for Column (5), otherwise zero.
### Capital Adequacy (E) Task Force

**Working Agenda Items for Calendar Year 2021**

<table>
<thead>
<tr>
<th>Working Agenda Item</th>
<th>Source</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing Items – Life RBC</td>
<td>CATF</td>
<td>Being addressed by the Variable Annuities Capital and Reserve (E/A) Subgroup</td>
</tr>
<tr>
<td>Carry-Over Items Currently Being Addressed – Life RBC</td>
<td>New Jersey</td>
<td>Being addressed by the Longevity (E/A) Subgroup</td>
</tr>
</tbody>
</table>

**2021 #** | **Owner** | **2021 Priority** | **Expected Completion Date** | **Working Agenda Item** | **Comments** |
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>1</td>
<td>Life RBCWG</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>Make technical corrections to LiK RBC instructions, blank and/or methods to provide for consistent treatment among asset types and among the various components of the RBC calculations for a single asset type.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Life RBCWG</td>
<td>1</td>
<td>2021 or later</td>
<td>Monitor the impact of the changes to the variable annuities reserve framework and risk-based capital (RBC) calculation and determine if additional revisions need to be made. Develop and recommend appropriate changes including those to improve accuracy and clarity of variable annuity (VA) capital and reserve requirements.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Life RBCWG</td>
<td>1</td>
<td>2021 or later</td>
<td>Provide recommendations for recognizing longevity risk in statutory reserves and/or RBC, as appropriate. Provide recommendations for the appropriate treatment of longevity risk transfers by the new longevity factors.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Life RBCWG</td>
<td>1</td>
<td>2021 or later</td>
<td>Update the current C-3 Phase I or C-3 Phase II methodology to include indexed annuities with consideration of contingent deferred annuities as well.</td>
<td>AAA</td>
</tr>
<tr>
<td>5</td>
<td>Life RBCWG</td>
<td>1</td>
<td>2021</td>
<td>Determine if any adjustment is needed to the XXX/AXXX RBC Shortfall calculation to address surplus notes issued by captives.</td>
<td>11/11/17 Referral from the Reinsurance (E) Task Force</td>
</tr>
<tr>
<td>6</td>
<td>Life RBCWG</td>
<td>1</td>
<td>2021</td>
<td>Determine if any adjustment is needed due to the changes made to the Life and Health Guaranty Association Model Act, Model #520.</td>
<td>9/1/2018</td>
</tr>
<tr>
<td>7</td>
<td>Life RBCWG</td>
<td>1</td>
<td>2021</td>
<td>Determine if any adjustment is needed due to the reinsurance credit risk in light of changes related to collateral and the changes made to the property RBC formula.</td>
<td>9/1/2018</td>
</tr>
<tr>
<td>8</td>
<td>Life RBCWG</td>
<td>1</td>
<td>2021</td>
<td>Choose and determine the bond factors for the 20 designations.</td>
<td>Referral from Investment RBC Task Force: July 2020</td>
</tr>
<tr>
<td>9</td>
<td>Life RBCWG</td>
<td>1</td>
<td>2021</td>
<td>Choose and determine the need to adjust the real estate factors.</td>
<td>Referral from Investment RBC Task Force: July 2020</td>
</tr>
<tr>
<td>10</td>
<td>Life RBCWG</td>
<td>1</td>
<td>2021 or later</td>
<td>Work with the Life Actuarial (A) Task Force and Conning to develop the economic scenario generator for implementation.</td>
<td></td>
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</tbody>
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**New Items – Life**

<table>
<thead>
<tr>
<th>Working Agenda Item</th>
<th>Source</th>
<th>Comments</th>
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<tbody>
<tr>
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</tr>
<tr>
<td>7</td>
<td>Life RBCWG</td>
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**Carry-Over Items Currently Being Addressed – P&C RBC**

<table>
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<tr>
<th>Working Agenda Item</th>
<th>Source</th>
<th>Comments</th>
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<tr>
<td>8</td>
<td>Cat Risk SG</td>
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<tr>
<td>9</td>
<td>Cat Risk SG</td>
<td>Year-end</td>
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<td>#</td>
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<td>Priority</td>
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<td>---</td>
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<tr>
<td>9</td>
<td>P&amp;C RBC WG</td>
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<td>10</td>
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<td>1</td>
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<td>11</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
</tr>
<tr>
<td>12</td>
<td>P&amp;C RBC WG</td>
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<tr>
<td>13</td>
<td>Cat Risk SG</td>
<td>1</td>
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<tr>
<td>14</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
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<tr>
<td>15</td>
<td>P&amp;C RBC WG</td>
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<tr>
<td>16</td>
<td>Cat Risk SG</td>
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<tr>
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<td>Owner</td>
<td>Priority</td>
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<tr>
<td>17</td>
<td>P&amp;C RBC WG</td>
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<td>18</td>
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<td>19</td>
<td>Cat Risk SG</td>
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**Ongoing Items – Health RBC**

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<tr>
<th>#</th>
<th>Owner</th>
<th>Priority</th>
<th>Expected Completion Date</th>
<th>Working Agenda Item</th>
<th>Source</th>
<th>Comments</th>
<th>Date Added to Agenda</th>
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<tbody>
<tr>
<td>21</td>
<td>Health RBC WG</td>
<td>3</td>
<td>Year-end 2022 RBC or later</td>
<td>Discuss and monitor the development of federal level programs and actions and the potential impact of these changes to the HRBC formula:</td>
<td>HRBCWG</td>
<td>Discuss and monitor the development of federal level programs and the potential impact on the HRBC formula.</td>
<td>1/11/2018</td>
</tr>
<tr>
<td>22</td>
<td>Health RBC WG</td>
<td>3</td>
<td>Year-end 2023 RBC or later</td>
<td>Consider changes for stop-loss insurance or reinsurance.</td>
<td>AAA Report at Dec. 2006 Meeting</td>
<td>(Based on academy report expected to be received at YE-2016) 2016-17-CA</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Health RBC WG</td>
<td>2</td>
<td>Year-end 2023 RBC or later</td>
<td>Review the individual factors for each health care receivables line with in the Credit Risk H3 component of the RBC formula.</td>
<td>HRBC WG</td>
<td>Adopted 2016-06-H Rejected 2019-04-H Annual Statement Guidance (Year-End 2020) and Annual Statement Blanks Proposal (Year-End 2021) referred to the Blanks (E) Working Group</td>
<td></td>
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</table>
### Working Agenda Items for Calendar Year 2021

<table>
<thead>
<tr>
<th>#</th>
<th>Owner</th>
<th>2021 Priority</th>
<th>Expected Completion Date</th>
<th>Working Agenda Item</th>
<th>Source</th>
<th>Comments</th>
<th>Date Added to Agenda</th>
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<tbody>
<tr>
<td>24</td>
<td>Health RBC WG</td>
<td>1</td>
<td>Year-end 2022 or later</td>
<td>Establish an Ad Hoc Group to review the Health Test and annual statement changes for reporting health business in the Life and P/C Blanks</td>
<td>HRBCWG</td>
<td>Evaluate the applicability of the current Health Test in the Annual Statement instructions in today's health insurance market. Discuss ways to gather additional information for health business reported in other blanks.</td>
<td>8/4/2018</td>
</tr>
<tr>
<td>25</td>
<td>Health RBC WG</td>
<td>1</td>
<td>Year-end 2022 RBC or later</td>
<td>Review the Managed Care Credit calculation in the Health RBC formula - specifically Category 2a and 2b. Review Managed Care Credit across formulas.</td>
<td>HRBCWG</td>
<td>Review the Managed Care Category and the credit calculated, more specifically the credit calculated when moving from Category 0 &amp; 1 to 2a and 2b.</td>
<td>12/3/2018</td>
</tr>
<tr>
<td>26</td>
<td>Health RBC WG</td>
<td>1</td>
<td>Year-end 2022 or later</td>
<td>Review referral letter from the Operational Risk (E) Subgroup on the excessive growth charge and the development of an Ad Hoc group to charge.</td>
<td>HRBCWG</td>
<td>Review if changes are required to the Health RBC Formula</td>
<td>4/7/2019</td>
</tr>
<tr>
<td>27</td>
<td>Health RBC WG</td>
<td>1</td>
<td>Year-End 2022 or later</td>
<td>Consider impact of COVID-19 and pandemic risk in the Health RBC formula.</td>
<td>HRBCWG</td>
<td></td>
<td>7/30/2020</td>
</tr>
</tbody>
</table>
| 28  | Health RBC WG          | 1             | Year-End 2021 or later   | Work with the Academy to evaluate incorporating and including investment income in the Underwriting Risk component of the Health RBC formula.  
* Develop a process for reviewing investment income in the underwriting risk factors.  
* Determine the frequency for which the adjustment should be updated.  
* Determine if other lines of business should include investment income. | HRBCWG | Referral Letter was sent to the Academy on Sept 21. - Adopted 5/25/21 by the WG                                              | 8/18/2020            |

**New Items – Health RBC**

<table>
<thead>
<tr>
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<th>Owner</th>
<th>2021 Priority</th>
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<th>Comments</th>
<th>Date Added to Agenda</th>
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<tbody>
<tr>
<td>30</td>
<td>Health RBC WG</td>
<td>1</td>
<td>Year-End 2022 or later</td>
<td>Work with the Academy to perform a comprehensive review of the H2 - Underwriting Risk component of the Health RBC formula including the Managed Care Credit review (Item 18, above)</td>
<td>HRBCWG</td>
<td></td>
<td>4/23/2021</td>
</tr>
</tbody>
</table>

**New Items – Task Force**

**Ongoing Items – Task Force**
### CAPITAL ADEQUACY (E) TASK FORCE

#### WORKING AGENDA ITEMS FOR CALENDAR YEAR 2021

<table>
<thead>
<tr>
<th>Priority 1 – High priority</th>
<th>Priority 2 – Medium priority</th>
<th>Priority 3 – Low priority</th>
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<td><strong>2021 #</strong></td>
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<td><strong>2021 Priority</strong></td>
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<tr>
<td>33</td>
<td>CADTF</td>
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<td>CADTF</td>
<td>2</td>
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<tr>
<td>33</td>
<td>CADTF</td>
<td>3</td>
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<td>CADTF</td>
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</tr>
<tr>
<td>35</td>
<td>CADTF</td>
<td>2</td>
</tr>
</tbody>
</table>

### Carry-Over Items Not Currently Being Addressed – Task Force

<p>| 32 | CADTF | 2 | 2022 or Later | Supplementary Investment Risks Interrogatories (SIRI) | Referral from Blackrock and IL DOI | The Task Force received the referral on Oct. 27. This referral will be tabled until the bond factors have been adopted and the TF will conduct a holistic review all investment referrals. | 11/19/2020 |
| 33 | CADTF | 3 | 2021          | Receivable for Securities factor | CADTF | Consider evaluating the factor every 3 years. (2021, 2024, 2027, etc.) | |
| 34 | CADTF | 2 | 2022 or Later | NAIC Designation for Schedule D, Part 2 Section 2 - Common Stocks Equity investments that have an underlying bond characteristic should have a lower RBC charge? Similar to existing guidance for SVO-identified ETFs reported on Schedule D-1, are treated as bonds. | SAPWG-April 16, 2019 | Referral from SAPWG 8/13/2018 | 10/8/19 - Exposed for a 30-day Comment period ending 11/8/2019 3-2-20 - Tabled discussion pending adoption of the bond structure and factors. | 10/11/2018 |
| 35 | CADTF | 2 | 2022 or Later | Structured Notes - defined as an investment that is structured to resemble a debt instrument, where the contractual amount of the instrument to be paid at maturity is at risk for other than the failure of the borrower to pay the contractual amount due. Structured notes reflect derivative instruments (i.e. put option or forward contract) that are wrapped by a debt structure. | SAPWG | Referral from SAPWG 8/13/2018 | 10/8/19 - Exposed for a 30-day Comment period ending 11/8/2019 3-2-20 - Tabled discussion pending adoption of the bond structure and factors. | 8/4/2019 |</p>
<table>
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<tr>
<th>#</th>
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<th>Source</th>
<th>Comments</th>
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</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>CADTF</td>
<td>2</td>
<td>2022 or Later</td>
<td>Comprehensive Fund Review for investments reported on Schedule D Pt 2 Sn2</td>
<td>Referral from VOSTF 9/21/2018</td>
<td>Discussed during Spring Mtg. NAIC staff to do analysis. 10/8/19 - Exposed for a 30-day comment period ending 11/8/19 3/22/20 - Tabled discussion pending adoption of the bond structure and factors.</td>
<td>11/6/2018</td>
</tr>
</tbody>
</table>

Carry-Over Items Currently being Addressed – Task Force
EXAMINATION OVERSIGHT (E) TASK FORCE

Examination Oversight (E) Task Force Aug. 5, 2021, Minutes.......................................................................................................................... 10-1014
  Information Technology (IT) Examination (E) Working Group April 19, 2021, Minutes (Attachment Two) .... 10-1018
The Examination Oversight (E) Task Force met Aug. 5, 2021. The following Task Force members participated: Judith L. French, Chair, represented by Dwight Radel (OH); Carter Lawrence, Vice Chair, represented by Joy Little (TN); Jim L. Ridling represented by Richard Ford (AL); Alan McClain represented by Mel Andersen (AR); Evan G. Daniels represented by Jon Savary (AZ); Ricardo Lara represented by Laura Clements (CA); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by William Arfanis (CT); Karima M. Woods represented by N. Kevin Brown (DC); Dean L. Cameron represented by Jessie Adamson (ID); Amy L. Beard represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Jeff Gaither (KY); James J. Donelon represented by Stewart Guerin (LA); Gary D. Anderson represented by John Turchi (MA); Anita G. Fox represented by Judy Weaver (MI); Grace Arnold represented by Kathleen Orth (MN); Chlorinda Lindley-Myers represented by Shannon Schmoeger (MO); Jon Godfread represented by Colton Schulz (ND); Eric Dunning represented by Justin Schrader (NE); Chris Nicolopoulos represented by Doug Bartlett (NH); Marlene Caride represented by Diana Sherman (NJ); Russell Toal represented by Leatrice Geckler (NM); Glen Mulready represented by Eli Snowbarger (OK); Elizabeth Kelleher Dwyer represented by John Tudino (RI); Raymond G. Farmer represented by Linda Haralson (SC); Larry D. Deiter represented by Johanna Nickelson (SD); Doug Slape represented by Shawn Frederick (TX); Jonathan T. Pike represented by Jake Garn (UT); Scott A. White represented by David Smith and Doug Stolte (VA); Mike Kreidler represented by Melanie Anderson (WA); Mark Afable represented by Amy Malm and John Litweiler (WI); and Jeff Rude represented by Linda Johnson and Doug Melvin (WY).

1. **Adopted its Spring National Meeting Minutes**

Mr. Eft made a motion, seconded by Ms. Malm, to adopt the Task Force’s March 25 minutes (see NAIC Proceedings – Spring 2021, Examination Oversight (E) Task Force). The motion passed.

2. **Adopted the Reports of its Working Groups**

   a. **Electronic Workpaper (E) Working Group**

   Mr. Radel provided the report of the Electronic Workpaper (E) Working Group. He stated that the Working Group met July 13 and April 28 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.

   b. **Financial Analysis Solvency Tools (E) Working Group**

   Mr. Radel provided the report of the Financial Analysis Solvency Tools (E) Working Group. He stated that the Working Group met June 21 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.

   c. **Financial Examiners Coordination (E) Working Group**

   Mr. Radel provided the report of the Financial Examiners Coordination (E) Working Group. He stated that the Working Group met Aug. 3 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.

   d. **Financial Examiners Handbook (E) Technical Group**

   Mr. Litweiler provided the report of the Financial Examiners Handbook (E) Technical Group. He stated that the Technical Group met July 28 (Attachment One) to discuss its 2021 project list. He said the Technical Group plans to prioritize updates to the Reserves/Claims Handling and Capital and Surplus examination repositories in the *Financial Condition Examiners Handbook* (Handbook) in 2021. The Technical Group will defer consideration of updates to Exhibit G – Fraud Consideration until 2022.

Mr. Litweiler said also that multiple NAIC working groups currently have ongoing projects that could result in revisions to guidance in the Handbook. Therefore, Technical Group members are encouraged to follow the work of those groups. These
projects include the following: 1) updates to salary range guidelines and per diem rates, as well as updates to incorporate guidance for evaluating appropriateness of market-based expense allocations (in development by the Risk-Focused Surveillance (E) Working Group); 2) updates to exam coordination guidance (in development by the Financial Examiners Coordination (E) Working Group); 3) updates to incorporate Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) elements into the examination process (in development by the Group Solvency Issues (E) Working Group); and 4) updates to procedures for evaluating the quality and portability of policyholder data to ensure the ability to transfer such data in the event of receivership or liquidation, and development of a mechanism for departments of insurance (DOIs) to respond to emerging cyber vulnerabilities or exposures during the period in between full scope exams (in development by Information Technology (IT) Examination (E) Working Group).

e. Information Technology (IT) Examination (E) Working Group

Mr. Ehlers provided the report of the IT Examination (E) Working Group. He stated that the Working Group met April 19 (Attachment Two) to discuss two recent referrals. He said the first referral came from the Chief Financial Regulator Forum and asked that the Working Group develop a mechanism that would allow for DOIs to respond to emerging cyber vulnerabilities and exposures during the period in between full scope exams. The second referral came from the Receivership Financial Analysis (E) Working Group and asked that the Working Group consider developing procedures for evaluating the quality and portability of policyholder data to ensure the ability to transfer such data in the event of receivership or liquidation. During this meeting, the Working Group formed a drafting group to develop a response to the referrals. Mr. Ehlers said the drafting group is finalizing a response to the first referral and beginning work on the second.


Having no further business, the Examination Oversight (E) Task Force adjourned.

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Draft: 8/3/21

Financial Examiners Handbook (E) Technical Group
Virtual Meeting
July 28, 2021

The Financial Examiners Handbook (E) Technical Group of the Examination Oversight (E) Task Force met via Webex July 28, 2021. The following Technical Group members participated: Susan Bernard, Chair (CA); John Litweiler, Vice Chair (WI); Blase Abreo (AL); William Arfanis (CT); N. Kevin Brown (DC); Cindy Andersen (IL); Gracy Kelly (MN); Shannon Schmoeger (MO); Justin Schrader (NE); Colin Wilkins (NH); Nancy Chice (NJ); Tracy Snow (OH); Eli Snowbarger (OK); Matt Milford (PA); John Jacobson (WA).

1. Discussed and Prioritized 2021 Projects

Ms. Bernard said that the 2021 project list includes three items. The first topic on the list is consideration of enhancements to Exhibit G and the consideration of fraud during an examination. Exhibit G is currently structured in a way that is more conducive to the former exam approach in which examiners were doing more of a financial statement audit. As the exam approach evolved to become more risk-focused, there may be an opportunity to modify the fraud review procedures to be more in line with the risk-focused approach.

The second topic is consideration of enhancements to the reserves repositories, specifically related to the completeness and accuracy of claims and reserve data. The auditor’s approach to testing the completeness and accuracy of data has evolved and now consists of a broader range of testing procedures than are accounted for in the existing examination repositories, including greater reliance on control testing and performance of analytical procedures. Updates will help ensure that the examination repositories reflect examples of common controls that may be in place at the insurer, as well as provide examples of the type of testing that examiners may perform to address those risks or that may be available for the exam team to leverage in its assessment.

The final topic is consideration of enhancements to the capital and surplus repository to incorporate high-level internal capital model review procedures. These additional revisions to the capital and surplus repository would be expected to build upon Own Risk and Solvency Assessment (ORSA) guidance that was adopted in 2020.

Mr. Litweiler proposed that the Technical Group prioritize addressing the repository-related items for the current year as those tools are broadly used in supporting the assessment of solvency risks during an examination and hold off consideration of updates to Exhibit G until 2022. The Technical Group agreed with this approach. Ms. Bernard asked for those interested in assisting with reviewing the repositories and drafting updates to contact Bailey Henning (NAIC).

2. Received an Update on Related Working Group Activities

Ms. Bernard said that there are multiple projects currently led by other groups that will eventually affect the guidance in the Financial Condition Examiners Handbook (Handbook). Ms. Bernard said that many of these projects will ultimately be referred to the Technical Group to consider for adoption, but a few will go through the exposure and adoption process at the group that is developing the guidance. For example, the Information Technology (IT) Examination (E) Working Group is composed of subject-matter experts (SMEs) and has historically been granted the ability to adopt IT-related guidance directly into the Handbook without going through a separate public comment period at the Technical Group. Because of this dynamic, it is important that Technical Group membership is aware of these ongoing projects.

Ms. Henning summarized the projects being led by other working groups. She said that the Risk-Focused Surveillance (E) Working Group has two projects that will affect examination guidance. The first project is to update the salary range guidelines. She noted that NAIC staff preformed a high-level analysis to determine how much fluctuation has occurred in salary rates for similar positions in related industries and found that the change to salaries overall was not material. Therefore, the Risk-Focused Surveillance (E) Working Group anticipates applying an incremental increase across each of the salary ranges instead of conducting a more in-depth data collection and analysis. The Risk-Focused Surveillance (E) Working Group is also considering enhancements to examination guidance for evaluating the appropriateness of affiliated service agreements using a market-based expense allocation. A drafting group has been formed to develop guidance in this area.

Ms. Henning said that the Group Solvency Issues (E) Working Group is has been asked to incorporate elements of the Common...
Framework for the Supervision of Internationally Active Insurance Groups (COMFRAME) into the examination, analysis and ORSA guidance. The Working Group assembled three drafting groups to work on each of these areas. She said the examination drafting group has begun meeting and considering how best to incorporate these elements into the examination process. She said that many of the elements will most likely fit within the assessment of the insurer’s corporate governance structure during an examination.

Ms. Henning said that the Financial Examiners Coordination (E) Working Group has formed a drafting group to develop updates to coordination-related guidance in the Handbook. She said that enhancements to other coordination-related tools will follow once the proposed guidance revisions have been adopted. Other possible updates include the development of a webinar focused on responsibilities of the lead state in conducting a coordinated examination and future updates to the work program used for documenting examination work.

Ms. Henning said the IT Examination (E) Working Group has two projects that will affect Handbook guidance. The first relates to the development of a mechanism that would allow for the department of insurance (DOI) to respond to significant cybersecurity vulnerabilities or exposures during the period in between full scope examinations. The Working Group is also working on developing guidance to assist an IT examiner in evaluating the quality and portability of an insurer’s policyholder data and systems to help ensure that data can be transferred to a receiver or guaranty fund in the event the insurer is placed in receivership or liquidation.

Mr. Snow asked if revisions related to updating the salary range guidelines would include the per diem rates outlined in the Handbook. Ms. Henning said that although the process for updating these rates is separate from the salary range guidelines, the per diem rates in the Handbook will also be updated for inclusion in the 2022 Handbook.

Tom Finnell (America’s Health Insurance Plans—AHIP) asked if the proposed revisions to the capital and surplus repositories would result in an expectation that financial examiners conduct a detailed analysis of an insurer’s capital model and what those procedures might entail. Ms. Henning said that revisions would be high-level and are meant to provide guidance for the type of test procedures an examiner might consider when reviewing this key activity. Bruce Jenson (NAIC) said that there are a few DOIs that are piloting work in this area and have raised questions about where certain procedures performed during an evaluation of the ORSA should be referenced in the examination file. He said that revisions in this area will attempt to respond to that need, while preserving the examiner’s flexibility in customizing the approach taken to address risks in this area.

Having no further business, the Financial Examiners Handbook (E) Technical Group adjourned.
The IT Examination (E) Working Group of the Examination Oversight (E) Task Force met April 19, 2021. The following Working Group members participated: Jerry Ehlers, Chair (IN); Ber Vang, Vice Chair (CA); Blase Abreo (AL); Mel Anderson (AR); William Arfanis and Ken Roulier (CT); Ginny Godek (IL); Dmitriy Valekha (MD); Kim Dobbs and Cynthia Amann (MO); Justin Schrader (NE), Eileen Fox (NY); Metty Nyangoro (OH), Eli Snowbarger (OK); Melissa Greiner and Matt Milford (PA); and Dave Jensen and Eleanor Lu (WI).

1. Exposed Two Referrals Sent to the Working Group

Mr. Ehlers explained that the Working Group received two referrals in March. The first referral was received from the Receivership Financial Analysis (E) Working Group and asked the Working Group to consider additional guidance for evaluating an insurer’s systems and data—including storage, format and portability—as part of the IT review during an examination. The second referral was received from the facilitator of the Chief Financial Regulator Forum and asked the Working Group to consider additional guidance for addressing cyber vulnerabilities, particularly in response to emerging vulnerabilities arising outside of the full-scope examination.

Mr. Vang stated that the request from the Receivership Financial Analysis (E) Working Group falls outside the normal scope of what is typically included in Exhibit C in the Financial Condition Examiners Handbook (Handbook). He said Exhibit C procedures are designed to monitor controls related to insurer solvency, while the data transfer standards recommended in the referral are mainly applicable to insurers that are troubled or potentially troubled. Mr. Vang said the IT Examination (E) Working Group could possibly consider some more creative solutions to this referral outside of an Exhibit C procedure. Mr. Vang asked the Working Group for thoughts on potential responses to this referral outside of the addition of Exhibit C procedures.

Ms. Amann concurred that an Exhibit C procedure may not be the best or only solution. She continued that she believes the Receivership Financial Analysis (E) Working Group is looking for a definitive or measurable statement on what should be done regarding data transfer formats and that the Working Group should keep this goal in mind when determining a solution.

Ms. Fox asks how expensive or burdensome it would be for companies to convert their data to Uniform Data Standards (UDS) as mentioned in the referral, because the companies that this mainly applies to are also the companies that are probably struggling the most.

Jacob Steilen (NAIC) stated that it would depend on the pervasiveness of legacy or outdated systems at the company, but specific cost implications are not known. He further stated that it would probably be in the company’s best interest to move from a legacy system to a UDS system because the knowledge pool of people who know how to use that system is larger.

Bruce Jenson (NAIC) stated that the transfer of data from insurers to receivers and/or guaranty funds has become an increasingly significant issue in receiverships. He continued that the Receivership Financial Analysis (E) Working Group is flexible in what sort of solution is offered, but since the IT examination is a regulator’s primary opportunity to look at an insurer’s IT systems, a review of an insurer’s data format would be an acceptable procedure as part of this process.

Mr. Ehlers moved the discussion to the second referral regarding cyber vulnerabilities and asked the IT Examination (E) Working Group to offer thoughts on the referral and how it should be addressed.

Ms. Dobbs pointed out that the referral mentioned that procedures should be flexible enough to be incorporated into the analysis process for addressing cybersecurity risks. Ms. Dobbs said the analysts on her team are not sure how to address these cybersecurity risks, so additional procedures would be beneficial.

Mr. Vang agreed. He said that unlike other parts of the analysis process, there is no metric for objectively gauging the cybersecurity risk at a company. As a result, there cannot be a trigger mechanism implemented like other risks where there are action steps if the risk level gets below a certain point.
Mr. Steilen proposed that an informal drafting group be formed to consider an appropriate response to the referrals. Given the significance and scope of work related to the referral from the Chief Financial Regulator Forum, the Working Group determined that it would prioritize its response to that referral before addressing the Receivership Financial Analysis (E) Working Group referral. Ms. Fox requested that the drafting group also consider training opportunities related to these referrals. The group agreed. Angela Gleason (American Property Casualty Insurance Association—APCIA) asked if comments made by interested parties could be considered by the drafting group.

The working group exposed the two referrals for a 30-day public comment period ending May 20. Any comments for the drafting group to consider should be received within that time frame.

Having no further business, the IT Examination (E) Working Group adjourned.
FINANCIAL STABILITY (E) TASK FORCE

Financial Stability (E) Task Force May 12, 2021, Minutes (Attachment One)................................. 10-1024
Suggested Edits to the 2020 Liquidity Stress Test (LST) Framework (Attachment One-A)................. 10-1026
2020 LST Framework (Attachment One-B)....................................................................................... 10-1033
Proposal to Repurpose the Liquidity Assessment (E) Subgroup as the Macroprudential (E) Working Group and Revised Charges (Attachment Two)................................................................. 10-1078
The Financial Stability (E) Task Force met July 27, 2021. The following Task Force members participated: Marlene Caride, Chair, represented by David Wolf (NJ); Eric A. Cioppa, Vice Chair (ME); Ricardo Lara represented by Susan Bernard (CA); Andrew N. Mais and Kathy Belfi (CT); Karima M. Woods represented by Philip Barlow (DC); David Altmaier represented by Ray Spudeck (FL); Doug Ommen represented by Carrie Mears (IA); Gary D. Anderson represented by John Turchi (MA); Kathleen A. Birrane represented by Lynn Beckner (MD); Chlora Lindley-Myers and John Rehagen (MO); Eric Dunning represented by Justin Schrader (NE); Linda A. Lacewell represented by Bill Carmello (NY); Jessica K. Altman represented by Kimberly Rankin (PA); Raymond G. Farmer represented by Michael Shull (SC); Carter Lawrence (TN); Doug Slaper represented by Jamie Walker (TX); and Scott A. White (VA).

1. **Heard Opening Remarks**

Superintendent Cioppa said materials for consideration and discussion for this meeting were sent by email to the member, interested state insurance regulator, and interested party distribution lists for the Task Force and the Liquidity Assessment (E) Subgroup, but they are also available on the NAIC website in the Committees section under the Financial Condition (E) Committee.

2. **Adopted its May 12 and Spring National Meeting Minutes**

The Task Force met May 12 and Feb. 22. During its May 12 meeting, the Task Force took the following action: 1) heard an update on Financial Stability Oversight Council (FSOC) developments; 2) adopted its revised mission and charges; 3) adopted the 2020 Liquidity Stress Test (LST) Framework; 4) heard an international update; and 5) heard a macroprudential risk assessment update. During its Feb. 22 meeting, the Task Force took the following action: 1) adopted its Oct. 13, 2020, minutes; 2) announced the membership of the 2021 Liquidity Assessment (E) Subgroup and its charges; 3) received the report of the Receivership and Insolvency (E) Task Force; and 4) received an update from the Liquidity Assessment (E) Subgroup on progress in achieving its deliverables related to liquidity stress testing.

Commissioner White made a motion, seconded by Mr. Schrader, to adopt the Task Force’s May 12 (Attachment One) and Feb. 22 (see NAIC Proceedings – Spring 2021, Financial Stability (E) Task Force) minutes.

3. **Received an Update on the 2020 LST Framework and Lead State Guidance**

Superintendent Cioppa reported that a final version of the 2020 LST Framework was posted to the Task Force’s web page after its adoption on May 12. He added that draft versions from prior meetings should not be used. He said that the LST Study Group continues to issue Lead State Guidance as needed for the 23 in-scope insurers performing the 2020 LST. Superintendent Cioppa added that the most current version is posted to the Task Force’s web page titled “2020 LST Framework with Lead State Guidance,” which is in track changes notation with comments included to reference the guidance number. He summarized that these tracked changes will be incorporated into the base document for the 2021 LST Framework. Todd Sells (NAIC) added that updated Lead State Guidance was also recently posted on the Task Force’s website.

4. **Adopted the Liquidity Assessment (E) Subgroup’s Revised Mission and Charges**

Superintendent Cioppa said that earlier this year, the Task Force moved from the Executive (EX) Committee to the Financial Condition (E) Committee and as part of that move was charged with building out the NAIC macroprudential surveillance system. He reported that in response, the Task Force exposed the proposal to repurpose the Liquidity Assessment (E) Subgroup into an ongoing group with broader responsibilities by renaming it the Macroprudential (E) Working Group and revising its 2021 charges, which are now in tracked changes to facilitate consideration for adoption.

Before addressing comments received, Superintendent Cioppa provided some general comments and reminders. He summarized that the new charges specifically reference the remaining MPI work because of the following facts:

- The 2020 Liquidity Stress Test Framework was adopted, and though the ongoing charges include maintaining that project, it has been addressed for the MPI.
• The Receivership and Insolvency (E) Task Force addressed the Task Force referral letter, so that MPI item is complete.
• The Group Capital Calculation (E) Working Group has developed the Group Capital Calculation, but the MPI includes capital stress testing which has not yet been addressed.
• And though the Task Force performed a stock take of existing counterparty disclosures, this MPI item will be completed once we have performed the work of considering any gaps that exist and addressed any such gaps identified.

Superintendent Cioppa also reminded industry how the current legal entity and group insurance surveillance system has been shaped over the last thirty years, and most of the tools in that system are regulator only and use data from many regulatory filings. The macroprudential surveillance system the Task Force is building out will rely heavily on the same data and tools of the legal entity and group surveillance system, particularly in the early years of development.

Finally, Superintendent Cioppa stated that the NAIC is committed to working in an open manner where possible, ensuring our efforts include different ideas and opinions from regulators and all parties interested in the NAIC work. Though regulators may not always agree with interested parties on specific points and outcomes, this Task Force has worked very well with interested parties to date, and the Chair and Vice Chair intend to see that dynamic continue in the ongoing work.

Moving to address specific comments received, Superintendent Cioppa thanked the American Council of Life Insurers (ACLI), the National Association of Mutual Insurance Companies (NAMIC), and Travelers for their comments. He summarized the resolution of their comments:

• With respect to the ACLI comments, Superintendent Cioppa referenced his final general comment and agreed that the Liquidity Study Group has been a good model for dealing with complex and complicated work in a more focused, time-sensitive manner while ensuring those entities impacted are able to participate in the development work. He indicated the Macroprudential Working (E) Group will use other study groups with key state insurance regulator and industry participants to address some of the detail work included in its charges.

• To address NAMIC, Superintendent Cioppa referenced his general comments. The macroprudential surveillance system the Task Force is developing will have to review the existing data and tools from the legal entity and group insurance surveillance system. This will include assessing what works well for macroprudential purposes and considering ways to aggregate and manipulate existing data to tailor the outcomes for macroprudential needs. While the Task Force has no specific plans for new data collections across the entire industry, state regulators cannot guarantee they will not need to create a new data collection tool even in the near term. The Covid pandemic proved that state regulators must keep their options open. Since the existing charges already included language to develop data collection tools “as needed” and “leveraging existing data where feasible,” it is not appropriate to eliminate the term “develop,” and any cost/benefit analysis should be addressed for a specific proposal rather than included in the ongoing charges.

• With respect to the Travelers comments, the charges are drafted broadly to cover ongoing and future work of the Macroprudential (E) Working Group. Much of the microprudential and macroprudential financial analysis work uses historical data to identify potential issues. Thus, limiting the work to “activities” that lead to systemic risk would be too narrow of a charge. For Travelers’ remaining comments, Superintendent Cioppa reported that the Task Force sought feedback from the North American Chief Risk Officer (CRO) Council on the Macroprudential Risk Assessment document and noted that the Macroprudential (E) Working Group will take up that issue as work progresses.

Jonathan Rodgers (NAMIC) asked that the general discussion for this agenda item be made public. Mr. Sells responded that NAIC staff will include Superintendent Cioppa’s general comments in the posted minutes of the Task Force meeting on its website.

Commissioner Lindley-Myers made a motion, seconded by Mr. Spudeck, to adopt the revised charges for the Liquidity Assessment (E) Subgroup and renaming it the Macroprudential (E) Working Group (Attachment Two). The motion passed unanimously.

5. Heard an International Update

Mr. Nauheimer reported that the Individual Insurer Monitoring (IIM) and the Sector-Wide Monitoring (SWM) helped determine the scope for an annual collective discussion by the International Association of Insurance Supervisors (IAIS) on potential systemic risk issues. He added that the collective discussion will take place for the first time since the adoption of the Holistic Framework for Systemic Risk in the Insurance Sector (Holistic Framework) by the IAIS. Mr. Nauheimer explained that the collective discussion will focus on firms identified by a quantitative scoring, as well as some overarching themes related
to financial stability that were identified by expert judgment. He said that the collective discussion will take place at the Macroprudential Committee and Executive Committee meetings at the end of September.

Mr. Nauheimer reported on the following IAIS projects:

- IIM’s ninth annual exercise was completed.
- SWM’s qualitative and quantitative exercise was completed, but work is ongoing to compare to IIM data.
- Re-insurance data for two years is due July 31.
- Publication of the *Global Insurance Market Report* (GIMAR) on climate-affected investments has been delayed until September.
- The IAIS Liquidity Workstream reviewed comments received on the public consultation on the Development of Liquidity Metrics – Phase I and will be working on a Phase II approach that uses a company’s cash-flow projections.
- The IAIS Macroprudential Supervision Working Group reviewed comments received on a draft of the Application Paper on Macroprudential Supervision, and the paper will go to the parent committee for final approval in August.

Mr. Nauheimer said that the NAIC has submitted three sets of questionnaire responses to the IAIS as part of a targeted jurisdictional assessment (TJA) of the implementation of the Holistic Framework’s supervisory materials. He added that the next step in the TJA will be either virtual or in-person meetings by the IAIS with a few state insurance regulators.

6. **Heard a Macroprudential Risk Assessment Update**

Mr. Nauheimer reported that NAIC staff have started to work on the Macroprudential Risk Assessment, which is a risk dashboard outlining proposed risk categories, key risk indicators, and an assessment scale. He added that the Macroprudential (E) Working Group will continue to develop the dashboard, and it plans to submit a draft to the Task Force for input and approval. He explained that the dashboard was shared in a meeting with the CRO Council to obtain some preliminary high-level feedback with industry experts. He added that the NAIC plans to expose the Macroprudential Risk Assessment document more broadly with interested parties in the future with time to comment.

Superintendent Cioppa said that Mr. Nauheimer will also report on the LST template. Mr. Nauheimer announced that the LST template was sent to the ACLI for feedback and once final, it will then be posted on the Task Force’s website for use by the in-scope companies for the 2020 LST.

Having no further business, the Financial Stability (E) Task Force adjourned.
Financial Stability (E) Task Force
Virtual Meeting
May 12, 2021

The Financial Stability (E) Task Force met May 12, 2021. The following Task Force members participated: Marlene Caride, Chair (NJ); Eric A. Cioppa, Vice Chair (ME); Alan McClain (AR); Ricardo Lara represented by Susan Bernard (CA); Andrew N. Mais represented by Kathy Belfi (CT); Karima M. Woods represented by Philip Barlow (DC); David Altmaier represented by Ray Spudeck (FL); Doug Ommen represented by Carrie Mears (IA); Gary D. Anderson represented by John Turchi (MA); Kathleen A. Birrane represented by Lynn Beckner (MD); Chlora Lindley-Myers represented by John Rehagen (MO); Eric Dunning represented by Justin Schrader (NE); Linda A. Lacewell represented by Bill Carmello (NY); Jessica K. Altman represented by Melissa Greiner (PA); Raymond G. Farmer represented by Michael Shull (SC); Carter Lawrence (TN); Doug Slape represented by Jamie Walker (TX); and Scott A. White represented by Thomas J. Sanford (VA).

1. Heard Opening Remarks

Commissioner Caride said materials for consideration and discussion for this meeting were sent by email to the member, interested state insurance regulator, and interested party distribution lists for the Task Force and the Liquidity Assessment (E) Subgroup, but they are also available on the NAIC website in the Committees section under the Financial Condition (E) Committee.

2. Heard an Update on FSOC Developments

Superintendent Cioppa reported that on March 21, the Financial Stability Oversight Council (FSOC) heard an update from the Office of Financial Research (OFR), which addressed hedge fund activities during the market stresses in March 2020, including the relationship between hedge funds’ deleveraging and price declines in certain financial markets. He added that the FSOC will reconvene its Hedge Fund Working Group that last reported in 2016 to enhance interagency data sharing and improve the FSOC’s ability to identify, assess and address potential risks to financial stability related to hedge funds.

Superintendent Cioppa said the FSOC heard a presentation from the Federal Reserve about climate change and its potential impact on financial stability. He added that he made remarks detailing the potential risks to the insurance sector and the work of the NAIC’s Climate and Resiliency (EX) Task Force. He also reported that the Federal Reserve released its semiannual financial stability report that raises concerns about increased leverage and liquidity risk in the life insurance sector, which highlights the importance of the Financial Stability (E) Task Force’s work on a liquidity stress test (LST) for insurers. He noted that the report can be found on the Federal Reserve website.

3. Considered Adoption of its Revised Mission and Charges

Commissioner Caride reported that the comment period for the proposed Task Force’s charges ended May 7. She added that he made remarks detailing the potential risks to the insurance sector and the work of the NAIC’s Climate and Resiliency (EX) Task Force. He also reported that the Federal Reserve released its semiannual financial stability report that raises concerns about increased leverage and liquidity risk in the life insurance sector, which highlights the importance of the Financial Stability (E) Task Force’s work on a liquidity stress test (LST) for insurers. He noted that the report can be found on the Federal Reserve website.

Mr. Schrader made a motion, seconded by Mr. Spudeck, to adopt the amended Task Force mission and charges including the IAIGs edit (see NAIC Proceedings – Summer 2021, Executive (EX) Committee and Plenary, Attachment One). The motion passed unanimously.

4. Considered Adoption of the 2020 LST Framework

Commissioner Caride reported that there are still a few open items to finalize the 2020 LST Framework that are captured in a spreadsheet (Attachment One-A), where it indicates that the American Council of Life Insurers (ACLI) is developing or refining proposals for basis point metrics for the Adverse Liquidity Stress scenario, as well as for the structured spread metrics. She suggested adopting the current version of the 2020 LST Framework document as final and directing the LST Study Group to continue working with the 23 insurers and their lead states, issuing lead state guidance for decisions that would otherwise have been included in the 2020 LST Framework. She clarified that the proposal would end the ability for the public to provide further comments on the 2020 LST Framework document, but she noted that there have been several public comment periods, which
established the concept, background and structure of the LST, including the two regulatory stress scenarios. She added that there will be an opportunity to comment on versions of the 2021 LST Framework document next year during its development.

Ms. Belfi made a motion, seconded by Mr. Schrader, to adopt the 2020 LST Framework (Attachment One-B) as final and direct the LST Study Group to develop lead state guidance as needed. The motion passed unanimously.

5. **Heard an International Update**

Mr. Nauheimer reported that the IAIS is in the process of conducting the following data calls:

- For Individual Insurer Monitoring (IIM): the fourth quarter 2020 COVID-19 and the annual Global Monitoring Exercise (GME).
- For Sector-Wide Monitoring (SWM): the fourth quarter 2020 COVID-19; the annual quantitative GME; the annual qualitative GME; reinsurance; and climate.

Mr. Nauheimer said after results continued to show resilience for the insurance industry, the IAIS decided to suspend quarterly COVID-19 data collections. He added that the IAIS intends to publish a Global Insurance Market Report (GIMAR) on stressed scenarios of climate data in June or July. He noted that NAIC staff are in close consultation with the Climate and Resiliency (EX) Task Force to coordinate both data submission and comments to the IAIS. He added that the IAIS Macroprudential Supervision Working Group (MSWG) released a draft Application Paper on Macroprudential Supervision with comments that were due May 7. He said the MSWG is now in the process of vetting all the comments received.

Mr. Nauheimer reported that the IAIS is conducting a targeted jurisdictional assessment (TJA) of the implementation of the Holistic Framework Supervisory materials on supervisors globally, including the NAIC and state insurance regulators. He explained that the TJAs involve three sets of questionnaires with different due dates for the NAIC to complete, followed by either virtual or in-person meetings, which is similar to an NAIC accreditation review.

6. **Heard a Macroprudential Risk Assessment Update**

Mr. Nauheimer announced the introduction of the Macroprudential Risk Assessment, which is a risk dashboard outlining proposed risk categories, key risk indicators, and an assessment scale. He added that the Liquidity Assessment (E) Subgroup will continue to develop the dashboard, and it plans to have a final draft by the end of the year. He explained that the dashboard will be used for top-down supervision, macro versus micro interplays, and a formal process for identifying systemic risk with input from various sources.

Mr. Nauheimer said the Subgroup plans to do the following:

- Publish the risk dashboard biannually along with existing Risk Alert publications.
- Publish one U.S. insurance industry risk dashboard and consider separate dashboards for life, health, and property/casualty (P/C).
- Publish the Summary and Executive Summary dashboards.

Having no further business, the Financial Stability (E) Task Force adjourned.
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<th>COMMENT</th>
<th>LST STUDY GROUP REGULATOR RESPONSE/CHANGE MADE</th>
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<tbody>
<tr>
<td>1. The source of the Baseline scenario should be identified consistently (Section 4.1 and Section 5.1.2). The exposed document appears to identify inconsistently the source of the Baseline scenario, most notably the economic assumptions within that scenario. We understand that the intent is for insurers to use their internal Baseline scenarios and assumptions, and the language of Section 4.1 is consistent with this intent. The references to the Fed’s Baseline scenario in Section 5.1.2, however, create potential confusion. We believe that the references to the Fed’s Baseline scenario are intended solely to determine the degree of stress within the Adverse scenario. Assuming that this is the case, we recommend appropriate clarifications within Section 5.1.2 and Annex 2i.</td>
<td>Add the references to the Fed’s Baseline scenario are intended solely to determine the degree of stress within the Adverse scenario.</td>
<td>ACLI</td>
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<td>2. A provision permitting prudent modeling simplifications should be added (Section 5). For both the Adverse scenario and the Interest Rate Spike scenario, we request that regulators explicitly allow for a simplification whereby shocks may be reflected on day 1 of the stress period vs. at specific points in time during the stress period if the practice can be demonstrated or reasonably assumed to be more conservative.</td>
<td>Regulators are supportive of this concept.</td>
<td>ACLI</td>
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<td>3. The degree of stress within the Adverse scenario should be described consistently (Section 5.1). The exposed document appears to characterize inconsistently the degree of stress to be applied under the Adverse scenario. In a couple of places, the level of stress is characterized as akin to the 2007-09 financial crisis. Our understanding, which is outlined in Section 5.1.2 and Annex 2i, is that regulators desire to utilize the 2017 Fed CCAR Adverse scenario, which applies a more moderated degree of stress. We would appreciate clarifications where appropriate and a single, harmonized approach to the Adverse scenario within the framework document.</td>
<td>Changed description.</td>
<td>ACLI</td>
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<td>4. To promote consistency, the prescribed Fed-generated scenario stress should be translated into basis point shocks (Section 5.1.2). Section 5.1.2 requires insurers to run the Adverse liquidity stress scenario using specific values from the Fed’s stress-testing exercise for banks. It is our understanding that the intent is: (1) for the companies to use internal baselines for the Baseline scenario and (2) for the direction and magnitude of the Adverse stress scenario to be consistent with that of the prescribed Fed-generated scenario as measured from the original scenario date, and the direction and magnitude of the Adverse stress scenario would be applied to the Baseline scenario. We believe that the relevant economic and regulatory prescribed assumptions should be translated into basis point shocks to ensure more uniformity in insurers’ interpretations of the stressed economic environment. We understand that regulators have suggested that the projected path of ten-year Treasury rates should be translated to quarterly percentage increases, with a 10 bps minimum increase. Although this guidance is helpful, we have questions about the appropriateness of extending this construct to a variety of metrics. Overall, it would be helpful to establish a process that ensures that the Adverse stress scenario is constructed and applied consistently across the industry. We would be pleased to offer our assistance in this process.</td>
<td>ACLI is working on its proposal - we will finalize as lead state guidance for 2020 LST.</td>
<td>ACLI</td>
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<td><strong>5. A provision directing companies to produce assumptions consistent with stated Moody’s values should be added for asset classes not covered by Moody’s (Sections 5.1.7, 5.1.8, 5.1.9).</strong> Sections 5.1.7, 5.1.8 and 5.1.9 refer to Moody’s tables for use in determining credit migrations, defaults, and recoveries. Other asset classes (structured credit, CMBS, MBS, other ABS, etc.) are not explicitly addressed. The framework document should more clearly direct companies to create “own” assumptions consistent with the Moody’s tables. This may be related to the requested clarification of “illustrative value” (see 9c, below).</td>
<td>Added language for companies to create “own” assumptions consistent with the Moody’s tables or reference Moody’s structured tables.</td>
<td>ACLI</td>
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<td><strong>6. Detailed specifications for the “What If” modification of the Adverse scenario should be provided (Section 5.1.10).</strong> Section 5.1.10 describes the “What If” modification of the Adverse scenario. The exposed framework document indicates that the “What If” modification “allows for insurers to use established funding commitments” including existing Home Loan Bank (FHLB) commitments. It further allows the rollover of expiring facilities “but eliminates the ability of the insurer to access additional extraordinary internal and external funding sources to satisfy any liquidity deficiency under stress.” We understand that, since the exposure, regulators would like to alter the “What If” modification to limit all external funding sources, including existing FHLB obligations and rollovers, and to prohibit any internal extraordinary transactions to make the scenario more stressful.</td>
<td>LST Study Group regulators emphasized the need for this “what if” data for macroprudential purposes. Again, the “What If” is not meant to represent how internal transfers would realistically play out during a crisis - that is what the adverse stress scenario itself is meant to represent. The “What If” variation is to establish quantitative concepts for “outer limits” asset sales by category to provide context for macroprudential concerns and discussions.</td>
<td>ACLI</td>
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<td><strong>7. The requirement to provide the insurer’s worst-case scenario information should be eliminated in future reporting (Section 5.3).</strong> Section 5.3 requires insurers to provide a narrative of their most severe internal liquidity stress scenario. We observe that companies will have provided essentially the same information on or before June 1st via the COVID-19 special reporting, but we understand the desire of regulators to have this information through the cashflow template at the group level for educational purposes. After this year, the educational purpose will have been largely fulfilled and regulators should consider that many companies provide information on their binding scenario(s) to their domestic regulators through ORSA and other means. We ask that this requirement be eliminated in future reporting after this year.</td>
<td>Regulators will consider when working on future LST requirements.</td>
<td>ACLI</td>
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<td><strong>8. Reporting for the What If modification of the Adverse scenario should be clarified (Section 7).</strong> For the “What If” modification of the Adverse scenario, the framework document is currently unclear as to which reporting templates are to be submitted and whether they are to be submitted at the legal entity or group level. Our understanding is that regulators want only the asset sales template at the group level. Assuming that our understanding is correct, we would appreciate appropriate clarifications within the framework document.</td>
<td>Clarified template reporting expectations in Section 7.</td>
<td>ACLI</td>
</tr>
<tr>
<td><strong>B. Recommended Baseline and Adverse stress spreads for structured credit instruments.</strong> Section 5.1.4 directs the industry to recommend year-end Baseline structured spreads. There is also a need to include uniform structured spreads for the Adverse stress scenario. ACLI is still developing a recommendation, and we aim to deliver a proposal in the coming weeks.</td>
<td></td>
<td>ACLI</td>
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### C. Conclusion.

We believe that the LST framework may require a fair amount of refinement, even after it is "finalized" at the end of April. We recommend establishing a Q&A process whereby questions can be submitted and addressed throughout the course of the 2021 exercise. The LST Study Group will continue to meet as needed during 2021 to address any issues. Lead State guidance will be developed as needed once the LST Framework has been "finalized." 

Regarding the scope of companies to which the LST applies, you could consider whether some sort of exception application or exclusion testing may be appropriate. We support the option shown on page 10 indicating that the "lead state regulators should have the ability to consult with the Task Force and require the LST from an insurer not meeting the scope criteria," since an Annual Statement based scope definition may inadvertently miss companies with high liquidity risk exposure. The reverse may also be true, i.e., an insurer with a relatively low liquidity risk profile may be incorrectly included under this approach. 

We also support the specific requirements that the Chief Investment Officer provide oversight and commentary regarding the approach to determining asset market values upon sale in an adverse liquidity scenario (p. 27). This will be particularly important for illiquid securities, since market prices in a crisis will be hard to establish. You could also consider whether a certification from the CIO might also help ensure that careful consideration is given to the appropriateness of the asset valuation results. 

Companies are requesting a September 30, 2021 Filing Deadline. No specific date deadline has been discussed; only "3rd Quarter." Regulators support this request since we are "finalizing" the 2020 LST Framework doc in mid-May and there will likely still be Lead State guidance provided after that. However, they indicated that as a result, less flexibility will be able to be allowed for insurers needing more time given the need to review and assess results prior to the Dec. national meeting.
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<tbody>
<tr>
<td>Various edits throughout the LST Framework for clarity and flow.</td>
<td>Edits were made and are marked in track changes.</td>
<td>Review</td>
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<td><strong>9.a. Section 2.2, Time Horizons, includes the following statement:</strong> “We do acknowledge liquidity risk may exist in shorter time horizons, but this is viewed as a cash management/Treasury function as part of the daily operations of individual insurers that would not affect the industry as a whole. Many insurers do have shorter term time horizons (7-days for example) as part of their internal liquidity stress testing framework. A 7-day time horizon may be appropriately applied to specifically ‘identified activities’ within an entity, such as posting collateral.” We recommend removing the struck-through language as the NAIC has determined that a 7-day time horizon is inappropriate. The IAIS reached the same conclusion in their liquidity consultation.</td>
<td><em>Consider edited version as follows:</em> We do acknowledge liquidity risk does exist with respect to shorter time horizons and that many insurers do consider shorter time horizons (7-days for example) as part of their internal liquidity stress testing framework. This is viewed as a cash management/Treasury function impacting the daily operations of individual insurers, however, that would not affect the industry as a whole. Hence, these considerations are typically reviewed as part of individual/microprudential surveillance efforts in the U.S.</td>
<td>ACLI</td>
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<tr>
<td><strong>9.b. In Section 4.1, Baseline Assumptions for Cash Flows,</strong> language in the framework document reads, “These cash flow projections should be consistent with those used for internal financial planning and analysis (FP&amp;A), risk management, etc.” We recognize the value of having consistency between assumptions in the Baseline scenario and assumptions that are used for internal purposes. However, we think the current language is overly specific in identifying the models with which the Baseline scenario should be consistent. We suggest the following clarification: “These cash flow projections should be consistent with those used for internal baseline liquidity forecasts, such as those used for financial planning and analysis (FP&amp;A), risk management, etc.”</td>
<td>Change made as requested.</td>
<td>ACLI</td>
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<td><strong>9.c. In Section 5, Introduction,</strong> the term “Illustrative value” is used in the following sentence: “If there is no specific value included in the 2020 LST Framework and instead there is an illustrative value, the company should use a value consistent with the illustrative value.” This term is not used elsewhere in the framework document and should be clarified or modified.</td>
<td>Inserted language: “For example, guidance is given below on using Moody’s values for migration, default and recoveries. However, insurers may use S&amp;P data or other appropriate data values.”</td>
<td>ACLI</td>
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<tr>
<td><strong>9.d. In Section 5.1.2,</strong> our understanding is that the intent is to use Q4 2020 actuals, with the first projection quarter being Q1 2021. This should be updated accordingly.</td>
<td>Agree. Added clarification to 5.1.2</td>
<td>ACLI</td>
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<tr>
<td>COMMENT</td>
<td>LST STUDY GROUP REGULATOR RESPONSE/CHANGE MADE</td>
<td>SOURCE</td>
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<td><strong>9.e. In Section 6, Available and Expected Asset Sales, new language in the framework reads “Regulators expect robust disclosures around the chief investment officer’s assumptions and decisions on expected asset sales.” Although we recognize the value of the involvement of senior investment professionals in the LST, we do not think it is necessary to require the involvement of a specific individual. We would appreciate more generic language on this topic, such as “the company’s assumptions...” or “the investment team’s assumptions...” or “the chief investment officer or CIO delegate’s assumptions...”</strong>.</td>
<td>Agree. Added clarification to 6.</td>
<td>ACLI</td>
</tr>
<tr>
<td><strong>9.f. In Section 7, the reporting instructions should expressly indicate the scenarios for which the cash flow sources and uses templates are required. It is our understanding that the templates would be required for the Baseline scenario, for the Adverse scenario, and for the Interest Rate Spike scenario at both the individual entity level and the group level and for the “Worst Case” scenario at the group level only. As noted above, it would not be required for the “What If” modification of the Adverse scenario.</strong></td>
<td>Revised section 7 to spell out these expectations. Including for the &quot;what if&quot; variation of the adverse liquidity stress test for insurers scenario and the company's own worst case scenario. Further refinements to the templates, particularly for the company's own worst case scenario, will likely occur as lead state guidance.</td>
<td>ACLI</td>
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<td><strong>9.g. In Section 7, we do not understand why certain boxes are greyed out in the Liquidity Sources and Uses template.</strong></td>
<td>Inserted updated templates.</td>
<td>ACLI</td>
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<td><strong>9.h. The Section 7 description of the narrative requirements of internal stress testing systems and processes should be aligned with Section 2.3. Section 2.3 indicates that &quot;insurers should provide a narrative description of their internal liquidity stress testing system and processes, including for example their materiality thresholds for stressed cash flows and methodology for converting foreign currencies to US dollars (see Section 7 Reporting)&quot; [emphasis added]. The italicized portion of the sentence above is not found in the corresponding bullet in Section 7. More generally, our understanding is that regulators would like, where appropriate, to have some understanding of how FX rates are used in internal processes. We think that is appropriate and would not support mandated currency conversions.</strong></td>
<td>Added specific language from Section 2.3 in Section 7. Regulators indicated they would not specify FX methodologies - and thus insurers can use their own processes. However, regulators DID express the need for US dollar results.</td>
<td>ACLI</td>
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<tr>
<td>COMMENT</td>
<td>LST STUDY GROUP REGULATOR RESPONSE/CHANGE MADE</td>
<td>SOURCE</td>
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<td>9.i. In Section 7, we request confirmation of the required practices around margin and collateral. For margin, the Sources and Uses template includes Initial Margin (IM) and Variation (VM) as a source. We request confirmation of this intent, noting that it is inconsistent with some internal practices, which exclude all margin received from sources unless trades are settled. For collateral, the reporting templates exclude “Other Collateral Received” (Sources) and “Other Collateral Sent” (Uses), and we would appreciate clarification and confirmation that non-cash collateral is to be excluded from the reporting templates.</td>
<td>The categories are included in the template because an insurer may consider these as sources and uses in the base case template. However in stress scenarios, these categories may not be considered as a source or use.</td>
<td>ACLI</td>
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<td>9.j. Annex 1 outlines the original scope criteria with annual statement references. While these criteria are relevant for the current exercise, it may be appropriate to update the references for future iterations of the LST.</td>
<td>Agree, these references should be updated as needed for future LST iterations.</td>
<td>ACLI</td>
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<tr>
<td>9.k. Annex 2iii provides both placeholder categories and references for structured spreads. ACLI’s recommendation will be forthcoming. Once these are finalized, Annex 2iii should be updated.</td>
<td>ACLI is refining the recommendation per recent discussions - we will finalize as lead state guidance for 2020 LST.</td>
<td>ACLI</td>
</tr>
<tr>
<td>A provision permitting prudent modeling simplifications should be added (Section 5). For both the Adverse scenario and the Interest Rate Spike scenario, we request that regulators explicitly allow for a simplification whereby shocks may be reflected on day 1 of the stress period vs. at specific points in time during the stress period if the practice can be demonstrated or reasonably assumed to be more conservative.</td>
<td>Regulators agreed to allow this option.</td>
<td>ACLI</td>
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<td><strong>COMMENT</strong></td>
<td><strong>LST STUDY GROUP REGULATOR RESPONSE/CHANGE MADE</strong></td>
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<td>Detailed specifications for the “What If” modification of the Adverse scenario should be provided (Section 5.1.10). Section 5.1.10 describes the “What If” modification of the Adverse scenario. The exposed framework document indicates that the “What If” modification “allows for insurers to use established funding commitments” including existing Federal Home Loan Bank (FHLB) commitments. It further allows the rollover of expiring facilities “but eliminates the ability of the insurer to access additional/extraordinary internal and external funding sources to satisfy any liquidity deficiency under stress.” We understand that, since the exposure, regulators would like to alter the “What If” modification to limit all external funding sources, including existing FHLB obligations and rollovers, and to prohibit any internal extraordinary transactions to make the scenario more stressful. We urge the regulators to reconsider this approach and, instead, maintain the language as drafted in the current framework exposure. Our view is that the suggested treatment of existing FHLB obligations, which would eliminate one of the primary tools that insurers have established to manage liquidity stresses, is not plausible even under a severe stress. Further, we believe all internal funding mechanisms, including extraordinary actions, should be allowed to the extent regulatory approval is not required, as that is how internal transfers would realistically play out during a crisis.</td>
<td>1. Prohibit any internal extraordinary transactions (i.e., actions taken in response to the stress rather than ongoing agreements or in response to a liquidity deficiency). Intragroup “Keep well” agreements would be considered extraordinary transactions. 2. Restrict ALL External Funding Sources including FHLB; thus no new FHLB draws/obligations and no rollovers of existing FHLB facilities.</td>
<td>ACLI</td>
</tr>
<tr>
<td><strong>Rationale for 1</strong>: The &quot;What If&quot; is not meant to represent how internal transfers would realistically play out during a crisis - that is what the adverse stress scenario itself is meant to represent. The &quot;What If&quot; variation is to establish quantitative concepts for &quot;outer limits&quot; asset sales by category to provide context for macroprudential concerns and discussions. We do not specify a stress scenario or event that precludes the internal transfer - we simply indicate the internal transfers are not able to occur (despite the unrealistic nature). Since the Group Level templates simply add up the Legal Entity Level templates (not required to be submitted for the 2020 LST), we need the Legal Entity Assets templates to reflect the asset sales using ONLY that Legal Entity’s existing resources in order to establish this outer limits asset sales figures for the group (and when aggregated, for the industry).</td>
<td></td>
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<td><strong>Rationale for 2</strong>: Again, this is supposed to be the &quot;outer limit&quot; of asset sales that could occur - not a reasonable amount or including a reasonable use of FHLB resources. While amounts from existing FHLB sources will not be canceled, rollovers may not occur.</td>
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NAIC 2020 LIQUIDITY STRESS TEST FRAMEWORK
For Life Insurers Meeting the Scope Criteria

May 2021

DRAFT
Table of Contents
INTRODUCTION

Macroprudential Implications of a Liquidity Stress

Beginning mid-year 2017, the NAIC embarked on a project to develop a liquidity stress testing framework. While the NAIC has existing tools and processes for assessing liquidity risk at a legal entity level (i.e., ‘inward’ impacts to the insurer), there was recognition that the NAIC toolbox could be further enhanced with the addition of more granular data in the annual statement and a tool that would enable an assessment of macroprudential impacts on the broader financial markets (i.e., ‘outward’ impacts) of a liquidity stress impacting a large number of insurers simultaneously.

Post-financial crisis, there were several attempts to assess potential market impacts emanating from a liquidity stress in the insurance sector. Many of these analyses relied heavily on anecdotal assumptions and observations from behaviors of other financial sectors. To provide more evidence-based analyses, the NAIC decided to develop a Liquidity Stress Test (LST) Framework for large life insurers that would aim to capture the outward impacts on the broader financial markets of aggregate asset sales under a liquidity stress.

The stress test will be run annually and the findings, on an aggregate basis, reported annually as part of the NAIC’s continuous macroprudential monitoring efforts. The NAIC’s pursuit of the liquidity stress test should not suggest any pre-judgement of the outcomes. The NAIC believes there is value to the exercise whether it points to vulnerabilities of certain asset classes or markets or, alternatively, suggests that even a severe liquidity stress impacting the insurance sector is unlikely to have material impacts on financial markets. The NAIC liquidity stress testing framework is intended to supplement, not replace, a firm-specific liquidity risk management framework. The NAIC has not yet discussed steps that might be taken to address any identified vulnerabilities but acknowledges that any recommendations may require collaboration with other financial regulators.

The NAIC’s revised proposed liquidity stress testing framework is contained in the pages that follow. The NAIC recognizes that, at least in the early years, the stress testing process and
analyses will be iterative. We expect refinements as the framework is developed, especially after the first year’s implementation.

**BACKGROUND**

**NAIC Macroprudential Initiative**

The NAIC’s Macroprudential Initiative (MPI) commenced in 2017. It recognized the post-financial crisis reforms that became part of our Solvency Modernization Initiative (SMI) that continue to serve us well today. However, in the ensuing years since those reforms, insurers have had to contend with sustained low interest rates, changing demographics and rapid advancements in communication and technology. They have responded by offering new products, adjusting investment strategies, making structural changes, and expanding into new global markets. There are new market players, new distribution channels, and a complex web of interconnections between financial market players.

What has not changed since the financial crisis is the scrutiny on the insurance sector in terms of understanding how insurers react to financial stress, and how that reaction can impact, via various transmission channels, policyholders, other insurers, financial market participants, and the broader public.

The proposed work on macroprudential measures is reflective of the state insurance regulators’ commitment to ensure that the companies they regulate remain financially strong for the protection of policyholders, while serving as a stabilizing force to contribute to financial stability, including in stressed financial markets. To that end, the NAIC’s three-year strategic plan (2018-2020), “State Ahead”, reflects the objective of “Evaluating Gaps and regulatory opportunities arising from macroprudential surveillance, and develop appropriate regulatory responses.”

The NAIC’s work on macroprudential surveillance is overseen by the Financial Stability Task Force of the NAIC Executive Committee. In April 2017, the Task Force was asked to consider new and improved tools to better monitor and respond to both the impact of external financial and economic risks on supervised firms, as well as the risks emanating from or amplified by these
firms that might be transmitted externally. The Task Force, in turn, focused its efforts on potential enhancements to identify and monitor liquidity risk, among other areas. More specifically, the Task Force was requested to further develop the U.S. regulatory framework on liquidity risk with a focus on life insurers due to the long-term cash-build up involved in many life insurance contracts and the potential for large scale liquidation of assets.

**Liquidity Assessment Subgroup**

To carry out its work on assessing liquidity considerations, the Task Force established the Liquidity Assessment Subgroup (“Subgroup”) mid-year 2017.

**Mandate**

The charges and workplan of the Subgroup reflect the following assignments:

- Review existing public and regulator-only data related to liquidity risk, identify any gaps based on regulatory needs and determine the scope of application, and propose recommendations to enhance disclosures.

- Develop a liquidity stress testing framework proposal for consideration by the Financial Condition (E) Committee, including the proposed universe of companies to which the framework will apply (e.g., large life insurers).

- Once the stress testing framework is completed, consider potential further enhancements or additional disclosures.

In addition, a small informal study group comprised of regulators, industry participants and NAIC staff was formed to consider the specific data needs and technical aspects of the project. The study group is NOT an official NAIC working group. All recommendations from the study group must be vetted and considered by the Liquidity Assessment Subgroup and/or the Financial Stability (EX) Task Force according to NAIC procedures.
Data Gaps

Prior to undertaking work on the Liquidity Stress Test, the Subgroup constructed an inventory list of existing life insurer disclosures as of 2018 that contribute to an understanding of liquidity risk. When assessing the current state, the Subgroup recognized the availability of significant detailed investment-related disclosures but contrasted it to the relatively sparse liability-related disclosures. To remedy this imbalance, a blanks proposal was constructed to significantly increase the disclosures for life insurance products.

Specifically, the Analysis of Operations by Line of Business schedule was expanded from a single exhibit to five exhibits, one each for Individual Life, Group Life, Individual Annuity, Group Annuity, and Accident and Health. The Analysis of Increase in Reserves schedule was similarly expanded. Within each of the five new exhibits, columns were added for more detailed product reporting. For example, columns were added to the Individual and Group Life exhibits to capture universal life insurance and universal life insurance with secondary guarantees, and columns were added to the Individual and Group Annuity exhibits to capture variable annuities and variable annuities with guaranteed benefits. In addition, two new lines were added to the now five exhibits of the Analysis of Increase in Reserves schedule: one capturing the cash surrender value of the products outstanding and another capturing the amount of policy loans available (less amounts already loaned). A new addition was also proposed to the Life Notes to Financial Statement. The new Note 33 considered the type of liquidity concerns disclosed in Note 32 for annuities and deposit-type contracts and added disclosures for life insurance products not covered in Note 32.

These proposals were exposed and commented upon several times at the Liquidity Assessment Subgroup, the Financial Stability (EX) Task Force, and at the Blanks (E) Working Group. Ultimately, they were adopted by NAIC Plenary for inclusion in the 2019 Life Annual Statement Blank. As an interim step, The Financial Stability Task Force performed a data call requesting a few key lines of information from the newly adopted 2019 format of the Analysis of Operations by Line of Business schedule and the Analysis of Increase in Reserves schedule, as well as the new Note 33, but populated with 2018 year-end data. This data call was completed in July 2019.
Discussions with Insurers

During the latter part of 2017 and first quarter of 2018, the Subgroup conducted calls with several large life insurers who agreed to share their internal liquidity risk assessment processes. The dialogue provided extremely helpful input and informed the establishment of the initial direction of the Liquidity Stress Testing Framework. Feedback from these discussions include:

• Scope criteria should be risk-focused, not solely based on size.
• Stress test framework should align with internal management reporting and leverage the ORSA.
• Stress test should be principle-based and complement a company’s internal stress testing methodology.
• Regulatory guidance should be provided to help define liquidity sources and uses, products/activities with liquidity risk, time horizons, level of aggregation, reporting frequency, and establishing stress scenarios.
• Public disclosure of results should be carefully considered to avoid exacerbating a liquidity crisis.

Regarding the specifics of liquidity assessments/stress test approaches, significant diversity in practice exist. Key observations in this regard included:

• Liquidity tests are performed at the material entity level and at the holding company level. Definitions of material entities differ.
• Most firms determine some sort of coverage ratio (Liquidity Sources) / (Liquidity Uses), for Base and Stress scenarios and monitor results to ensure they align with the firm’s (internal) risk appetite. Categories of liquidity sources and uses differ across firms and assumptions vary depending on time horizon. Some insurers determine coverage ratios utilizing balance sheet values, applying different haircuts by asset class, time horizon and type of stress. Other insurers determine liquidity coverage gaps (Liquidity Inflows – Liquidity Outflows) utilizing a cash flow approach.
• Stress scenarios vary by company, reflecting a combination of market-driven, as well as idiosyncratic and insurer-specific scenarios.
- Time horizons tested also vary, typically ranging from 7 days to 1 year.

**Regulatory Goals of the Liquidity Stress Test**

- The primary goal of this liquidity stress testing, and the specific stress scenarios utilized, is for macroprudential uses – to allow the FSTF regulators to identify amounts of asset sales by insurers that could impact the markets under stressed environments. Thus, the selected stress scenarios are consciously focused on industry-wide stresses – those that can impact many insurers within a similar timeframe. These may not be the most stressful scenarios for specific legal entity insurers, or even their groups. Regulators have indicated the liquidity stress testing is also meant to assist regulators in their micro prudential supervision, in the context of being helpful for domiciliary and lead state regulators to better understand liquidity stress testing programs at those legal entities and groups. There is no intent to require these stress scenarios to be used by individual insurers for some sort of assessment or regulatory intervention mechanism. Similarly, there has not been any consideration given to requiring them in the management of any entities in receivership.

- Regulatory concerns regarding liquidity risk for legal entity insurers and/or groups is more about the stress scenarios of most concern to those entities (not those identified for macro prudential purposes). Similarly, when considering liquidity risk at a legal entity and/or group, regulators need to understand the insurer’s entire risk management framework. Much of this understanding may come from the ORSA filings. Thus, the LST is not meant to be a legal entity insurer requirement, or used as a ranking tool, etc. However, it is recognized that simply reviewing these LST results may help regulators better understand the role of liquidity stress testing within the entities – which may result in more questions and information requests regarding the entities’ own liquidity risk management framework and dynamics of their internal liquidity stress tests.

Section 1. Scope Criteria for Determining Groups Subject to 2020 LST

In determining the companies subject to the liquidity stress test (LST), consideration was given to activities assumed to be correlated with liquidity risk. Another consideration was the desirability of tying data used in the criteria back to the statutory financial statements. Ultimately six activities were identified. Those activities are Fixed and Indexed Annuities, Funding Agreements, Derivatives, Securities Lending, Repurchase Agreements and Borrowed Money. Minimum thresholds were established for each of these six activities. A life insurance legal entity or life insurance group exceeding the threshold for any of the six activities is subject to the stress test (see Annex 1 for more details).

While the scope criteria only utilize statutory annual statement data, the stress test is not similarly limited. Thus, the stress test will consider many more liquidity risk elements than the scope criteria, and internal company data will be the source for many of those elements.

Just as the liquidity stress test structure and methodology may change over time, the scope criteria may also be modified, for example, in response to new data points in the NAIC Annual Statement Blank. The scope criteria will be reviewed annually.

Using the agreed criteria, NAIC staff obtained the amounts for all life insurance legal entities from the 2018 annual statutory financial statements (filed by March 1, 2019). If two or more life insurers were part of an insurance group with an NAIC group code, then the numbers for each of those legal entity life insurers was summed together to represent an insurance group result. Thus, a legal entity life insurer not in an insurance group can meet the threshold on its own, or the sum of legal entity life insurers in a group could meet the threshold. Twenty-three insurance groups met the initial scope criteria.

In establishing whether an insurer or group met or exceeded the threshold criteria, the Subgroup members supported using the most current single year activity rather than a multi-year average.
This resulted in coverage amounts ranging from 60% to 80% of the industry total for each activity based on 2018 data. It was recognized that using single year activity could result in more instances of an insurance group being in scope one year and out of scope the next, but regulators viewed it more important to have the most recent financial data utilized for determining scope. To address concerns about insurers moving in and out of scope, regulatory judgment will be used to address an insurer’s exit from or entry to the scope of insurers subject to the liquidity stress test. The lead state regulator will consult with the Task Force in determining when it is appropriate to remove an insurer from the LST requirement if it no longer meets the scope criteria. Similarly, lead state regulators should have the ability to consult with the Task Force and require the LST from an insurer not meeting the scope criteria (e.g., an insurer close to triggering the scope criteria for more than one year).

Section 2. Liquidity Stress Test

2.1 Summary

The stress testing framework employs a company cash flow projection approach incorporating liquidity sources and uses over various time horizons under a baseline assumption and some number of stress scenarios (for 2020 there are 2 stress scenarios and also an insurer-specific request for information). The available assets are then recorded by asset category. The framework then calls for identification of expected asset sales by category, or other funding as allowed in the stress test, to cure any cash flow deficits (liquidity uses exceed liquidity sources) under the stress scenarios. The stress tests are to be performed at the legal entity level; the aggregated group does not perform the LST.

2.2 Time Horizons

The time horizons chosen by regulators are 30 days, 90 days, and 1 year, because, overall, insurance products are designed to be for the benefit of customers as risk protection over the long term and not designed to provide short term liquidity like other financial products. Historical experience in times of stress demonstrate slow policyholder reaction in short periods of time, as opposed to an event that occurs over months or years. Features designed to protect the long-
term nature of the product for the policyholders ultimately reduce the likelihood of policyholder reaction to short-term volatility in markets. Therefore, evaluating shorter than 30-day time horizons has been deemed not warranted for the overarching macroprudential purpose of gauging liquidity risk in the Life insurance industry.

Policyholders do not “run” from an insurer in times of economic stress to the extent depositors do from a bank, because insurance is purchased to obtain the protection insurance provides, not as a source of liquidity or discretionary funds. In the United States, life insurance and annuities are purchased primarily for long-term financial protections upon death or retirement. Surrendering a life insurance contract to harvest its cash surrender value would leave the policyholder without death benefit protection that would be expensive or impossible to replace at a future date. Surrendering a variable annuity contract would lock in potentially temporary decreases in account value and could result in the loss of living benefit protection that becomes more valuable when market conditions depress account values below trigger points. Further, mitigating contract features such as surrender charges and the insurer’s right to delay the processing of withdrawals and surrenders for up to 30 days are common.

There are also non-contractual mitigating factors at play, such as potential negative tax consequences, that further reduce the short-term nature of liquidity risk for life insurers.

Simply put, policyholders are highly disincentivized to give up the likely irreplaceable protection for which they have already paid. The run-like mass surrender of insurance policies would require large numbers of policyholders to act against their self-interest.

From a holistic risk perspective, liquidity stress is traditionally experienced on the asset side. One short-term consequence of market turmoil could be a requirement to post collateral in connection with existing derivative contracts. However, even in this scenario, collateral is typically posted in the form of securities, so a demand for cash is not generated.

We do acknowledge liquidity risk does exist with respect to shorter time horizons and that many insurers do consider shorter time horizons (7-days for example) as part of their internal liquidity stress testing framework. This is viewed as a cash management/Treasury function impacting the
daily operations of individual insurers, however, that would not affect the industry as a whole. Hence, these considerations are typically reviewed as part of individual/microprudential surveillance efforts in the U.S.

2.3 Insurer’s Internal Liquidity Stress Testing System

Insurers are to use their own internal liquidity stress testing system to perform the regulatory LST, adjusting for regulatory assumptions, metrics, etc., as specified in this document. For example, assessing materiality of stressed cash flows for inclusion in the liquidity uses and sources templates is per the insurer’s own internal methodology, but determining which legal entities are to perform the LST and report on those templates is specified in this document. Insurers should provide a narrative description of their internal liquidity stress testing system and processes, including for example their materiality thresholds for stressed cash flows and methodology for converting foreign currencies to US dollars (see Section 7. Reporting). The stress scenarios may vary from year-to-year and contain variations referred to as “What-if” scenarios. The following sections provide a further description of each of the key components of the framework.

Section 3. Legal Entities Required to Perform the LST for Insurers Meeting the Scope Criteria

The scope of entities included within an insurance group for the purposes of liquidity stress testing to assess the potential for large scale liquidation of assets (i.e., the legal entities within the group which should perform the LST), should include:

- U.S. Life insurance legal entities, including reinsurers, regardless of corporate structure, so including captive (regulators specifically want all U.S. life insurance/reinsurance legal entities to perform the 2020 LST for informational purposes – future LST iterations may see a materiality consideration added);
  - Non-guaranteed/market value separate accounts are not included in the 2020 LST. However, regulators may want to perform a separate account study in the future. The current thinking is that even though non-guaranteed/market value separate accounts may experience asset sales during stressed
environments, those sales are at the policyholder’s discretion and do not generate liquidity stress for the insurer/group. As such they are deemed other market activity rather than insurance entity activity. Thus, for annuities that provide both non-guaranteed and guaranteed benefits, insurers should only include the cash flow impact of the guaranteed benefits.

- Non-U.S. life insurance/reinsurance legal entities should perform the 2020 LST if they pose material liquidity risks to the U.S. group (see below on non-U.S. legal entities).

- Where applicable, holding companies that could be a source or draw of liquidity to the life insurance legal entities; and

- Non-life insurance entities and non-insurance entities with material sources of liquidity, or that carry out material liquidity risk-bearing activities and could, directly or indirectly, pose material liquidity risk to the U.S. group. This materiality consideration should occur within the context of the specific stress scenario (and “what if” modification if applicable). The materiality criteria and initial list of legal entities in scope should be reviewed by the lead state regulator and modified by the insurer as needed based on regulator direction.

  - Non-U.S. legal entities (including non-U.S. holding companies) are subject to this materiality consideration and should be subject to performing the LST if they pose material liquidity risk to the U.S. group.

  - U.S. non-life insurers and reinsurers are not automatically exempted. If the U.S. non-life insurer poses material liquidity risk, per the stress scenario, to the U.S. group, then that legal entity insurer should perform the LST.

- Legal entity asset managers and mutual funds (both U.S. and non-U.S.) are excluded from performing the 2020 LST.

  - However, those legal entities performing the LST (e.g., holding companies that could be a source or use of liquidity for the life insurers) must reflect any material stressed cash flows from/to the legal entity asset manager/mutual fund in their 2020 LST results (e.g., the liquidity sources and liquidity uses templates, as they
do with any other type of legal entity that has material stressed cash flows from/to the legal entities performing the LST).

- If such material stressed cash flows from/to the legal entity asset manager/mutual fund exist, the regulators want specific disclosures on those in the results (either by adjusting the templates to include a line for these and/or in the narrative/explanatory disclosures submitted along with the templates).

- Examples of when such legal entity asset manager/mutual fund considerations and disclosures would need to be made for a specific stress scenario include:
  - If the holding company or another legal entity(ies) in the group is expected to fund a material liquidity shortfall of a mutual fund/asset manager (i.e., redemptions exceed the ability to sell assets), then the expected cash flows must be reflected (especially where there are established inter-affiliate support agreements);
  - If the holding company or another legal entity(ies) in the group is expected to provide capital to the mutual fund/asset manager or is expecting dividends from them, the material expected cash flows must be reflected; and
  - If the asset manager manages financial instruments under which it retains some risk, such as new European CLOs, or has contractual risk retention agreements for US CLOs, the required risk retention limit (5% for Europe) must be reflected if sourced from the holding company or another legal entity(ies) in the group and considered material.

- Legal entity banks (both U.S. and non-U.S.) are excluded from performing the 2020 LST.

- However, those legal entities performing the LST (e.g., holding companies that could be a source or use of liquidity for the life insurers) must reflect any material stressed cash flows from/to the legal entity bank in their 2020 LST results (e.g., the liquidity sources and liquidity uses templates, as they do with any other type of legal entity that has material stressed cash flows from/to the legal entities performing the LST).
If such material stressed cash flows from/to the legal entity bank exist, the regulators want specific disclosures on those in the results (either by adjusting the templates to include a line for these and/or in the explanatory disclosures submitted along with the templates).

Examples of when such legal entity bank considerations and disclosures would need to be made for a specific stress scenario include:

- If the holding company or another legal entity(ies) in the group is expected to fund a material liquidity shortfall of a bank, then the expected cash flows must be reflected (especially where there are established inter-affiliate support agreements); and
- If the holding company or another legal entity(ies) in the group is expected to provide capital to the bank or is expecting dividends from them, the material expected cash flows must be reflected.

For 2020, the legal entities identified in the bullets above, per a Company’s ORSA and/or other materiality criteria applied to the specific stress scenario, must be considered as material or identified as carrying out material liquidity risk bearing activities and hence subject to internal liquidity stress testing requirements. Although a legal entity in the group may not be required to perform the stress test due to materiality considerations or exemptions, those entities’ material cash impacts on entities performing the stress test must be captured in the sources and uses templates of the entities performing the LST. The insurer will need to disclose the materiality criteria (agreed upon by the Lead State regulator) used in determining the legal entities subject to the 2020 LST in the submission of its results. Based on the results of the 2020 initial LST exercise, the Subgroup will determine if additional materiality criteria should be developed to ensure better comparability amongst insurers.

Section 4. Cash Flow Approach – Liquidity Sources and Uses

The Liquidity Stress Testing Framework is anchored by a cash flow approach, utilizing companies’ actual cash flow projections of sources and uses of liquidity over various time horizons based
upon experience and expectations. This contrasts with a Balance Sheet Approach, which employs static balance sheet amounts and generic assumptions about asset liquidity. While a Balance Sheet Approach is easier to apply and provides calculation consistency (and thus the perception of increased comparability), its ‘one-size fits all’ approach could result in a misleading assessment of liquidity risk and fail to capture certain asset activities or product features under different stress scenarios and time horizons. The cash flow approach is deemed more dynamic and hence to capture liquidity risk impacts more precisely.

The insurer should produce cash flow projections for sources of liquidity and uses of liquidity that cover: operating items, investments and derivatives, capital items, and funding arrangements. (See Liquidity Sources and Uses templates in Section 7). To clarify an issue regarding funding arrangements, the projected cash flows for liquidity sources and uses should include already existing funding arrangements such as FHLB draws outstanding in the current time period. Also, specific to the holding company, these projected cash flows for liquidity sources and uses should include material non-U.S. impacts as well.

The insurer will produce these liquidity sources and uses cash flow projections in a baseline, normal course of business scenario, for each time horizon. The insurer will also produce these cash flows for each time horizon for a specific number of required stress scenarios (for 2020 there are 2 stress scenarios and also an insurer-specific worst-case scenario).

4.1 Baseline Assumptions for Cash flows

Baseline (pre-stress) cash flows are the insurer-specific cash flows from normal expected operations. Insurers should prepare cash flow projections under normal operating conditions and report the net cash flows (projected liquidity sources less uses) for each time horizon. These cash flow projections should be consistent with those used for internal baseline liquidity forecasts, such as those used for financial planning and analysis (FP&A), risk management, etc. A positive net cash flow is presumed in the baseline cash flows since companies are usually not expected to be operating in a net cash flow deficiency state.
Section 5. Stress Scenarios and their Assumptions

For year-end 2020 there are two regulatory liquidity stress scenarios: an adverse liquidity stress scenario for insurers, and an interest rate spike scenario. There is also an insurer-specific information request for each group’s own most adverse liquidity stress scenario(s). The adverse liquidity stress scenario contains a regulator provided narrative, regulator-prescribed assumptions and company-specific assumptions. The interest rate spike scenario allows all other narrative description components and key metrics (including how much interest rates spike) to be provided by each company. The insurer-specific information request contains a company provided narrative and a description of key company metrics. The regulator provided narrative will be a qualitative description of the specified stress scenario to highlight the particular risks and sensitivities associated with that stress scenario. The regulator prescribed assumptions are specific parameters insurers should incorporate into their process for a particular stress scenario. Company-specific assumptions should be consistent with the information provided in the regulator provided narrative and regulator prescribed assumptions, and represent the detailed assumptions needed for a specific company’s liquidity stress testing process. Examples of where companies should provide their assumptions include: debt issuance, lapse sensitivity, new business sensitivity and mortality sensitivity. Regulators expect insurers to utilize policyholder behavior assumptions (e.g., surrenders and policy loan withdrawals, existence of new sales activity) as well as the insurer’s response (e.g., assuming delays in payment of policyholder benefits), consistent with the severity of the stress, and to provide very thorough explanatory information. All key business activities and product-type impacts to liquidity should be considered by the companies.

If the insurer’s internal model does not utilize a specific economic and/or company-specific assumption included in this document, the internal model does not need to be modified to incorporate it. However, if the insurer’s internal model does utilize a specific economic and/or company-specific assumption included in this document, the insurer must utilize the specific value for that assumption provided in this document. (This emphasizes the macro surveillance benefit of the 2020 LST, allowing for a level of consistency of assumptions across the industry. As
discussed previously, this is not meant to specify assumptions used by the insurers in their own internal liquidity stress testing work.) If there is no specific value included in the 2020 LST Framework and instead there is an illustrative value or suggested guidance, the company should use a value consistent with the illustrative value or suggested guidance. For example, guidance is given below on using Moody’s values for migration, default and recoveries. However, insurers may use S&P data or other appropriate data sources.

5.1 Adverse Liquidity Stress Scenario for Insurers

5.1.1 Narrative

Insurers are required to apply an adverse liquidity stress scenario as one of the two stress scenarios. The following is a summary of market conditions in the adverse scenario extracted from the Federal Reserve Board’s 2017 Supervisory Scenarios for Annual Stress Tests Required under the Dodd-Frank Act Stress Testing Rules and the Capital Plan Rule.

- The adverse scenario is characterized by weakening economic activity across all economies included in the scenario. This economic downturn is accompanied by a global aversion to long-term fixed-income assets that, despite lower short-term rates, brings about a near-term rise in long-term rates and steepening yield curves in the United States and the four countries/country blocks in the scenario. Macroeconomic
  - Real GDP falls slightly more than 2 percent from the pre-recession peak in the fourth quarter of 2016 to the recession trough in the first quarter of 2018.
  - Unemployment rate approaches 7.4%.
  - Headline CPI falls 1.6 %and rises to 2.1 % over the scenario period.
- Interest Rates and Credit Spreads
  - Short-term Treasury rates fall and remain near zero throughout the stress.
  - 10-year Treasury yields rise to 2.7%.
  - Investment Grade (IG) corporate credit spreads widen to approximately 3.75%.
- Asset Valuations
  - Equity prices decline by roughly 40%.
The Volatility Index (VIX) peaks at 34.4

Housing prices and commercial real estate prices decline by 12% and 15% respectively through 8 quarters.

- Description of International Market Conditions
  - Recessions and slowdowns in growth are experienced in the Euro area, United Kingdom, Japan, and developing Asia economies.
  - All foreign economies experience a decline in consumer prices.
  - U.S. Dollar appreciates against the Euro, British Pound, and developing Asia currencies.
  - U.S. Dollar depreciates modestly against the Japanese Yen, driven by flight-to-safety capital flow.

5.1.2 Regulator-Prescribed Assumptions

Insurers should utilize the specific values for the economic indicators from the Federal Reserve Board’s annual Supervisory Scenarios for Annual Stress Tests Required under the Dodd-Frank Act Stress Testing Rules and the Capital Plan Rule, Table A.1 Historical data and Table A.5 Supervisory adverse scenario. Insurers should use the version published in February 2017 (refer to the tables in Annex 2i). Specifically, insurers should run the adverse liquidity stress scenario using the values for the Treasury curve, Corporate spreads, GDP, Unemployment, U.S. Inflation (CPI), Housing Price Index (HPI), S&P 500 index (SPX SPOT), Commercial Real Estate Index (CREI) and VIX index to the extent these variables are included in their internal liquidity stress test process or models.

This scenario also requires a consistent baseline scenario to be employed. Insurers should apply the same change in economic variables experienced between Q4 2016 Table A.1 and the stress scenarios in Table A.5 to current economic variable levels. For example, insurers should use 2020 (or most recent year-end) 10 Yr. Treasury rates and apply the same % or b.p. change shown from Q4 2016 to the 2017 Table A.5 amounts in their 2021 stress scenarios. Projected values should be used for the 30-day, 90-day and 1-year horizons. The table is included in Annex 2i of this document.
Guidance on Select Economic Variables (TBD subsequent to small group deliberations)

10 Yr. Treasury
The projected path of 10-year Treasury rates should be translated to quarterly percentage increases, with a 10 b.p. minimum increase. The 10 b.p. minimum is to address a situation where current rates are zero or negative.

GDP
b.p.

CPI
b.p.

Unemployment
b.p.

FX

In addition, other market indicators are necessary for insurers to apply to stressed cash flows and to assess the impact on expected asset sales. These are as follows (with details to be found in Annex 2):

- Market Capacity Assumption
- Structured Spreads over Treasuries
- SWAP Spreads
- Swaption Volatility
- Credit Assumptions: Moody’s Transition Matrix/Migration Rates
- Credit Assumptions: Moody’s Default Table
- Credit Assumptions: Moody’s Recovery Rate Table

5.1.3 Market Capacity Assumption

The following is suggested guidance to determine market constraints on asset categories to be sold in times of stress. It represents standards followed by many insurers to estimate assets sales
by stress scenario, asset category and time horizon that can be sold without meaningfully impacting the entire market by widening bid-offer spreads. We recognize each company has its own individual methodology for determining potential asset sales under stress, and we request a written narrative be provided as to how they make their determination.

Once an asset class has been identified as available to be sold to satisfy a cash deficiency from cash flow stress testing, the insurer should calculate its percentage of the total amount issued and outstanding. Next the insurer should obtain average daily trading volumes (ADTV) and make an assumption for the haircut amount to apply to that volume to reflect stressed conditions (the “haircut ADTV”). Next, the insurer would apply its calculated percentage of total outstanding owned to the haircut ADTV, and the result would be divided by the number of days in the stress testing time horizon to arrive at a daily amount that can be sold. This daily amount able to be sold would be multiplied by the number of days in the prescribed time horizon: 30 days for the 30-day horizon, 60 days for the 90-day horizon (31-90 days) and 274 days for the 1-year horizon (91-365 days). An illustrative example best explains the above-described process.

**Illustrative example (also included in Appendix 2ii):**

**Step 1: Estimate Unconstrained Sales Per Day**

Insurer A has a $100 billion portfolio of investment-grade corporate bonds, priced at par. Insurer A estimates that it holds approximately 5% of outstanding corporate bonds. In the adverse liquidity stress scenario, Insurer A’s unconstrained liquidity stress testing model assumes that it can sell:

<table>
<thead>
<tr>
<th>Time Horizon</th>
<th>% Able to Be Sold</th>
<th>Sale Price</th>
<th>Total Sale</th>
<th>Sales / Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 30 Days</td>
<td>10%</td>
<td>97</td>
<td>$9.7 B</td>
<td>$440 M</td>
</tr>
<tr>
<td>31-90 Days</td>
<td>20%</td>
<td>94</td>
<td>$18.8 B</td>
<td>$430 M</td>
</tr>
<tr>
<td>91-365 Days</td>
<td>50%</td>
<td>90</td>
<td>$45.0 B</td>
<td>$230 M</td>
</tr>
</tbody>
</table>

**Step 2: Add Market Capacity Constraint**
Assume the average daily trading volume in the secondary market for investment grade corporate bonds has been $13.0 Billion over the past year. Insurer A estimates that trading volumes would decline by 40% in the adverse liquidity stress scenario to $8.0 B per day. Since Insurer A is 5% of the market, Insurer A can only trade $400 M per day ($8B x 5%) without paying a significant illiquidity premium and impacting the overall market.

Insurer A then repeats this process for every asset class in its investment portfolio.

<table>
<thead>
<tr>
<th>Time Horizon</th>
<th>Unconstrained Sales / Day</th>
<th>Market Capacity Assumption</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 30 Days</td>
<td>$440 M</td>
<td>$400 M</td>
<td>($40 M)</td>
</tr>
<tr>
<td>31-90 Days</td>
<td>$430 M</td>
<td>$400 M</td>
<td>($30 M)</td>
</tr>
<tr>
<td>91-365 Days</td>
<td>$230 M</td>
<td>$400 M</td>
<td>$0</td>
</tr>
</tbody>
</table>

5.1.4 Structured Spreads Over Treasuries

Insurers should use Annex 2iii to assist in determining cash flows, asset values and the quantity of assets to be sold in stressed markets. For baseline values, the industry shall submit year-end spreads to the regulators shortly after year-end. The regulators will review and approve the values for use in the table for liquidity stress testing purposes. Regulators shall use structured spread data from the 2007-2009 period provided by JPMorgan added to baseline values to calculate stressed amounts for the 30-day, 90-day and 1-year horizons to complete the table.

Regulators ask industry members to agree on one set of structured spread values amongst themselves to submit for approval, not each insurer submitting values that each need to be approved. Regulators and/or the NAIC need to do a reasonableness check of current baseline/market levels of spreads insurers use before applying the stressed amounts in the JPMorgan spreadsheet. For example, if current spreads are already greater than the JPMorgan stressed spread amounts, regulators may have to consider alternatives or additional stressed levels. One agreed upon set of values will help provide uniformity, consistency, and comparability of stress testing results across insurers.
When utilizing these spreads, insurers should assume the percentage increase in spreads experienced in 2008-09 from the JPMorgan spreadsheet; and apply that percentage increase to the agreed upon December 31 spreads.

- 2020 LST and beyond - Since the reasonableness check is merely a check of current market rates, it is not anticipated that it will be burdensome for insurers to provide an agreed upon set of December 31 baseline values to regulators by January 31 of each year or for the regulators to be able to respond by February 28 of every year to allow insurers sufficient time to incorporate into their stress testing framework.
- For the 2020 LST – Industry agreed upon values will be established as Lead State guidance.

5.1.5 SWAP Spreads

Stressed spread levels may impact assets prices for expected sales calculations necessary for the stress scenarios. Insurers should complete the SWAP Spread table in Annex 2iv to document assumptions used in determining asset values and the quantity of assets to be sold in stressed markets. SWAP spread source data from the Federal Reserve’s H.15 FRED data should be incorporated into the SWAP Spread table. The H.15 FRED data is also included in Annex 4iv.

5.1.6 Swaption Volatility

Insurers should use the table in Annex 2v to assist in determining asset values and the quantity of assets to be sold in stressed markets. Insurers should obtain the information to populate the table using Bloomberg’s Swaption Volatility for various time horizons and expiry. For consistency, insurers should use the table found on Bloomberg at NSV [Go].

5.1.7 Moody’s Transition Matrix/Migration Rates

Insurers should use the table in Annex 2vi to assist in determining Corporate credit migrations, asset values and the quantity of assets to be sold in stressed markets. The table is imported from Moody’s Corporate-Global: Annual default study, Exhibit 39 - Average one-year alphanumeric rating migration rates, 1983-2019. If available, insurers should use the equivalent Moody’s tables for U.S. Public Finance for municipal bonds and the appropriate Moody’s tables for structured
/asset-backed securities. Alternative sources may be used but should be disclosed as well as the rationale for their use.

5.1.8 Moody’s Default Table

Insurers should use the table in Annex 2vii to assist in determining asset values and the quantity of assets to be sold in stressed markets. The table is imported from Moody’s Corporate-Global: Annual default study, Exhibit 45 - Average cumulative issuer-weighted global default rates by letter rating, 1983-2019. Insurers should use the equivalent Moody’s tables for U.S. Public Finance for municipal bonds and the appropriate Moody’s tables for structured /asset-backed securities. Alternative sources may be used but should disclosed as well as the rationale for their use.

5.1.9 Moody’s Recovery Rate Table

Insurers should use the table in Annex 2viii to assist in determining asset values and the quantity of assets to be sold in stressed markets. The table is imported from Moody’s Corporate-Global: Annual default study, Exhibit 8 - Average corporate debt recovery rates measured by ultimate recoveries, 1987-2019. Insurers should use the equivalent Moody’s tables for U.S. Public Finance for municipal bonds and the appropriate Moody’s tables for structured /asset-backed securities. Alternative sources may be used but should disclosed as well as the rationale for their use.

If relevant for a given insurer, the adverse liquidity stress scenario for insurers can be run considering sources other than expected asset sales (e.g., FHLB credit line draws, bank lines of credit and holding company contributions). Should that be the case, the insurer must clearly identify the sources other than asset sales utilized to meet expected liquidity deficiencies.

5.1.10 “What If” Modification

The “What if” modification to the adverse liquidity stress scenario removes the ability for insurers to use extraordinary internal and external funding sources to satisfy any liquidity deficiency under stress, i.e., no actions taken in response to the stress (as opposed to ongoing operational funding agreements included in the insurer’s baseline templates) or in response to a liquidity deficiency. Intragroup “keep well” agreements would be considered extraordinary transactions. Thus,
expected asset sales will be the primary source of meeting any liquidity deficiency for the “What if” scenario. Any existing funding such as commercial paper will not be assumed to roll, nor will FHLB facilities ability to roll upon maturity.

5.1.11 Company-Specific Assumptions

Insurers must construct the assumptions needed for their internal models to run the above adverse liquidity stress scenario for insurers. Company specific assumptions should be consistent with the above scenario as narrative and regulator prescribed assumptions. Examples include the inability to roll or issue new debt, potential increases in lapse rates, new business sensitivity, mortality experience and policyholder behavior (e.g., surrenders and policy loans).

5.2 Interest Rate Spike Scenario

5.2.1 Narrative

Insurers should run an interest rate spike stress test that resembles the late 70’s/early 80’s inflationary period as it most closely mirrors the regulatory desired interest rate spike scenario. Historical data from the late 70’s/early 80’s show the following economic conditions:

- Inflationary forces caused interest rates to rise quickly.
- Investors rotated out of fixed income and into equities, real estate, and commodities.
- Central bank responded by tightening monetary policy in tandem, eventually causing the yield curve to invert.

Insurers should provide a detailed narrative outlining their scenario and assumptions around general economic conditions bulleted above and specific assumptions for economic variables for each time horizon. The economic variables in the table below and the amount of expected movement in each variable should be fully described in the narrative to the extent are used in a company’s internal model. The table outlines the directional movement of the relevant economic indicators. Insurers should specify the amount of movement for each variable they consider to be part of the scenario for a severe interest rate spike. For example, insurers may indicate a parallel shift in Treasury rates up 100bps in the first 30 days, up 200bps in 90 days and 300bps over 12 months. The table is a guide and not to be interpreted as a strict template and may be
supplemented or customized by the insurer. **Narrative/Explanatory disclosures should explain these assumptions.**

### 5.2.2 Regulator-Prescribed Assumptions

Regulators did not adopt any regulator-prescribed assumption values for this stress scenario. Instead, they provided the below regulator guidance for insurers to use when establishing their own company specific assumptions for this stress scenario.

<table>
<thead>
<tr>
<th>Economic Variable</th>
<th>Expected Movement</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treasury rates</td>
<td>Increase rapidly</td>
<td>Critical factors for modeling impacts to asset prices, collateral flows, and product cash flows</td>
</tr>
<tr>
<td>Equity prices</td>
<td>Increase rapidly</td>
<td></td>
</tr>
<tr>
<td>Credit spreads</td>
<td>Increase moderately</td>
<td></td>
</tr>
<tr>
<td>Inflation rates</td>
<td>Increase rapidly</td>
<td>These factors help define the macroeconomic conditions of the scenario</td>
</tr>
<tr>
<td>Real GDP growth</td>
<td>Flat</td>
<td>These factors help define the macroeconomic conditions of the scenario</td>
</tr>
<tr>
<td>Unemployment rate</td>
<td>Flat</td>
<td></td>
</tr>
<tr>
<td>Real estate prices</td>
<td>Increase</td>
<td></td>
</tr>
<tr>
<td>Swap spreads</td>
<td>Increase</td>
<td>Impact derivative collateral requirements</td>
</tr>
<tr>
<td>FX rates</td>
<td>Unclear</td>
<td></td>
</tr>
<tr>
<td>Implied volatility</td>
<td>Increase</td>
<td></td>
</tr>
<tr>
<td>Credit assumptions (transition, default, recovery rates)</td>
<td>Unclear</td>
<td>May not be an important assumption to define for the scenario</td>
</tr>
</tbody>
</table>

### 5.2.3 Company-Specific Assumptions

Insurers must construct the assumptions needed for their internal models to run the above stress scenario. Companies are encouraged to provide more information beyond these guidelines as they feel is appropriate to help regulators understand their assumptions for the scenario. Company specific assumptions should be consistent with the stress scenario’s narrative and regulator prescribed assumptions.
5.3 Insurer Specific Information Request - Worst-Case Scenario

5.3.1 Narrative

This information request requires insurers to provide a detailed narrative of their most severe liquidity stress scenario(s) to obtain greater insight to the drivers of liquidity risk for specific insurers. The most severe scenario should be one that results in the largest liquidity deficiency (liquidity sources less uses) from their existing internal liquidity stress testing process. The scenario should be focused on the insurers internal model scenario with the worst-case outcome for the group. Regulators may use this information to inform future prescribed stress scenarios. Insurers should provide a comprehensive narrative describing the stress scenario(s) and the economic environment(s). This stress scenario(s) could be a combination of multiple stressors.

Section 6. Available and Expected Asset Sales

Once the stressed sources and uses of liquidity have been established, and the net cash flows calculated, insurers then project the assets available at the end of the time horizon by asset category (please refer to the asset categories in the Assets Template in Section 7). The valuation of available assets for the baseline scenario utilizes current and projected asset values for a normal operating environment. The valuation of available assets for a stress scenario will be based upon fair value haircuts per the specific stress scenario narrative, its regulatory prescribed assumptions, and/or the company assumptions based on the narrative and regulatory prescribed assumptions (e.g., fair market value haircuts and capacity indicators). Note: Any securities pledged as part of institutional funding agreements (e.g., FHLB) should be excluded and considered encumbered. However, any pre-pledged assets that are not securing credit that has been extended and remains outstanding (i.e., excess) should be considered unencumbered.

To the extent that stressed cash inflows are insufficient to meet the anticipated cash outflows, the insurer must provide for cash flows to meet the deficiency. Unless a stress scenario (or “What-if” modification of a stress scenario) indicates otherwise, the insurer can utilize internal and external funding sources (e.g., FHLB new draws) as well as asset sales to satisfy a liquidity deficiency.
deficiency. Any expected asset sales must be reported in the appropriate column(s) of the template. Insurers decide which categories of available assets to sell, as well as the quantity to sell. (Please refer to the Assets Template in Section 7.)

Asset sales will appear in two different places - 1) within the liquidity sources template for expected/planned activity during the time horizon (pre-liquidity deficiency calculation), and 2) in the assets template for any amount of asset sales used to meet a liquidity deficiency (Liquidity Sources less Liquidity Uses). If an insurer has no liquidity deficiency, then there are no asset sales needed in the Assets Template (though available assets still apply). Similarly, if cash on hand was sufficient to meet the liquidity deficiency and the insurer chose to utilize that cash, then no asset sales would be reported in the Assets template.

The expected asset sales amounts calculated based on the insurer’s own models should also be subjected to portfolio manager and/or Chief Investment Officer (CIO) feedback. This feedback may take the form of “topside” adjustments to the expected asset sales. Regulators expect robust disclosures around the chief investment officer’s (or equivalent title or designee) assumptions and decisions on expected asset sales. The intent is for these asset sales to most accurately represent what actions the insurer could reasonably take in the given scenario, market conditions, and the company’s anticipated investment policy and/or strategy.

**Section 7. Reporting**

Insurers should submit data in the reporting template for liquidity sources, liquidity uses, and assets (available assets and expected asset sales) in US dollars. These templates utilize categories for 30-day, 90-day and 1-year time horizons. The assets template further illustrates available assets and final expected asset sales by asset sub-category to cover any liquidity deficiency (negative amounts of net liquidity sources less liquidity uses over the prescribed time horizons). Use of these consistent sub-categories of assets is critical for allowing the Task Force to aggregate the asset sales results.
A liquidity sources report and a liquidity uses report should be generated for each legal entity within the group that was subjected to liquidity stress testing, using the NAIC templates. These legal entity amounts should also be aggregated into a group liquidity sources report and a group liquidity uses report for submission (the LST is not performed at the group level; rather it is performed at the legal entity level and those results are aggregated to present a group level report).

- For the Baseline, the Adverse Liquidity stress scenario, and the Interest Rate Spike stress scenario, Liquidity Sources and Liquidity Uses templates at both the individual entity level and the aggregated group level are to be submitted.
- For the insurer’s own “Worst Case” scenario, only the group level Liquidity Sources and Liquidity Uses templates are required to be submitted, not the legal entity templates.
- For the “What If” Variation of the Adverse Liquidity stress scenario, a group level Liquidity Sources template and/or a group level Liquidity Uses template is only required if there is a material difference from the Adverse Liquidity stress scenario’s group level Liquidity Sources and Liquidity Uses templates.

Assets Template:
As with the Liquidity Uses and Liquidity Sources templates, the Assets template is to be generated for each legal entity performing the LST. For the 2020 LST, the insurer may submit the assets template at the group level only, without submission of the legal entity asset sales templates.

- A group level assets template is required for the Baseline and all stress scenarios, including the insurer’s own “Worst Case” scenario and the “What If” variation of the Adverse Liquidity stress scenario.

Modification of Templates:
Insurers are allowed to add lines to the templates to provide more detailed breakdown of existing categories (e.g., for cash flows to/from legal entity asset manager/mutual funds as well as banks), but deletions of existing lines(categories are highly discouraged.

Submission Deadline:
The reporting templates and many other narrative disclosures referenced in this document are to be submitted to the Lead State by September 30, 2021.
Liquidity Sources and Uses

Note: Certain flows could be settled in securities (e.g., margins on derivatives, capital contributions/dividends, etc.). Alternatively, eligible securities could be pledged to FHLB (or REPO with the street) to raise short-term funding.

### Cash Flows in Time Horizon

<table>
<thead>
<tr>
<th>Cash Flow</th>
<th>CF Type</th>
<th>CF Category</th>
<th>1 Month</th>
<th>3 Months</th>
<th>12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sources</td>
<td>Operating</td>
<td>Premiums and Deposits (Renewal / New Business)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cash Charges / Fees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reinsurance Recoverables</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expenses – Intercompany Settlements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tax Payments (Inflows)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Flows</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment and Derivatives</td>
<td>Principal and Interest</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dividends / Distributions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Initial and Variation Margin Received</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other Collateral Received</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Asset Sales (Pending Settlement)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other Flows</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital</td>
<td>Capital Contributions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Commitments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dividends from subsidiaries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other Flows</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funding</td>
<td>Debt Issuance / Refinancing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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### Cash Flows in Time Horizon

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<td>Expenses - Other</td>
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<td>Expenses - Intercompany Settlements</td>
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<td>Tax Payments (Outflows)</td>
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<td>Credit Facilities (Incl. Contingency Funding Facilities)</td>
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<td>Intercompany Loans</td>
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**Total Uses**
## Assets Template

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<td>Other Equity and Alternative Investments</td>
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### Summary

<table>
<thead>
<tr>
<th>Total Assets Available for Sale</th>
<th>Amounts Available in Time Horizon</th>
<th>Expected Asset Sales in Time Horizon</th>
<th>Final Asset Sales given PM review</th>
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<tr>
<td></td>
<td>1 Month</td>
<td>3 Months</td>
<td>12 Months</td>
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<td></td>
<td>1 Month</td>
<td>3 Months</td>
<td>12 Months</td>
</tr>
<tr>
<td></td>
<td>Comments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note 1: Insurers will enter “illiquid” in a data field for any asset category deemed such within a specific time horizon. (Regulators can then follow up with questions later if there are concerns, etc.)

Note 2: Any securities pledged as part of institutional funding agreements (e.g., FHLB) should be excluded and considered encumbered. However, any pre-pledged assets that are not securing credit that has been extended and remains outstanding (i.e., excess) should be considered unencumbered.

Note 3: Reminder that regulators want robust disclosures regarding the chief investment officer’s (or equivalent title or designee) assumptions and decisions on expected asset sales. Might need to supplement the template comments with additional narrative disclosures.

Note 4: Excluding the “What If” variation, insurers are to provide disclosures indicating when affiliated amounts are provided to assist a legal entity in addressing a liquidity deficiency.
Narrative/Explanatory Disclosures noted in the 2020 LST:

**Narrative/explanatory disclosures are expected to be in English.**

- **Insurers should provide a narrative description of their internal liquidity stress testing system and processes,** including for example their materiality thresholds for stressed cash flows and methodology for converting foreign currencies to US dollars.
- **Specific disclosures on material stressed cash flows to/from legal entity banks/asset managers/mutual funds if needed.**
- **Company-specific narrative on assumptions and metrics used for the adverse liquidity stress scenario for insurers,** for example the inability to roll or issue new debt, potential increases in lapse rates, new business sensitivity, mortality experience and policyholder behavior (e.g., surrenders and policy loans).
- **Company-specific narrative on the interest rate shock scenario,** assumptions around general economic conditions bulleted in 5.2.1 Narrative, and specific metrics for economic variables for each time horizon. The economic variables in the table in 5.2.2 Regulator-Prescribed Assumptions should be fully described in the narrative, to the extent they are use in the company’s internal model.
- **Insurers should provide a comprehensive narrative describing their worst-case liquidity stress scenario(s) and the economic environment(s),** including assumptions, key metrics and results.
- **Written narrative on the insurer’s own individual methodology for determining asset sales under stress.**
- **Robust disclosures regarding the chief investment officer’s (or equivalent title or designee) assumptions and decisions on expected asset sales,** if needed.
- **Excluding the “What If” variation,** disclosures to identify when affiliated amounts are contributed to assist a legal entity in addressing a liquidity deficiency.
- **Disclose when a regulatory prescribed variable is not used for the LST because it is not used in the internal liquidity stress testing process or models.**
Data Aggregation

Given the NAIC’s primary focus is on macroprudential impacts of a liquidity stress impacting the life insurance sector, the NAIC will aggregate final expected asset sales data across the insurance groups subject to the liquidity stress test. The aggregation will be done by asset category. The NAIC aims to compare the aggregated results against various benchmarks, potentially including normal and/or stressed trading volumes and asset values for various asset classes, to determine the impact such sales may have on the capital markets in times of stress. Findings from this analysis may also inform expected asset sale assumptions utilized in future runs of the liquidity stress test.

As part of its macroprudential surveillance, the insurance regulators and/or NAIC may reach out to other regulatory agencies to discuss aggregate results that may impact other regulated industries such as banks, securities brokers and asset managers. Insurance regulators may also coordinate with other agencies to identify appropriate and perhaps coordinated action they may take to prevent or minimize the effect large asset sales may have on the financial markets and overall economy.

Regulatory Authority

For the 2020 liquidity stress test, lead state regulators will utilize their examination authority to collect the reporting results from insurers and to keep the data confidential. A long-term solution was developed at the Financial Stability (EX) Task Force in coordination with addressing similar issues related to the Group Capital Calculation project, resulting in revisions to Model #440. However, it will take several years for states to adopt these revisions.

Confidentiality

For the 2020 liquidity stress test, lead state regulators will utilize their examination authority to collect the reporting results from insurers identified by the scope criteria. Existing protocols for collecting confidential/sensitive data for each state and insurer will be utilized. A long-term solution was developed at the Financial Stability (EX) Task Force in coordination with addressing
similar issues related to the Group Capital Calculation project, resulting in revisions to Model #440. However, it will take several years for states to adopt these revisions.

Timeline

- March 1, 2021 – FSTF call – exposed revised draft 2020 LST Framework
- May 12, 2021 – “finalize” revised draft 2020 LST Framework (LST Study Group will issue Lead State guidance as needed after this date)
- September 30, 2021 – receive submissions from 23 insurance groups
- January 2022 – Incorporate all appropriate Lead State Guidance into the 2020 LST Framework document as the starting place for the 2021 LST Framework and begin work on changes specific to the 2021 LST.
Annex 1: Original Scope Criteria with Annual Statement References

The Subgroup proposes to include in the scope of the Liquidity Stress Testing Framework any insurer/group that exceeds the following thresholds for any of the noted activities (or account balance as a proxy for that activity). The thresholds have been established taking into consideration both the account balance of the insurer/group to the total balance for the life insurance sector, as well as the aggregate account balance of insurers/groups within scope to the aggregate account balance for the life insurance sector.

<table>
<thead>
<tr>
<th>Account Balances</th>
<th>Threshold in $B “greater than”</th>
<th>Reference to 2017 NAIC life/accident and health (A&amp;H) annual financial statement blank</th>
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<tbody>
<tr>
<td>Fixed and Indexed Annuities</td>
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<td>Analysis of Increase in Annuity Reserves&lt;br&gt;Page: Supplement 62&lt;br&gt;Line: Reserves December 31, current year (15)&lt;br&gt;Column: Sum of Individual Fixed Annuities, Individual Indexed Annuities, Group Fixed Annuities, and Group Indexed Annuities</td>
</tr>
<tr>
<td>Funding Agreements and GICs</td>
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<td>Deposit-Type Contracts&lt;br&gt;Page: Exhibit 7 – Deposit-Type Contracts&lt;br&gt;Line: 9&lt;br&gt;Column: Guaranteed Investment Contracts (Column 2)&lt;br&gt;+ Column: Premium and Other Deposit Funds (Column 6) IF the amount of FHLB Funding Reserves from Note 11.B(4)(b) suggests funding agreements are not reported in Column 2 of Exhibit 7&lt;br&gt;+ Synthetic GICS&lt;br&gt;Page: Exhibit 5 – Interrogatories&lt;br&gt;Line: 7.1</td>
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<td>Derivatives—Notional Value (absolute value)</td>
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<td>Derivatives — Notional Value (absolute value)&lt;br&gt;Pages: Schedule DB, Part A; Schedule DB, Part B, Section 1&lt;br&gt;Column: Notional Value (sum all)</td>
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<td>Securities Lending</td>
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<td>Securities Lending Collateral Assets&lt;br&gt;Pages: Schedule DL, Part 1; Schedule DL, Part 2&lt;br&gt;Line: Total (9999999)&lt;br&gt;Column: Fair Value</td>
</tr>
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<td>Repurchase Agreements</td>
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<td>Repurchase Agreements&lt;br&gt;Page: Notes to Financial Statement Investments Restricted Assets&lt;br&gt;Line: Sum of 05L1C, 05L1D, 05L1E, 05L1F&lt;br&gt;Column: Total (General Account Plus Separate Account)</td>
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</tbody>
</table>
In performing the addition of the FHLB funding agreement amount to the GICs amount, NAIC staff discovered that the reporting of FHLB funding agreements is not consistent in Exhibit 7, Deposit-Type Contracts. The source of the FHLB amount is Note 11.B(4)(b):

Line: Funding agreements, current year, amount as of the reporting date, borrowing from FHLB, collateral pledged to FHLB Column: Funding Agreement Reserves Established

For some insurers, we were able to match amounts from the FHLB funding agreement footnote to the exact same amount in Exhibit 7, either Column 2 (GICs) or Column 6 (Premiums and Other Deposit Funds). For those insurers where the FHLB amount matched Exhibit 7, Column 2, we did not add the FHLB funding agreement amount to the GICs amount, because that would be double-counting the FHLB funding agreements. For other insurers, even though the amounts did not match exactly, we were able to assume the FHLB funding agreements were reported in either Column 2 or Column 6 (e.g., the amount in Exhibit 7, Column 2 was zero or much smaller than the FHLB note, while the Column 6 amount was larger). However, for several insurers, we were not able to make an informed assumption (e.g., both Column 2 and Column 6 amounts were larger than the FHLB funding agreement amount). To be conservative in these instances, we added the FHLB funding agreement amount to the GICs amount. Overall, for the $10 billion threshold, adding FHLB funding agreements to GICs does not result in a different list of insurance groups from the list with GICs of more than $10 billion.

<table>
<thead>
<tr>
<th>Borrowed Money (includes commercial papers, letters of credit, etc.)</th>
<th>1</th>
<th>Borrowed Money</th>
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<tr>
<td><strong>Page:</strong> Liabilities</td>
<td><strong>Line:</strong> Borrowed Money (22)</td>
<td><strong>Column:</strong> Current Year</td>
</tr>
</tbody>
</table>

\[1\] In performing the addition of the FHLB funding agreement amount to the GICs amount, NAIC staff discovered that the reporting of FHLB funding agreements is not consistent in Exhibit 7, Deposit-Type Contracts. The source of the FHLB amount is Note 11.B(4)(b):

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Annex 2: Regulatory Prescribed Assumptions

Annex 2i. Economic and Market Variables from the 2017 Supervisory Scenarios for Annual Stress Tests Required under the Dodd-Frank Act Stress Testing Rules and the Capital Plan Rule

Table A.3 Baseline Scenario

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<th>Date</th>
<th>Real GDP growth</th>
<th>Nominal GDP growth</th>
<th>Real disposable income growth</th>
<th>Nominal disposable income growth</th>
<th>Unemployment rate</th>
<th>CPI inflation rate</th>
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<th>5-year Treasury yield</th>
<th>10-year Treasury yield</th>
<th>BBB corporate yield</th>
<th>Mortgage rate</th>
<th>Prime rate</th>
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<th>House Price Index</th>
<th>Commercial Real Estate Price Index</th>
<th>Market Volatility Index</th>
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Table A.5 Adverse Scenario

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<th>Nominal GDP growth</th>
<th>Real disposable income growth</th>
<th>Nominal disposable income growth</th>
<th>Unemployment rate</th>
<th>CPI inflation rate</th>
<th>3-month Treasury yield</th>
<th>5-year Treasury yield</th>
<th>10-year Treasury yield</th>
<th>BBB corporate yield</th>
<th>Mortgage rate</th>
<th>Prime rate</th>
<th>Dow Jones Total Stock Market Index</th>
<th>House Price Index</th>
<th>Commercial Real Estate Price Index</th>
<th>Market Volatility Index</th>
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<td>17,519</td>
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<td>2.0</td>
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<td>20,867</td>
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Source: 2017 Supervisory Scenarios for Annual Stress Tests Required under the Dodd-Frank Act Stress Testing Rules and the Capital Plan Rule
Annex 2ii. Market Capacity Assumption

Illustrative Example only

Step 1: Estimate Unconstrained Sales Per Day

Insurer A has a $100 billion portfolio of investment-grade corporate bonds, priced at par. Insurer A estimates that it holds approximately 5% of outstanding corporate bonds. In the adverse liquidity stress scenario, Insurer A’s unconstrained liquidity stress testing model assumes that it can sell:

<table>
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<tr>
<th>Time Horizon</th>
<th>% Able to Be Sold</th>
<th>Sale Price</th>
<th>Total Sale</th>
<th>Sales / Day</th>
</tr>
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<tbody>
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<td>First 30 Days</td>
<td>10%</td>
<td>97</td>
<td>$9.7 B</td>
<td>$440 M</td>
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<td>31-90 Days</td>
<td>20%</td>
<td>94</td>
<td>$18.8 B</td>
<td>$430 M</td>
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<tr>
<td>91-365 Days</td>
<td>50%</td>
<td>90</td>
<td>$45.0 B</td>
<td>$230 M</td>
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</table>

Step 2: Add Market Capacity Constraint

Assume the average daily trading volume in the secondary market for investment grade corporate bonds has been $13.0 Billion over the past year. Insurer A estimates that trading volumes would decline by 40% in the adverse liquidity stress scenario to $8.0 B per day.

Since Insurer A is 5% of the market, Insurer A can only trade $400 M per day ($8B x 5%) without paying a significant illiquidity premium and impacting the overall market.

Insurer A then repeats this process for every asset class in its investment portfolio.

<table>
<thead>
<tr>
<th>Time Horizon</th>
<th>Unconstrained Sales / Day</th>
<th>Market Capacity Assumption</th>
<th>Impact</th>
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<tbody>
<tr>
<td>First 30 Days</td>
<td>$440 M</td>
<td>$400 M</td>
<td>($40 M)</td>
</tr>
<tr>
<td>31-90 Days</td>
<td>$430 M</td>
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<td>($30 M)</td>
</tr>
<tr>
<td>91-365 Days</td>
<td>$230 M</td>
<td>$400 M</td>
<td>$0</td>
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Annex 2iii. Structured Spreads over Treasuries

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<th>Asset Type</th>
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<th>3 Mo.</th>
<th>6 Mo.</th>
<th>9 Mo.</th>
<th>12 Mo.</th>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Non-Agency MBS</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>CMBS</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>CLO/CDO</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
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<td>ABS-Auto</td>
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</table>

Source: JPMorgan

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<tr>
<th>Asset Type</th>
<th>Tab</th>
<th>Column</th>
<th>Notes</th>
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<td>Agency MBS</td>
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<td>IC</td>
<td>10yr Spreads</td>
</tr>
<tr>
<td>Non-Agency MBS*</td>
<td>CDO-col</td>
<td>S</td>
<td>10yr AA Spreads. Use dates prior to liquidity event</td>
</tr>
<tr>
<td>CMBS</td>
<td>U.S.</td>
<td>GG</td>
<td>10 yr AA Spreads</td>
</tr>
<tr>
<td>CLO/CDO</td>
<td>CDO-lia</td>
<td>R</td>
<td>AAA 7-10 yr LIBOR spreads</td>
</tr>
<tr>
<td>ABS-Cards</td>
<td>U.S.</td>
<td>W</td>
<td>AAA 5yr Spreads</td>
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<tr>
<td>ABS-Auto</td>
<td>U.S.</td>
<td>AT</td>
<td>Near prime AAA 3yr Spreads</td>
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</table>

*-Values for all categories except Non-agency MBS will begin with the Lehman collapse. Values for Non-agency MBS will be determined before the collapse since there is no spread data available subsequent to the Lehman collapse.

Column reference is to the JPMorgan ABS Weekly Asset Spreads Spreadsheet

Annex 2iv. SWAP Spread Table

<table>
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<th>Maturity</th>
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<th>3 Mo.</th>
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<th>12 Mo.</th>
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<td>X</td>
<td>X</td>
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<tr>
<td>5 Yr</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>10 Yr</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>20 Yr</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>30 Yr</td>
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<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
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</tbody>
</table>

1 - (Nominal) Swap Spreads (in BPS)
2 - IR Par Swap Spreads for USD, EUR, JPY, GBP, AUD and CAD
Timeseries of Swap Rates, Treasury Rates, and Swap Spreads

Swap and Treasury rates from FRED.
Spread paid by fixed-rate payer on an interest rate swap over constant maturity Treasury at the given maturities.

Source: Federal Reserve
Annex 2v. Implied Volatility of IR Swaptions

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### Annex 2vi. Credit Assumptions: Moody's Transition Matrix/Migration Rates

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<th>Ba2</th>
<th>Ba3</th>
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<td>0.02%</td>
<td>0.01%</td>
<td>0.03%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
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**Source:** Moody's Investors Service

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Annex 2vii. Credit Assumptions: Moody’s Default Table

Exhibit 45 Average cumulative issuer-weighted global default rates by letter rating, 1983-2019

<table>
<thead>
<tr>
<th>Source: Moody’s Investors Service</th>
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</table>

Source: Moody’s

Annex 2vii. Credit Assumptions: Moody’s Recovery Rate Table

Exhibit 8 Average corporate debt recovery rates measured by ultimate recoveries, 1987-2019

Source: Moody’s Investors Service

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<thead>
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<th>Priority position</th>
<th>Emergence Year</th>
<th>Default Year</th>
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<tr>
<td>Loans</td>
<td>70.2%</td>
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<tr>
<td>Senior Secured Bonds</td>
<td>51.5%</td>
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<td>Senior Unsecured Bonds</td>
<td>16.0%</td>
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<td>Subordinated Bonds</td>
<td>24.7%</td>
<td>6.9%</td>
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Source: Moody’s
July 20, 2021

**Proposed Repurposing of the Liquidity Assessment Subgroup**

*From June 24 email:*

*Sent on behalf of Commissioner Caride (NJ), Chair of the Financial Stability (E) Task Force*

**Dear Members, Interested Regulators, and Interested Parties of the Financial Stability (E) Task Force and Liquidity Assessment (E) Subgroup,**

Now that we have the 2020 Liquidity Stress Test Framework document finalized, the Financial Stability (E) Task Force needs to address other areas of the NAIC Macro Prudential Initiative (MPI) and enhance and expand our macroprudential surveillance system. To ensure the Task Force has appropriate support for this work, I propose we rename and repurpose the Liquidity Assessment (E) Subgroup to be an ongoing group (named the Macroprudential (E) Working Group) to address the following charges:

A. Oversee the implementation and maintenance of the liquidity stress testing framework for 2020 data as well as future iterations;

B. Assist with the remaining MPI projects related to counterparty disclosures and capital stress testing as needed;

C. Continue to develop and administer data collection tools as needed, leveraging existing data where feasible, to provide the Financial Stability (E) Task Force with meaningful macroprudential information regarding how the insurance sector is navigating the prevailing market conditions;

D. Oversee the development, implementation, and maintenance process for a new Macroprudential Risk Assessment system (i.e., policies, procedures, and tools) to enhance regulators’ ability to monitor industry trends from a macroprudential perspective;

E. Oversee the documentation of the NAIC’s macroprudential policies, procedures, and tools; and

F. Provide the Task Force with proposed responses to IAIS and other international initiatives as needed.
July 15, 2021

Gabrielle Griffith  
Senior Policy Analyst and NAIC Coordinator  
202-624-2371  
gabriellegiffith@acli.com

July 15, 2021

Commissioner Marlene Caride  
Chair, NAIC Financial Stability Task Force  
State of New Jersey  
Department of Banking and Insurance  
20 West State Street  
Trenton, NJ 08625

Todd Sells, Director  
Financial Regulatory Policy & Data  
tsells@naic.org

Re: NAIC Financial Stability Task Force’s proposal to repurpose the Liquidity Assessment (E) Subgroup as the Macroprudential (E) Working Group

Dear Commissioner Caride:

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit comments in response to the NAIC Financial Stability Task Force’s proposal to repurpose the Liquidity Assessment (E) Subgroup as the Macroprudential (E) Working Group.

ACLI supports the formation of Macroprudential (E) Working Group (“MWG”) along with the proposed charges. Although continued development and ongoing maintenance of the liquidity stress testing is necessary, broadening the group’s scope to identify and review macroprudential risks, related and emerging risks, and other topics is sensible. ACLI recommends that the group consider using the operating model of the Liquidity Assessment Subgroup as a paradigm for the broader group. Leveraging the current membership of the Liquidity Assessment Subgroup in the MWG would maintain the strong momentum of the liquidity workstream and assist rapid progress in remaining macroprudential workstreams. It may take time for newer members of the MWG to gain the context needed to make meaningful contributions to the MWG’s success. Further, we encourage NAIC to continue the significant regulator and industry partnerships established under the Liquidity Assessment Subgroup via the Liquidity Stress Testing Study Group into the new...
This collaboration has produced meaningful and nuanced solutions to identifying and reviewing potential liquidity challenges and will continue to be a valuable tool to the NAIC as it evaluates other macroprudential and other emerging risks.

Thank you again for the opportunity to comment on the Task Forces proposal. The ACLI celebrates the success of the Liquidity Assessment Subgroup and looks forward to continuing discussions with the newly formed Working Group.

Sincerely,

Gabrielle Griffith
Senior Policy Analyst
202-624-2371
gabriellegriffith@acli.com
July 15, 2021

Commissioner Marlene Caride  
Chair, Financial Stability (E) Task Force  
National Association of Insurance Commissioners  
c/o Todd Sells, Aida Guzman – tsells@naic.org, aguzman@naic.org  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106  

RE: Proposal for Macroprudential (E) Working Group  

Dear Ms. Caride and Task Force Members:

On behalf of the member companies of the National Association of Mutual Insurance Companies\(^1\) we respectfully submit these comments which are responsive to the proposal to enhance and expand the current macroprudential surveillance system through a new set of charges to be addressed by the Macroprudential (E) Working Group (“MWG”).

On June 24, an email from Commissioner Caride, acting as chair of the Financial Stability (E) Task Force was sent to members of the Task Force, interested regulators, and interested parties, proposing to rename and repurpose the Liquidity Assessment (E) Subgroup (“LAS”) as the MWG. With the work completed on the 2020 Liquidity Stress Test Framework document, the LAS has fulfilled its charges; however, the proposal indicates that other areas of the NAIC’s Macroprudential Initiative need to be addressed to enhance and expand the macroprudential surveillance system. In addition to renaming the subgroup, a set of five new charges were included in the proposal. They are as follows:

A. Oversee the implementation and maintenance of the liquidity stress testing framework for 2020 data as well as future iterations;

\(^1\) The National Association of Mutual Insurance Companies is the largest property/casualty insurance trade group with a diverse membership of more than 1,400 local, regional, and national member companies, including seven of the top 10 property/casualty insurers in the United States. NAMIC members lead the personal lines sector representing 66 percent of the homeowner’s insurance market and 53 percent of the auto market. Through our advocacy programs we promote public policy solutions that benefit NAMIC member companies and the policyholders they serve and foster greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.
B. Continue to develop and administer data collection tools as needed, leveraging existing data where feasible, to provide the Financial Stability (E) Task Force with meaningful macroprudential information regarding how the insurance sector is navigating the prevailing market conditions;

C. Oversee the development, implementation, and maintenance process for a new Macroprudential Risk Assessment system (i.e., policies, procedures, and tools) to enhance regulators’ ability to monitor industry trends from a macroprudential perspective;

D. Oversee the documentation of the NAIC’s macroprudential policies, procedures, and tools; and

E. Provide the Task Force with proposed responses to IAIS and other international initiatives as needed.

When it was first initiated, the NAIC’s Macroprudential Initiative was viewed as the next logical step in the continuation of the Solvency Modernization Initiative to further enhance the credibility of the state system of insurance regulation. The MPI focused on four key areas to consider new or improved tools: liquidity risk, capital stress testing, recovery and resolution, and counterparty exposure/concentration. Over the last several years, the Task Force has developed tools in each of the four areas, including a new liquidity risk assessment tool and the adoption of the Group Capital Calculation which includes mechanisms to analyze capital at the group level and the ability to stress capital at the group level. Given all of the enhancements made to the existing financial solvency regime since MPI was initiated (and even back when SMI was being worked through), NAMIC members respectfully request the Task Force refrain from developing any new data-collection or risk assessment tools until more consideration can be given to the overall financial solvency surveillance regulatory structure that is currently in place.

Further, it would be prudent for regulators to consider how the tools created out of the MPI fit with existing tools such as risk-based capital, enterprise risk reports, or ORSA summary reports, which are much more individualized and completed in a timely fashion and provide valuable insight into the legal entities that are being regulated for financial solvency. Before creating a new data-collection tool or risk assessment framework, it is important to review and analyze how the tools that were in place prior to MPI interact with those created since MPI. It is not clear from the proposal if the Task Force desires additional filings of new information and who would be requesting and/or collecting this information and further whether the information being requested can be accessed from different sources. Additionally, if new information is to be required to be filed with the NAIC or the lead-state regulator, it is not clear whether this information would be proprietary in nature and therefore it is not clear if confidential information would be protected.

By pausing on the creation of new surveillance tools and assessment frameworks, it allows regulators to consider the existing solvency framework that has undergone significant changes since MPI was initiated. For this reason, NAMIC suggests the following changes to the proposed charges:
B. Continue to develop and administer existing data collection tools as needed, leveraging existing data where feasible, to provide the Financial Stability (E) Task Force with meaningful macroprudential information regarding how the insurance sector is navigating the prevailing market conditions;

C. Conduct a needs assessment/cost benefit analysis to oversee the development, implementation, and maintenance process for a new Macroprudential Risk Assessment system (i.e., policies, procedures, and tools) to enhance regulators’ ability to monitor industry trends from a macroprudential perspective and consider how, if at all, those trends benefit the solvency regulation of a regulated entity.

We submit these comments in hopes that regulators will consider these views before taking action. While we do not oppose the concept of providing meaningful macroprudential information, it is important to first determine if the existing framework is adequate; however, additional time for these newer tools to mature is needed before an adequate assessment can be completed and a determination can be made on whether new macroprudential information is beneficial.

* * * * *

NAMIC appreciates the opportunity to take part in the process. Thank you for your consideration of these comments on this matter of importance to NAMIC, its member companies and their policyholders. If there are any questions, please feel free to contact me at 317-875-5250.

Sincerely,

Jonathan Rodgers
Director of Financial and Tax Policy
National Association of Mutual Insurance Companies
July 13, 2021

Honorable Marlene Caride, Commissioner
State of New Jersey Department of Banking & Insurance
Chairperson, NAIC Financial Stability (E) Task Force
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Via E-mail:
Attn: tsells@naic.org

Re: Proposal to Create a Macroprudential (E) Working Group to succeed the Liquidity Assessment (E) Subgroup

Dear Commissioner:

The Travelers Companies, Inc. (Travelers) appreciates the opportunity to comment on the proposal to create a Macroprudential (E) Working Group to succeed the Liquidity Assessment (E) Subgroup. The charges to the new group would be:

A. Oversee the implementation and maintenance of the liquidity stress testing framework for 2020 data as well as future iterations;
B. Continue to develop and administer data collection tools as needed, leveraging existing data where feasible, to provide the Financial Stability (E) Task Force with meaningful macroprudential information regarding how the insurance sector is navigating the prevailing market conditions;
C. Oversee the development, implementation, and maintenance process for a new Macroprudential Risk Assessment system (i.e., policies, procedures, and tools) to enhance regulators’ ability to monitor industry trends from a macroprudential perspective;
D. Oversee the documentation of the NAIC's macroprudential policies, procedures, and tools; and
E. Provide the Task Force with proposed responses to IAIS and other international initiatives as needed.

The NAIC is to be commended for your starting point here, correctly focusing resources on liquidity testing of large life insurers where systemic risk may occur. However, we believe there should be a focus on an “activities-based” perspective in this next step of the proposed new working group.
NAIC Financial Stability Task Force
Proposed Macroprudential Working Group
Page 2

We note that there is no mention of the identification of “activities” that lead to systemic risks in the charges to the proposed working group. There should be a study of emerging products and practices (i.e., “activities”) that lead to systemic risk. By the time some of the data is available for the analysis of new products or practices, the crisis is already upon us. As a result, we believe the working group should be looking at trends in products that lead to interconnectedness rather than trying to measure interconnectedness after-the-fact. The data will always be available on a lagged basis, sometimes by several months, so the analysis that would be available to the working group presents a significant risk of being reactive rather than proactive. To mitigate this impact, we recommend that an “activities-based” approach be employed to avoid being reactive to some extent.

We also note that in the Quantitative Review section of the draft NAIC Macroprudential Risk Assessment document there is no mention of a time horizon of the quantitative analysis. In addition, the interconnectedness analysis has no relevance without measuring cash movements instead of market values for the given timeframe. Interconnectedness also needs to have a material qualitative component to be useful. Similarly, market value changes have no meaning if they don’t impact cashflows, and mid-period volatility is far less important than quarter and year-end valuations if there are no cash implications of the mid-period movement. As a result, we recommend identifying a time horizon for the quantitative analysis and a requirement to measure cash movements.

The danger is that this next step becomes a checklist exercise, collecting data that has no relevance and reaching conclusions that have little value based on that data. Raw numbers with no relevant context are not helpful and can cause harm if used as the basis for action. We believe that taking into consideration the time horizon and the impact on cash flows adds context that is currently missing from the proposed approach to data collection and analysis.

Thank you for the opportunity to comment on the proposal to form a Macroprudential (E) Working Group to succeed the Liquidity Assessment (E) Subgroup. Please feel free to call me at (860) 277-0537 if you have any questions.

Regards,

D. Keith Bell
RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

Receivership and Insolvency (E) Task Force July 27, 2021, Minutes ................................................................. 10-1087
Receivership and Insolvency (E) Task Force May 20, 2021, Minutes (Attachment One) ........................................ 10-1089
    Adoption of Amendments to the Insurance Holding Company System Regulatory Act (#440)
    (Attachment One-A) ................................................................................................................................. 10-1091
    Adoption of Amendments to the Insurance Holding Company System Model Regulation with Reporting
    Forms and Instructions (#450) (Attachment One-B) ................................................................................. 10-1124
Receivership Law (E) Subgroup June 14, 2021, Minutes (Attachment Two) ............................................................. 10-1153
Receivership Law (E) Subgroup May 26, 2021, Minutes (Attachment Two-A) ...................................................... 10-1154
Receivership Law (E) Working Group May 4, 2021, Minutes (Attachment Three) ............................................... 10-1155
American Council of Life Insurers (ACLI) Comment Letter Regarding Model #440 (Attachment Three-A) .... 10-1156
Task Force’s 2022 Proposed Charges (Attachment Four) ..................................................................................... 10-1158

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The Receivership and Insolvency (E) Task Force met July 27, 2021. The following Task Force members participated: Doug Slape, Chair, represented by James Kennedy (TX); James J. Donelon, Vice Chair, represented by Nick Lorusso (LA); Michael Conway and Rolf Kaumann (CO); Andrew N. Mais represented by Jared Kosky (CT); David Altmaier represented by Toma Wilkerson (FL); Colin M. Hayashida represented by Patrick P. Lo (HI); Dana Popish Severyinghaus represented by Kevin Baldwin (IL); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Bill Clark (KY); Gary D. Anderson represented by Cara Toomey (MA); Eric A. Cioppa represented by Robert Wake (ME); Anita G. Fox represented by James Gerber (MI); Chlora Lindley-Myers and Shelley Forrest (MO); Mike Causey represented by Jeff Trendel (NC); Eric Dunning and Lindsay Crawford (NE); Russell Toal (NM); Glen Mulready represented by Donna Wilson (OK); Jessica K. Altman represented by Laura Lyon Slaymaker (PA); Elizabeth Kelleher Dwyer represented by Matt Gendron (RI); and Raymond G. Farmer represented by Daniel Morris (SC).

1. **Adopted its May 20 Minutes**

The Task Force met May 20 and took the following action: 1) adopted its March 12 minutes; and 2) adopted amendments to the *Insurance Holding Company System Regulatory Act (#440)* and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450).*

Superintendent Toal made a motion, seconded by Mr. Baldwin, to adopt the Task Force’s May 20 minutes (Attachment One). The motion passed unanimously.


Ms. Wilson said the Receivership Financial Analysis (E) Working Group met March 1, in lieu of the Spring National Meeting, in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss companies in receivership. The Working Group plans to meet Aug. 5, in lieu of the Summer National Meeting, in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings.

Ms. Wilson made a motion, seconded by Mr. Kaumann, to adopt the Working Group’s report. The motion passed unanimously.


Mr. Baldwin said the Receiver’s Handbook (E) Subgroup met June 14 and May 26. During these meetings, the Subgroup formed drafting groups to begin work on developing edits to each chapter of the *Receiver’s Handbook for Insurance Company Insolvencies (Handbook)* to make it more user friendly and concise without diminishing its value to seasoned and new receivers. The drafting group has begun work drafting revisions to the first chapter.

Superintendent Toal made a motion, seconded by Ms. Wilson, to adopt the Subgroup’s report (Attachment Two). The motion passed unanimously.


Mr. Baldwin said the Receivership Law (E) Working Group met May 4 to adopt amendments to Model #440 and Model #450. The amendments address the Working Group’s charge related to the continuation of essential services by affiliates of an insurer in receivership, as well as receiver’s access to data and records held by affiliates belonging to the insurer in receivership. Given that the work of the Receiver’s Handbook (E) Subgroup has begun, the Working Group recommended the development of guidance related to the model changes by the Subgroup as part of its charge to update the Handbook. These actions complete the Working Group’s current charge related to the Macroprudential Initiative (MPI).

Mr. Baldwin made a motion, seconded by Ms. Slaymaker, to adopt the Working Group’s report (Attachment Three). The motion passed unanimously.
Mr. Kennedy said that once the Executive (EX) Committee and Plenary adopts the amendments to Models #440 and #450, the Financial Standards and Accreditation (F) Committee will ask the Task Force for a recommendation regarding the accreditation requirement for these models, which have a “substantially similar” standard. He said that NAIC staff will send out a memo requesting input from members after the Summer National Meeting.

Mr. Wake recommended that the Task Force continue to monitor the Penn Treaty Network America Insurance Company liquidation, given the recent opinion from the Pennsylvania court.

5. **Adopt its 2022 Proposed Charges**

Mr. Kennedy discussed the 2022 proposed charges of the Task Force and its working groups and subgroup. The proposed charges would remain the same, with one exception. The charges of the Receivership Law (E) Working Group related to the MPI will be deleted, as this has been completed.

Superintendent Toal made a motion, seconded by Ms. Wilson, to adopt the Task Force’s 2022 proposed charges (Attachment Four). The motion passed unanimously.

6. **Heard an Update on International Resolution Activities**

Mr. Kennedy said the International Association of Insurance Supervisors (IAIS) Resolution Working Group completed the *Application Paper on Resolution Powers and Planning*. The Working Group will begin work on an application paper on policyholder protection schemes in September.

7. **Heard an Update on the Status of MPI Recommendations**

a. **Training and Outreach to State Insurance Departments**

Mr. Kennedy said the Task Force will plan more training on receivership matters to educate state insurance departments, specifically their legal and legislative staff. He said the NAIC staff will include new model and guideline amendments in upcoming meetings with legislative liaisons. He asked for volunteers from Task Force members to present on these topics during zone meetings in the fall.

b. **Monitor the Work of Other NAIC Groups**

Mr. Kennedy said the Group Solvency Issues (E) Working Group is in the process of reviewing comments on draft updates to financial analysis guidance, including guidance regarding crisis management groups, recovery planning, and resolution planning for internationally active insurance groups (IAIGs). The Working Group is meeting Aug. 4, and will hear from commentors on the draft guidance.

Having no further business, the Receivership and Insolvency (E) Task Force adjourned.
Draft: 6/1/21

Receivership and Insolvency (E) Task Force
Virtual Meeting
May 20, 2021

The Receivership and Insolvency (E) Task Force met May 20, 2021. The following Task Force members participated: Doug Slape, Chair, represented by James Kennedy (TX); James J. Donelon, Vice Chair, represented by Tom Travis (LA); Andrew N. Mais represented by Jared Kosky (CT); David Altmaier represented by Toma Wilkerson (FL); Colin M. Hayashida represented by Patrick P. Lo (HI); Doug Ommen represented by Kevin Clark (IA); Dana Popish Severinghaus represented by Kevin Baldwin (IL); Vicki Schmidt represented by Justin McFarland (KS); Sharon P. Clark represented by Bill Clark (KY); Gary D. Anderson represented by Christopher Joyce (MA); Eric A. Cioppa represented by Robert Wake (ME); Anita G. Fox represented by James Gerber (MI); Chlora Lindley-Myers represented by Shelley Forrest (MO); Mike Causey represented by Jackie Obusek (NC); Eric Dunning (NE); Glen Mulready represented by Donna Wilson (OK); Jessica K. Altman represented by Laura Lyon Slaymaker (PA); Elizabeth Kelleher Dwyer represented by Matt Gendron (RI); and Raymond G. Farmer represented by Gwen Fuller McGriff (SC).

1. **Adopted its March 12 Minutes**

The Task Force met March 12 to: 1) adopt its Nov. 19, 2020, minutes; 2) adopt the report of the Receivership Financial Analysis (E) Working Group; 3) adopt the report of the Receivership Law (E) Working Group; 4) adopt the Guideline for Definition of Reciprocal State in Receivership Laws; 5) form the Receiver’s Handbook (E) Subgroup and adopt its 2021 proposed charges; and 6) hear an update on the status of Macroprudential Initiative (MPI) recommendations.

Ms. Obusek made a motion, seconded by Mr. Kosky, to adopt the Task Force’s March 12 minutes (see NAIC Proceedings – Spring 2021, Receivership and Insolvency (E) Task Force). The motion passed unanimously.

2. **Adopted Amendments to Model #440 and Model #450**

Ms. Slaymaker said in 2020, the Receivership Law (E) Working Group was given the charge to provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including non-regulated entities and specifically for agreements with affiliated entities whose sole business purpose is to provide services to the insurance company. This charge came out of prior recommendations from the Task Force as part of the MPI that identified the continuation of essential services as an area where regulatory powers are implicit rather than explicit. Further, the experiences of state insurance regulators have shown that receivers continue to be challenged by this issue, as current remedies may not immediately address the need to continue services in receivership.

Ms. Slaymaker said the Working Group began meeting in 2020 to address the charge. It first conducted a survey to identify recommendations for how to address this issue, including amendments to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). The draft amendments to Model #440 and Model #450 were exposed for public comment twice with subsequent revisions made to address comments. The amendments to Model #440 were exposed a third time following a final round of edits. The amendments were made to Section 5—Standards and Management of an Insurer Within an Insurance Holding Company System of Model #440 and Section 19—Transactions Subject to Prior Notice - Notice Filing (Form D) of Model #450. Ms. Slaymaker summarized the amendments as follows:

1. Books and records of the insurer are updated to specifically include data of the insurer, being the property of the insurer. The data and records should be identifiable and capable of segregation; i.e., available to the receiver in the event of insolvency, including the systems necessary to access them. The data is specifically defined in Model #450.
2. If the commissioner deems the insurer to be in a statutorily defined hazardous financial condition, he or she may require a bond or deposit, limited in amount, after consideration of whether there are concerns about the affiliated party’s ability to fulfill the contract in the event of a liquidation.
3. Premiums are the property of the insurer, with any right of offset subject to receivership law.
4. The affiliated entity is subject to the jurisdiction of the receivership court, and in certain circumstances, the commissioner may require the affiliate to agree to this in writing.
5. Provisions are included relating to the indemnification of the insurer in the event of gross negligence or willful misconduct by the affiliate.

6. In the event of receivership, which now includes supervision and conservatorship:
   a. The rights of the insurer extend to the receiver or guaranty fund.
   b. The affiliate will make available essential personnel.
   c. The affiliate will continue the services for a minimum time period, as specified in the agreement, with timely payment for post-receivership work.
   d. The affiliate will maintain necessary systems, programs or infrastructure and make them available to the receiver or commissioner for as long as the affiliate receives timely post-receivership payment, unless released by the receiver, commissioner or receivership court.

Ms. Slaymaker made a motion, seconded by Ms. Wilkerson, to adopt the amendments to Model #440 (Attachment One-A) and Model #450 (Attachment One-B). The motion passed unanimously.

3. Heard an Update on the Group Solvency Issues (E) Working Group

Mr. Kennedy said the Group Solvency Issues (E) Working Group exposed draft updates to guidance in the *Financial Analysis Handbook* regarding international standards under the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) for a 60-day public comment period ending July 16. He encouraged members, interested state insurance regulators, and interested parties to review the guidance specifically related to crisis management groups, recovery planning, and resolution planning.

Having no further business, the Receivership and Insolvency (E) Task Force adjourned.
INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT

As used in this Act, the following terms shall have these meanings unless the context shall otherwise require:

A. “Affiliate.” An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

B. “Commissioner.” The term “commissioner” shall mean the insurance commissioner, the commissioner’s deputies, or the Insurance Department, as appropriate.

C. “Control.” The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by Section 4K that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

D. “Group-wide supervisor.” The regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is determined or acknowledged by the commissioner under Section 7.1 to have sufficient significant contacts with the internationally active insurance group.
Insurance Holding Company System Regulatory Act

E. “Group Capital Calculation instructions” means the group capital calculation instructions as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

F. “Insurance Holding Company System.” An “insurance holding company system” consists of two (2) or more affiliated persons, one or more of which is an insurer.

G. “Insurer.” The term “insurer” shall have the same meaning as set forth in Section [insert applicable section] of this Chapter, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

Drafting Note: References in this model act to “Chapter” are references to the entire state insurance code.

Drafting Note: States should consider applicability of this model act to fraternal societies and captives.

H. “Internationally active insurance group.” An insurance holding company system that (1) includes an insurer registered under Section 4; and (2) meets the following criteria: (a) premiums written in at least three countries, (b) the percentage of gross premiums written outside the United States is at least ten percent (10%) of the insurance holding company system’s total gross written premiums, and (c) based on a three-year rolling average, the total assets of the insurance holding company system are at least fifty billion dollars ($50,000,000,000) or the total gross written premiums of the insurance holding company system are at least ten billion dollars ($10,000,000,000).

I. “Enterprise Risk.” “Enterprise risk” shall mean any activity, circumstance, event or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including, but not limited to, anything that would cause the insurer’s Risk-Based Capital to fall into company action level as set forth in [insert cross reference to appropriate section of Risk-Based Capital (RBC) Model Act] or would cause the insurer to be in hazardous financial condition [insert cross reference to appropriate section of Model Regulation to define standards and commissioner’s authority over companies deemed to be in hazardous financial condition].

J. “NAIC” means the National Association of Insurance Commissioners.

K. “NAIC Liquidity Stress Test Framework.” The “NAIC Liquidity Stress Test Framework” is a separate NAIC publication which includes a history of the NAIC’s development of regulatory liquidity stress testing, the Scope Criteria applicable for a specific data year, and the Liquidity Stress Test instructions and reporting template being as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

L. “Person.” A “person” is an individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert, but shall not include any joint venture partnership exclusively engaged in owning, managing, leasing or developing real or tangible personal property.

M. “Scope Criteria.” The “Scope Criteria,” as detailed in the NAIC Liquidity Stress Test Framework, are the designated exposure bases along with minimum magnitudes thereof for the specified data year, used to establish a preliminary list of insurers considered scoped into the NAIC Liquidity Stress Test Framework for that data year.

N. “Securityholder.” A “securityholder” of a specified person is one who owns any security of such person, including common stock, preferred stock, debt obligations and any other security convertible into or evidencing the right to acquire any of the foregoing.

O. “Subsidiary.” A “subsidiary” of a specified person is an affiliate controlled by such person directly or indirectly through one or more intermediaries.
“Voting Security.” The term “voting security” shall include any security convertible into or evidencing a right to acquire a voting security.

Section 2. Subsidiaries of Insurers

A. Authorization. A domestic insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries. The subsidiaries may conduct any kind of business or businesses and their authority to do so shall not be limited by reason of the fact that they are subsidiaries of a domestic insurer.

Drafting Note: This bill neither expressly authorizes noninsurance subsidiaries nor restricts subsidiaries to insurance related activities. It is believed that this is a policy decision which should be made by each individual state. Attached as an appendix are alternative provisions which would authorize the formation or acquisition of subsidiaries to engage in diversified business activity.

B. Additional Investment Authority. In addition to investments in common stock, preferred stock, debt obligations and other securities permitted under all other sections of this Chapter, a domestic insurer may also:

(1) Invest, in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, amounts which do not exceed the lesser of ten percent (10%) of the insurer’s assets or fifty percent (50%) of the insurer’s surplus as regards policyholders, provided that after such investments, the insurer’s surplus as regards policyholders will be reasonable in relation to the insurer’s outstanding liabilities and adequate to meet its financial needs. In calculating the amount of such investments, investments in domestic or foreign insurance subsidiaries and health maintenance organizations shall be excluded, and there shall be included:

(a) Total net monies or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities, and

(b) All amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities; and all contributions to the capital or surplus of a subsidiary subsequent to its acquisition or formation;

Drafting Note: When considering whether to amend its Holding Company Act to exempt health maintenance organizations and other similar entities from certain investment limitations, a state should consider whether the solvency and general operations of the entities are regulated by the insurance department. In addition to, or in place of, the term “health maintenance organizations” in Paragraph (1) above, a state may include any other entity which provides or arranges for the financing or provision of health care services or coverage over which the commissioner possesses financial solvency and regulatory oversight authority.

(2) Invest any amount in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer provided that each subsidiary agrees to limit its investments in any asset so that such investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in Paragraph (1) or in Sections [insert applicable section] through [insert applicable section] of this Chapter applicable to the insurer. For the purpose of this paragraph, “the total investment of the insurer” shall include:

(a) Any direct investment by the insurer in an asset, and

(b) The insurer’s proportionate share of any investment in an asset by any subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary’s investment by the percentage of the ownership of the subsidiary;
(3) With the approval of the commissioner, invest any greater amount in common stock, preferred stock, debt obligations, or other securities of one or more subsidiaries; provided that after the investment the insurer’s surplus as regards policyholders will be reasonable in relation to the insurer’s outstanding liabilities and adequate to its financial needs.

C. Exemption from Investment Restrictions. Investments in common stock, preferred stock, debt obligations or other securities of subsidiaries made pursuant to Subsection B shall not be subject to any of the otherwise applicable restrictions or prohibitions contained in this Chapter applicable to such investments of insurers [except the following: ].

Drafting Note: The last phrase is optional in those states having certain special qualitative limitations, such as prohibitions on investments in stock of mining companies, which the state may wish to retain as a matter of public policy.

D. Qualification of Investment; When Determined. Whether any investment made pursuant to Subsection B meets the applicable requirements of that subsection is to be determined before the investment is made, by calculating the applicable investment limitations as though the investment had already been made, taking into account the then outstanding principal balance on all previous investments in debt obligations, and the value of all previous investments in equity securities as of the day they were made, net of any return of capital invested, not including dividends.

E. Cessation of Control. If an insurer ceases to control a subsidiary, it shall dispose of any investment therein made pursuant to this section within three (3) years from the time of the cessation of control or within such further time as the commissioner may prescribe, unless at any time after the investment shall have been made, the investment shall have met the requirements for investment under any other section of this Chapter, and the insurer has so notified the commissioner.

Section 3. Acquisition of Control of or Merger with Domestic Insurer

A. Filing Requirements.

(1) No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities for, seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the consummation thereof, such person would, directly or indirectly (or by conversion or by exercise of any right to acquire) be in control of the insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time the offer, request or invitation is made or the agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, such person has filed with the commissioner and has sent to the insurer, a statement containing the information required by this section and the offer, request, invitation, agreement or acquisition has been approved by the commissioner in the manner prescribed in this Act.

(2) For purposes of this section, any controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer, in any manner, shall file with the commissioner, with a copy to the insurer, confidential notice of its proposed divestiture at least 30 days prior to the cessation of control. The commissioner shall determine those instances in which the party(ies) seeking to divest or to acquire a controlling interest in an insurer, will be required to file for and obtain approval of the transaction. The information shall remain confidential until the conclusion of the transaction unless the commissioner, in his or her discretion determines that confidential treatment will interfere with enforcement of this section. If the statement referred to in Paragraph (1) is otherwise filed, this paragraph shall not apply.

(3) With respect to a transaction subject to this section, the acquiring person must also file a pre-acquisition notification with the commissioner, which shall contain the information set forth in Section 3.1C(1). A failure to file the notification may be subject to penalties specified in Section 3.1E(3).
(4) For purposes of this section a domestic insurer shall include any person controlling a domestic insurer unless the person, as determined by the commissioner, is either directly or through its affiliates primarily engaged in business other than the business of insurance. For the purposes of this section, “person” shall not include any securities broker holding, in the usual and customary broker’s function, less than twenty percent (20%) of the voting securities of an insurance company or of any person which controls an insurance company.

B. Content of Statement. The statement to be filed with the commissioner shall be made under oath or affirmation and shall contain the following:

(1) The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in Subsection A is to be effected (hereinafter called the “acquiring party”), and

(a) If the person is an individual, his or her principal occupation and all offices and positions held during the past five (5) years, and any conviction of crimes other than minor traffic violations during the past ten (10) years;

(b) If the person is not an individual, a report of the nature of its business operations during the past five (5) years or for the lesser period as the person and any predecessors shall have been in existence; an informative description of the business intended to be done by the person and the person’s subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of the person, or who perform or will perform functions appropriate to such positions. The list shall include for each individual the information required by Subparagraph (a) of this paragraph;

(2) The source, nature and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction where funds were or are to be obtained for any such purpose (including any pledge of the insurer’s stock, or the stock of any of its subsidiaries or controlling affiliates), and the identity of persons furnishing consideration; provided, however, that where a source of consideration is a loan made in the lender’s ordinary course of business, the identity of the lender shall remain confidential, if the person filing the statement so requests;

(3) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five (5) fiscal years of each acquiring party (or for such lesser period as the acquiring party and any predecessors shall have been in existence), and similar unaudited information as of a date not earlier than ninety (90) days prior to the filing of the statement;

(4) Any plans or proposals which each acquiring party may have to liquidate the insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management;

(5) The number of shares of any security referred to in Subsection A which each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement or acquisition referred to in Subsection A, and a statement as to the method by which the fairness of the proposal was arrived at;

(6) The amount of each class of any security referred to in Subsection A which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party;

(7) A full description of any contracts, arrangements or understandings with respect to any security referred to in Subsection A in which any acquiring party is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. The description shall identify the persons with whom the contracts, arrangements or understandings have been entered into;
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(8) A description of the purchase of any security referred to in Subsection A during the twelve (12) calendar months preceding the filing of the statement by any acquiring party, including the dates of purchase, names of the purchasers and consideration paid or agreed to be paid;

(9) A description of any recommendations to purchase any security referred to in Subsection A made during the twelve (12) calendar months preceding the filing of the statement by any acquiring party, or by anyone based upon interviews or at the suggestion of the acquiring party;

(10) Copies of all tender offers for, requests, or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in Subsection A, and (if distributed) of additional soliciting material relating to them;

(11) The term of any agreement, contract or understanding made with or proposed to be made with any broker-dealer as to solicitation of securities referred to in Subsection A for tender, and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto;

Drafting Note: An insurer required to file information pursuant to sub-sections 3B(12) and 3B(13) may satisfy the requirement by providing the commissioner with the most recently filed parent corporation reports that have been filed with the SEC, if appropriate.

(12) An agreement by the person required to file the statement referred to in Subsection A that it will provide the annual report, specified in Section 4L(1), for so long as control exists;

(13) An acknowledgement by the person required to file the statement referred to in Subsection A that the person and all subsidiaries within its control in the insurance holding company system will provide information to the commissioner upon request as necessary to evaluate enterprise risk to the insurer; and

(14) Such additional information as the commissioner may by rule or regulation prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest.

If the person required to file the statement referred to in Subsection A is a partnership, limited partnership, syndicate or other group, the commissioner may require that the information called for by Paragraphs (1) through (14) shall be given with respect to each partner of the partnership or limited partnership, each member of the syndicate or group, and each person who controls the partner or member. If any partner, member or person is a corporation or the person required to file the statement referred to in Subsection A is a corporation, the commissioner may require that the information called for by Paragraphs (1) through (14) shall be given with respect to the corporation, each officer and director of the corporation, and each person who is directly or indirectly the beneficial owner of more than ten percent (10%) of the outstanding voting securities of the corporation.

If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to the insurer pursuant to this section, an amendment setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the commissioner and sent to the insurer within two (2) business days after the person learns of the change.

C. Alternative Filing Materials.

If any offer, request, invitation, agreement or acquisition referred to in Subsection A is proposed to be made by means of a registration statement under the Securities Act of 1933 or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934, or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in Subsection A may utilize the documents in furnishing the information called for by that statement.
D. Approval by Commissioner: Hearings.

(1) The commissioner shall approve any merger or other acquisition of control referred to in Subsection A unless, after a public hearing, the commissioner finds that:

(a) After the change of control, the domestic insurer referred to in Subsection A would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(b) The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly. In applying the competitive standard in this subparagraph:

(i) The informational requirements of Section 3.1C(1) and the standards of Section 3.1D(2) shall apply;

(ii) The merger or other acquisition shall not be disapproved if the commissioner finds that any of the situations meeting the criteria provided by Section 3.1D(3) exist; and

(iii) The commissioner may condition the approval of the merger or other acquisition on the removal of the basis of disapproval within a specified period of time;

(c) The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders;

(d) The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest;

(e) The competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control; or

(f) The acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

(2) The public hearing referred to in Paragraph (1) shall be held within thirty (30) days after the statement required by Subsection A is filed, and at least twenty (20) days notice shall be given by the commissioner to the person filing the statement. Not less than seven (7) days notice of the public hearing shall be given by the person filing the statement to the insurer and to such other persons as may be designated by the commissioner. The commissioner shall make a determination within the sixty (60) day period preceding the effective date of the proposed transaction. At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and in connection therewith shall be entitled to conduct discovery proceedings in the same manner as is presently allowed in the [insert title] Court of this state. All discovery proceedings shall be concluded not later than three (3) days prior to the commencement of the public hearing.

(3) If the proposed acquisition of control will require the approval of more than one commissioner, the public hearing referred to in Paragraph (2) may be held on a consolidated basis upon request of the person filing the statement referred to in Subsection A. Such person shall file the statement referred to in Subsection A with the National Association of Insurance Commissioners (NAIC) within five (5) days of making the request for a public hearing. A commissioner may opt out of a consolidated hearing, and shall provide notice to the applicant of the opt-out within ten (10) days of the receipt of the statement referred to in Subsection A. A hearing conducted on a consolidated basis shall be public and shall be held within the United States before the commissioners of the states in which the insurers are domiciled. Such commissioners shall hear and receive evidence. A
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commissioner may attend such hearing, in person or by telecommunication.

(4) In connection with a change of control of a domestic insurer, any determination by the commissioner that the person acquiring control of the insurer shall be required to maintain or restore the capital of the insurer to the level required by the laws and regulations of this state shall be made not later than sixty (60) days after the date of notification of the change in control submitted pursuant to Section 3A(1) of this Act.

(5) The commissioner may retain at the acquiring person’s expense any attorneys, actuaries, accountants and other experts not otherwise a part of the commissioner’s staff as may be reasonably necessary to assist the commissioner in reviewing the proposed acquisition of control.

E. Exemptions. The provisions of this section shall not apply to:

(1) [Any transaction which is subject to the provisions of Sections [insert applicable section] and [insert applicable section] of the laws of this state, dealing with the merger or consolidation of two or more insurers].

Drafting Note: Optional for use in those states where existing law adequately governs standards and procedures for the merger or consolidation of two or more insurers.

(2) Any offer, request, invitation, agreement or acquisition which the commissioner by order shall exempt as not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer, or as otherwise not comprehended within the purposes of this section.

F. Violations. The following shall be violations of this section:

(1) The failure to file any statement, amendment or other material required to be filed pursuant to Subsection A or B; or

(2) The effectuation or any attempt to effectuate an acquisition of control of, divestiture of, or merger with, a domestic insurer unless the commissioner has given approval.

G. Jurisdiction, Consent to Service of Process. The courts of this state are hereby vested with jurisdiction over every person not resident, domiciled or authorized to do business in this state who files a statement with the commissioner under this section, and overall actions involving such person arising out of violations of this section, and each such person shall be deemed to have performed acts equivalent to and constituting an appointment by the person of the commissioner to be his true and lawful attorney upon whom may be served all lawful process in any action, suit or proceeding arising out of violations of this section. Copies of all lawful process shall be served on the commissioner and transmitted by registered or certified mail by the commissioner to the person at his last known address.

Section 3.1 Acquisitions Involving Insurers Not Otherwise Covered

A. Definitions. The following definitions shall apply for the purposes of this section only:

(1) “Acquisition” means any agreement, arrangement or activity the consummation of which results in a person acquiring directly or indirectly the control of another person, and includes but is not limited to the acquisition of voting securities, the acquisition of assets, bulk reinsurance and mergers.

(2) An “involved insurer” includes an insurer which either acquires or is acquired, is affiliated with an acquirer or acquired, or is the result of a merger.

B. Scope

(1) Except as exempted in Paragraph (2) of this subsection, this section applies to any acquisition in which there is a change in control of an insurer authorized to do business in this state.
(2) This section shall not apply to the following:

(a) A purchase of securities solely for investment purposes so long as the securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this state. If a purchase of securities results in a presumption of control under Section 1C, it is not solely for investment purposes unless the commissioner of the insurer’s state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and the disclaimer action or affirmative finding is communicated by the domiciliary commissioner to the commissioner of this state;

(b) The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if pre-acquisition notification is filed with the commissioner in accordance with Section 3.1C(1) thirty (30) days prior to the proposed effective date of the acquisition. However, such pre-acquisition notification is not required for exclusion from this section if the acquisition would otherwise be excluded from this section by any other subparagraph of Section 3.1B(2);

(c) The acquisition of already affiliated persons;

(d) An acquisition if, as an immediate result of the acquisition,

(i) In no market would the combined market share of the involved insurers exceed five percent (5%) of the total market,

(ii) There would be no increase in any market share, or

(iii) In no market would

(I) The combined market share of the involved insurers exceeds twelve percent (12%) of the total market, and

(II) The market share increase by more than two percent (2%) of the total market.

For the purpose of this Paragraph (2)(d), a market means direct written insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state;

(e) An acquisition for which a pre-acquisition notification would be required pursuant to this section due solely to the resulting effect on the ocean marine insurance line of business;

(f) An acquisition of an insurer whose domiciliary commissioner affirmatively finds that the insurer is in failing condition; there is a lack of feasible alternative to improving such condition; the public benefits of improving the insurer’s condition through the acquisition exceed the public benefits that would arise from not lessening competition; and the findings are communicated by the domiciliary commissioner to the commissioner of this state.

C. Pre-acquisition Notification; Waiting Period. An acquisition covered by Section 3.1B may be subject to an order pursuant to Section 3.1E unless the acquiring person files a pre-acquisition notification and the waiting period has expired. The acquired person may file a pre-acquisition notification. The commissioner shall give confidential treatment to information submitted under this subsection in the same manner as provided in Section 8 of this Act.

(1) The pre-acquisition notification shall be in such form and contain such information as prescribed by the National Association of Insurance Commissioners (NAIC) relating to those markets which, under Section 3.1B(2)(d), cause the acquisition not to be exempted from the provisions of this
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section. The commissioner may require such additional material and information as deemed necessary to determine whether the proposed acquisition, if consummated, would violate the competitive standard of Section 3.1D. The required information may include an opinion of an economist as to the competitive impact of the acquisition in this state accompanied by a summary of the education and experience of such person indicating his or her ability to render an informed opinion.

(2) The waiting period required shall begin on the date of receipt of the commissioner of a pre-acquisition notification and shall end on the earlier of the thirtieth day after the date of receipt, or termination of the waiting period by the commissioner. Prior to the end of the waiting period, the commissioner on a one-time basis may require the submission of additional needed information relevant to the proposed acquisition, in which event the waiting period shall end on the earlier of the thirtieth day after receipt of the additional information by the commissioner or termination of the waiting period by the commissioner.

D. Competitive Standard

(1) The commissioner may enter an order under Section 3.1E(1) with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in this state or tend to create a monopoly or if the insurer fails to file adequate information in compliance with Section 3.1C.

(2) In determining whether a proposed acquisition would violate the competitive standard of Paragraph (1) of this subsection, the commissioner shall consider the following:

(a) Any acquisition covered under Section 3.1B involving two (2) or more insurers competing in the same market is prima facie evidence of violation of the competitive standards.

(i) If the market is highly concentrated and the involved insurers possess the following shares of the market:

<table>
<thead>
<tr>
<th>Insurer A</th>
<th>Insurer B</th>
</tr>
</thead>
<tbody>
<tr>
<td>4%</td>
<td>4% or more</td>
</tr>
<tr>
<td>10%</td>
<td>2% or more</td>
</tr>
<tr>
<td>15%</td>
<td>1% or more</td>
</tr>
</tbody>
</table>

(ii) Or, if the market is not highly concentrated and the involved insurers possess the following shares of the market:

<table>
<thead>
<tr>
<th>Insurer A</th>
<th>Insurer B</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>5% or more</td>
</tr>
<tr>
<td>10%</td>
<td>4% or more</td>
</tr>
<tr>
<td>15%</td>
<td>3% or more</td>
</tr>
<tr>
<td>19%</td>
<td>1% or more</td>
</tr>
</tbody>
</table>

A highly concentrated market is one in which the share of the four (4) largest insurers is seventy-five percent (75%) or more of the market. Percentages not shown in the tables are interpolated proportionately to the percentages that are shown. If more than two (2) insurers are involved, exceeding the total of the two columns in the table is prima facie evidence of violation of the competitive standard in Paragraph (1) of this subsection. For the purpose of this item, the insurer with the largest share of the market shall be deemed to be Insurer A.
(b) There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two (2) largest to the eight (8) largest, has increased by seven percent (7%) or more of the market over a period of time extending from any base year five (5) to ten (10) years prior to the acquisition up to the time of the acquisition. Any acquisition or merger covered under Section 3.1B involving two (2) or more insurers competing in the same market is prima facie evidence of violation of the competitive standard in Paragraph (1) of this subsection if:

(i) There is a significant trend toward increased concentration in the market;

(ii) One of the insurers involved is one of the insurers in a grouping of large insurers showing the requisite increase in the market share; and

(iii) Another involved insurer’s market is two percent (2%) or more.

(c) For the purposes of Section 3.1D(2):

(i) The term “insurer” includes any company or group of companies under common management, ownership or control;

(ii) The term “market” means the relevant product and geographical markets. In determining the relevant product and geographical markets, the commissioner shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the NAIC and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, such line being that used in the annual statement required to be filed by insurers doing business in this state, and the relevant geographical market is assumed to be this state;

(iii) The burden of showing prima facie evidence of violation of the competitive standard rests upon the commissioner.

(d) Even though an acquisition is not prima facie violative of the competitive standard under Paragraphs (2)(a) and (2)(b) of this subsection, the commissioner may establish the requisite anticompetitive effect based upon other substantial evidence. Even though an acquisition is prima facie violative of the competitive standard under Paragraphs (2)(a) and (2)(b) of this subsection, a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this subparagraph include, but are not limited to, the following: market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry, and ease of entry and exit into the market.

(3) An order may not be entered under Section 3.1E(1) if:

(a) The acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from such economies exceed the public benefits which would arise from not lessening competition; or

(b) The acquisition will substantially increase the availability of insurance, and the public benefits of the increase exceed the public benefits which would arise from not lessening competition.

E. Orders and Penalties

(1) If an acquisition violates the standards of this section, the commissioner may enter an order:
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(i) Requiring an involved insurer to cease and desist from doing business in this state with respect to the line or lines of insurance involved in the violation; or

(ii) Denying the application of an acquired or acquiring insurer for a license to do business in this state.

(b) Such an order shall not be entered unless:

(i) There is a hearing;

(ii) Notice of the hearing is issued prior to the end of the waiting period and not less than fifteen (15) days prior to the hearing; and

(iii) The hearing is concluded and the order is issued no later than sixty (60) days after the date of the filing of the pre-acquisition notification with the commissioner.

Every order shall be accompanied by a written decision of the commissioner setting forth findings of fact and conclusions of law.

(c) An order pursuant to this paragraph shall not apply if the acquisition is not consummated.

(2) Any person who violates a cease and desist order of the commissioner under Paragraph (1) and while the order is in effect may, after notice and hearing and upon order of the commissioner, be subject at the discretion of the commissioner to one or more of the following:

(a) A monetary penalty of not more than $10,000 for every day of violation; or

(b) Suspension or revocation of the person’s license.

(3) Any insurer or other person who fails to make any filing required by this section, and who also fails to demonstrate a good faith effort to comply with any filing requirement, shall be subject to a fine of not more than $50,000.

F. Inapplicable Provisions. Sections 10B, 10C, and 12 do not apply to acquisitions covered under Section 3.1B.

Section 4. Registration of Insurers

A. Registration. Every insurer which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the commissioner, except a foreign insurer subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained in:

(1) Section 4;

(2) Section 5A(1), 5B, 5D; and

(3) Either Section 5A(2) or a provision such as the following: Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within fifteen (15) days after the end of the month in which it learns of each change or addition.

Any insurer which is subject to registration under this section shall register within fifteen (15) days after it becomes subject to registration, and annually thereafter by [insert date] of each year for the previous calendar year, unless the commissioner for good cause shown extends the time for registration, and then within the extended time. The commissioner may require any insurer authorized to do business in the state which is a member of an insurance holding company system,
and which is not subject to registration under this section, to furnish a copy of the registration statement, the summary specified in Section 4C or other information filed by the insurance company with the insurance regulatory authority of its domiciliary jurisdiction.

**B. Information and Form Required.** Every insurer subject to registration shall file the registration statement with the commissioner on a form and in a format prescribed by the NAIC, which shall contain the following current information:

1. The capital structure, general financial condition, ownership and management of the insurer and any person controlling the insurer;
2. The identity and relationship of every member of the insurance holding company system;
3. The following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between the insurer and its affiliates:
   - Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;
   - Purchases, sales or exchange of assets;
   - Transactions not in the ordinary course of business;
   - Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer’s assets to liability, other than insurance contracts entered into in the ordinary course of the insurer’s business;
   - All management agreements, service contracts and all cost-sharing arrangements;
   - Reinsurance agreements;
   - Dividends and other distributions to shareholders; and
   - Consolidated tax allocation agreements;
4. Any pledge of the insurer’s stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;
5. If requested by the commissioner, the insurer shall include financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include but are not limited to annual audited financial statements filed with the U.S. Securities and Exchange Commission (SEC) pursuant to the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended. An insurer required to file financial statements pursuant to this paragraph may satisfy the request by providing the commissioner with the most recently filed parent corporation financial statements that have been filed with the SEC;
6. Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the commissioner;
7. Statements that the insurer’s board of directors oversees corporate governance and internal controls and that the insurer’s officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures; and

**Drafting Note:** Neither option below is intended to modify applicable state insurance and/or corporate law requirements.
Alternative Section 4B(7):

(7) Statements that the insurer’s board of directors is responsible for and oversees corporate governance and internal controls and that the insurer’s officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures; and

(8) Any other information required by the commissioner by rule or regulation.

C. Summary of Changes to Registration Statement. All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

D. Materiality. No information need be disclosed on the registration statement filed pursuant to Subsection B if the information is not material for the purposes of this section. Unless the commissioner by rule, regulation or order provides otherwise; sales, purchases, exchanges, loans or extensions of credit, investments, or guarantees involving one-half of one percent (0.5%) or less of an insurer’s admitted assets as of the 31st day of December next preceding shall not be deemed material for purposes of this section. The definition of materiality provided in this subsection shall not apply for purposes of the Group Capital Calculation or the Liquidity Stress Test Framework.

E. Reporting of Dividends to Shareholders. Subject to Section 5B, each registered insurer shall report to the commissioner all dividends and other distributions to shareholders within fifteen (15) business days following the declaration thereof.

F. Information of Insurers. Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurer, where the information is reasonably necessary to enable the insurer to comply with the provisions of this Act.

G. Termination of Registration. The commissioner shall terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.

H. Consolidated Filing. The commissioner may require or allow two (2) or more affiliated insurers subject to registration to file a consolidated registration statement.

I. Alternative Registration. The commissioner may allow an insurer which is authorized to do business in this state and which is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under Subsection A and to file all information and material required to be filed under this section.

J. Exemptions. The provisions of this section shall not apply to any insurer, information or transaction if and to the extent that the commissioner by rule, regulation or order shall exempt the same from the provisions of this section.

K. Disclaimer. Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer or a disclaimer may be filed by the insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the commissioner, within thirty (30) days following receipt of a complete disclaimer, notifies the filing party the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer has been granted by the commissioner, or if the disclaimer is deemed to have been approved.
L. Enterprise Risk Filings.

(1) The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report shall, to the best of the ultimate controlling person’s knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners;

(2) Group Capital Calculation. Except as provided below, the ultimate controlling person of every insurer subject to registration shall concurrently file with the registration an annual group capital calculation as directed by the lead state commissioner. The report shall be completed in accordance with the NAIC Group Capital Calculation Instructions, which may permit the lead state commissioner to allow a controlling person that is not the ultimate controlling person to file the group capital calculation. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the commissioner in accordance with the procedures within the Financial Analysis Handbook adopted by the NAIC. Insurance holding company systems described below are exempt from filing the group capital calculation:

(a) An insurance holding company system that has only one insurer within its holding company structure, that only writes business [and is only licensed] in its domestic state, and assumes no business from any other insurer;

(b) An insurance holding company system that is required to perform a group capital calculation specified by the United States Federal Reserve Board. The lead state commissioner shall request the calculation from the Federal Reserve Board under the terms of information sharing agreements in effect. If the Federal Reserve Board cannot share the calculation with the lead state commissioner, the insurance holding company system is not exempt from the group capital calculation filing;

(c) An insurance holding company system whose non-U.S. group-wide supervisor is located within a Reciprocal Jurisdiction as described in [insert cross-reference to appropriate section of Credit for Reinsurance Law] that recognizes the U.S. state regulatory approach to group supervision and group capital;

(d) An insurance holding company system:

(i) That provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program, either directly or indirectly through the group-wide supervisor, who has determined such information is satisfactory to allow the lead state to comply with the NAIC group supervision approach, as detailed in the NAIC Financial Analysis Handbook, and

(ii) Whose non-U.S. group-wide supervisor that is not in a Reciprocal Jurisdiction recognizes and accepts, as specified by the commissioner in regulation, the group capital calculation as the world-wide group capital assessment for U.S. insurance groups who operate in that jurisdiction.

Drafting Note: On September 22, 2017, the United States and the European Union (EU) entered into the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance.” A similar agreement with the United Kingdom (UK) was signed on December 18, 2018. Both agreements are considered to be a “covered agreement” entered into pursuant to Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. §§ 313 and 314, that addresses the U.S. state regulatory approach to group supervision and group capital, and provides that insurers and insurance groups that are domiciled or maintain their headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the commissioner or the commissioner of the domiciliary state and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group. Under the revised Credit for Reinsurance Models, not only are jurisdictions that are subject to the EU and UK Covered Agreements treated as Reciprocal Jurisdictions, but any other Qualified Jurisdiction can also qualify as Reciprocal Jurisdiction if they provide written confirmation that they recognize and accept the U.S. state regulatory approach to group supervision and group capital.
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Drafting Note: The phrase “Recognizes and accepts” does not require the non-U.S. group-wide supervisor to require the U.S. insurance groups to actually file the group capital calculation with the non-U.S. supervisor but rather does not apply its own version of a group capital filing to U.S. insurance groups.

(e) Notwithstanding the provisions of Sections 4L(2)(c) and 4L(2)(d), a lead state commissioner shall require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system where, after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace.

(f) Notwithstanding the exemptions from filing the group capital calculation stated in Section 4L(2)(a) through Section 4L(2)(d), the lead state commissioner has the discretion to exempt the ultimate controlling person from filing the annual group capital calculation or to accept a limited group capital filing or report in accordance with criteria as specified by the commissioner in regulation.

(g) If the lead state commissioner determines that an insurance holding company system no longer meets one or more of the requirements for an exemption from filing the group capital calculation under this section, the insurance holding company system shall file the group capital calculation at the next annual filing date unless given an extension by the lead state commissioner based on reasonable grounds shown.

(3) Liquidity Stress Test. The ultimate controlling person of every insurer subject to registration and also scoped into the NAIC Liquidity Stress Test Framework shall file the results of a specific year’s Liquidity Stress Test. The filing shall be made to the lead state insurance commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners:

(a) The NAIC Liquidity Stress Test Framework includes Scope Criteria applicable to a specific data year. These Scope Criteria are reviewed at least annually by the Financial Stability Task Force or its successor. Any change to the NAIC Liquidity Stress Test Framework or to the data year for which the Scope Criteria are to be measured shall be effective on January 1 of the year following the calendar year when such changes are adopted. Insurers meeting at least one threshold of the Scope Criteria are considered scoped into the NAIC Liquidity Stress Test Framework for the specified data year unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should not be scoped into the Framework for that data year. Similarly, insurers that do not trigger at least one threshold of the Scope Criteria are considered scoped out of the NAIC Liquidity Stress Test Framework for the specified data year, unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should be scoped into the Framework for that data year.

(i) Regulators wish to avoid having insurers scoped in and out of the NAIC Liquidity Stress Test Framework on a frequent basis. The lead state insurance commissioner, in consultation with the Financial Stability Task Force or its successor, will assess this concern as part of the determination for an insurer.

(b) The performance of, and filing of the results from, a specific year’s Liquidity Stress Test shall comply with the NAIC Liquidity Stress Test Framework’s instructions and reporting templates for that year and any lead state insurance commissioner determinations, in conjunction with the Financial Stability Task Force or its successor, provided within the Framework.

Drafting Note: The delay included in the change to the NAIC Liquidity Stress Test Framework or to the data year for which the Scope Criteria are to be measured being effective on January 1 of the year following the calendar year when such changes are adopted is present to: 1) allow sufficient time for states needing to adopt by rule the NAIC Liquidity Stress Test Framework for a given data year and 2) to ensure scoped in insurers have adequate time to comply with the requirements for a given data year.
M. Violations. The failure to file a registration statement or any summary of the registration statement or enterprise risk filing required by this section within the time specified for filing shall be a violation of this section.

Section 5. Standards and Management of an Insurer Within an Insurance Holding Company System

A. Transactions Within an Insurance Holding Company System

(1) Transactions within an insurance holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

(a) The terms shall be fair and reasonable;

(b) Agreements for cost sharing services and management shall include such provisions as required by rule and regulation issued by the commissioner;

(c) Charges or fees for services performed shall be reasonable;

(d) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(e) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties;

(f) The insurer’s surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer’s outstanding liabilities and adequate to meet its financial needs;

(g) If an insurer subject to this Act is deemed by the commissioner to be in a hazardous financial condition as defined by [insert citation for Model Regulation to Define Standards and Commissioner’s Authority for Companies Deemed to be in Hazardous Financial Condition] or a condition that would be grounds for supervision, conservation or a delinquency proceeding, then the commissioner may require the insurer to secure and maintain either a deposit, held by the commissioner, or a bond, as determined by the insurer at the insurer’s discretion, for the protection of the insurer for the duration of the contract(s) or agreement(s), or the existence of the condition for which the commissioner required the deposit or the bond.

In determining whether a deposit or a bond is required, the commissioner should consider whether concerns exist with respect to the affiliated person’s ability to fulfill the contract or agreement if the insurer were to be put into liquidation. Once the insurer is deemed to be in a hazardous financial condition or a condition that would be grounds for supervision, conservation or a delinquency proceeding, and a deposit or bond is necessary, the commissioner has discretion to determine the amount of the deposit or bond, not to exceed the value of the contract(s) or agreement(s) in any one year, and whether such deposit or bond should be required for a single contract, multiple contracts or a contract only with a specific person(s).

Drafting Note: This section is intended to apply to a broad range of affiliate managerial and support service contracts including, for example, general managerial services, financial accounting and other support services, data management, investment portfolio management and support and policy and policyholder services. Performance collateralization for reinsurance and other risk transfer or financial contracts with affiliates is typically addressed in the underlying contractual agreements and is beyond the scope of these deposit/bond requirements. The intent of the deposit or bond is to ensure the affiliated services provided under the contract(s) are fulfilled. In determining appropriate circumstances when a commissioner may require a deposit or bond to be determined by the insurer, and in specifying an amount, the commissioner should evaluate and consider whether an insurer subject to this act is in a hazardous financial condition or a condition that would be grounds for supervision, conservation or a delinquency proceeding. If it is, the deposit or bond requirement would be available as an additional regulatory remedy at the discretion of the commissioner. Note, the commissioner should consider whether the affiliated person is already required to post a deposit or bond under applicable laws regulating third-party administrators.
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(b) All records and data of the insurer held by an affiliate are and remain the property of the insurer, are subject to control of the insurer, are identifiable, and are segregated or readily capable of segregation, at no additional cost to the insurer, from all other persons' records and data. This includes all records and data that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records or similar records within the possession, custody or control of the affiliate. At the request of the insurer, the affiliate shall provide that the receiver can obtain a complete set of all records of any type that pertain to the insurer’s business; obtain access to the operating systems on which the data is maintained; obtain the software that runs those systems either through assumption of licensing agreements or otherwise; and restrict the use of the data by the affiliate if it is not operating the insurer’s business. The affiliate shall provide a waiver of any landlord lien or other encumbrance to give the insurer access to all records and data in the event of the affiliate’s default under a lease or other agreement; and,

Drafting Note: The “at no additional cost to the insurer” language is not intended to prohibit recovery of the fair and reasonable cost associated with transferring records and data to the insurer. Since records and data of the insurer are the property of the insurer, the insurer should not pay a cost to segregate commingled records and data from other data of the affiliates.

(i) Premiums or other funds belonging to the insurer that are collected by or held by an affiliate are the exclusive property of the insurer and are subject to the control of the insurer. Any right of offset in the event an insurer is placed into receivership shall be subject to [the receivership act of the state].

(2) The following transactions involving a domestic insurer and any person in its insurance holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, which are subject to any materiality standards contained in subparagraphs (a) through (g), may not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into the transaction at least thirty (30) days prior thereto, or such shorter period as the commissioner may permit, and the commissioner has not disapproved it within that period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported, within thirty (30) days after a termination of a previously filed agreement, to the commissioner for determination of the type of filing required, if any.

(a) Sales, purchases, exchanges, loans, extensions of credit, or investments, provided the transactions are equal to or exceed:

(i) With respect to nonlife insurers, the lesser of three percent (3%) of the insurer’s admitted assets or twenty-five percent (25%) of surplus as regards policyholders as of the 31st day of December next preceding;

(ii) With respect to life insurers, three percent (3%) of the insurer’s admitted assets as of the 31st day of December next preceding;

(b) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit provided the transactions are equal to or exceed:

(i) With respect to nonlife insurers, the lesser of three percent (3%) of the insurer’s admitted assets or twenty-five percent (25%) of surplus as regards policyholders as of the 31st day of December next preceding;

(ii) With respect to life insurers, three percent (3%) of the insurer’s admitted assets as of the 31st day of December next preceding;
(c) Reinsurance agreements or modifications thereto, including:

(i) All reinsurance pooling agreements;

(ii) Agreements in which the reinsurance premium or a change in the insurer’s liabilities, or the projected reinsurance premium or a change in the insurer’s liabilities in any of the next three years, equals or exceeds five percent (5%) of the insurer’s surplus as regards policyholders, as of the 31st day of December next preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a non-affiliate, if an agreement or understanding exists between the insurer and non-affiliate that any portion of the assets will be transferred to one or more affiliates of the insurer;

(d) All management agreements, service contracts, tax allocation agreements, guarantees and all cost-sharing arrangements;

(e) Guarantees when made by a domestic insurer; provided, however, that a guarantee which is quantifiable as to amount is not subject to the notice requirements of this paragraph unless it exceeds the lesser of one-half of one percent (.5%) of the insurer’s admitted assets or ten percent (10%) of surplus as regards policyholders as of the 31st day of December next preceding. Further, all guarantees which are not quantifiable as to amount are subject to the notice requirements of this paragraph;

(f) Direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount which, together with its present holdings in such investments, exceeds two and one-half percent (2.5%) of the insurer’s surplus to policyholders. Direct or indirect acquisitions or investments in subsidiaries acquired pursuant to Section 2 of this Act (or authorized under any other section of this Chapter), or in non-subsidiary insurance affiliates that are subject to the provisions of this Act, are exempt from this requirement; and

(g) Any material transactions, specified by regulation, which the commissioner determines may adversely affect the interests of the insurer’s policyholders.

Nothing in this paragraph shall be deemed to authorize or permit any transactions which, in the case of an insurer not a member of the same insurance holding company system, would be otherwise contrary to law.

(3) A domestic insurer may not enter into transactions which are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the commissioner determines that separate transactions were entered into over any twelve-month period for that purpose, the commissioner may exercise his or her authority under Section 11.

(4) The commissioner, in reviewing transactions pursuant to Subsection A(2), shall consider whether the transactions comply with the standards set forth in Subsection A(1) and whether they may adversely affect the interests of policyholders.

(5) The commissioner shall be notified within thirty (30) days of any investment of the domestic insurer in any one corporation if the total investment in the corporation by the insurance holding company system exceeds ten percent (10%) of the corporation’s voting securities.

(6) Supervision, seizure, conservatorship or receivership proceedings.
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(a) Any affiliate that is party to an agreement or contract with a domestic insurer that is subject to Subsection A(2)(d) shall be subject to the jurisdiction of any supervision, seizure, conservatorship or receivership proceedings against the insurer and to the authority of any supervisor, conservator, rehabilitator or liquidator for the insurer appointed pursuant to [supervision and receivership acts] for the purpose of interpreting, enforcing and overseeing the affiliate’s obligations under the agreement or contract to perform services for the insurer that:

(i) are an integral part of the insurer’s operations, including, but not limited to management, administrative, accounting, data processing, marketing, underwriting, claims handling, investment or any other similar functions; or

(ii) are essential to the insurer’s ability to fulfill its obligations under insurance policies.

(b) The commissioner may require that an agreement or contract pursuant to Subsection A(2)(d) for the provision of services described in (i) and (ii) above specify that the affiliate consents to the jurisdiction as set forth in this Section 5A(6).

Drafting Note: Section 5A(6) is not intended to subject affiliates, in particular those that may be subject to regulation in other jurisdictions, to the general jurisdiction of pending supervision, seizure, conservatorship or receivership court proceedings in this state or the general authority of a supervisor, conservator or receiver for a domestic insurer. Rather, the jurisdiction and authority conferred by this provision is limited to ensuring that a domestic insurer continues to receive essential services from an affiliate that it has contracted with to provide such services, in accordance with the terms of the contract and applicable law, during the aforementioned proceedings. Section 5A(6)(b) gives the commissioner discretion to require documentation of an affiliate’s consent to this jurisdiction in the agreement or contract. In determining appropriate circumstances when a commissioner may require such provision, the commissioner should consider the scope and materiality to the domestic insurer of the contract, the nature of the holding company system, and whether examination or investigation of the domestic insurer warrants requirement of such a provision.

B. Dividends and other Distributions

No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until thirty (30) days after the commissioner has received notice of the declaration thereof and has not within that period disapproved the payment, or until the commissioner has approved the payment within the thirty-day period.

For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding twelve (12) months exceeds the lesser of:

(1) Ten percent (10%) of the insurer’s surplus as regards policyholders as of the 31st day of December next preceding; or

(2) The net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the twelve-month period ending the 31st day of December next preceding, but shall not include pro rata distributions of any class of the insurer’s own securities.

In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two (2) calendar years that has not already been paid out as dividends. This carry-forward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the commissioner’s approval, and the declaration shall confer no rights upon shareholders until (1) the commissioner has approved the payment of the dividend or distribution or (2) the commissioner has not disapproved payment within the thirty-day period referred to above.
C. Management of Domestic Insurers Subject To Registration.

(1) Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with this Act.

(2) Nothing in this section shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property or services with one or more other persons under arrangements meeting the standards of Section 5A(1).

(3) Not less than one-third of the directors of a domestic insurer, and not less than one-third of the members of each committee of the board of directors of any domestic insurer shall be persons who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or entity. At least one such person must be included in any quorum for the transaction of business at any meeting of the board of directors or any committee thereof.

(4) The board of directors of a domestic insurer shall establish one or more committees comprised solely of directors who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or any such entity. The committee or committees shall have responsibility for nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer and recommending to the board of directors the selection and compensation of the principal officers.

(5) The provisions of Paragraphs (3) and (4) shall not apply to a domestic insurer if the person controlling the insurer, such as an insurer, a mutual insurance holding company, or a publicly held corporation, has a board of directors and committees thereof that meet the requirements of Paragraphs (3) and (4) with respect to such controlling entity.

(6) An insurer may make application to the commissioner for a waiver from the requirements of this subsection, if the insurer’s annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, is less than $300,000,000. An insurer may also make application to the commissioner for a waiver from the requirements of this subsection based upon unique circumstances. The commissioner may consider various factors including, but not limited to, the type of business entity, volume of business written, availability of qualified board members, or the ownership or organizational structure of the entity.

D. Adequacy of Surplus. For purposes of this Act, in determining whether an insurer’s surplus as regards policyholders is reasonable in relation to the insurer’s outstanding liabilities and adequate to meet its financial needs, the following factors, among others, shall be considered:

(1) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria;

(2) The extent to which the insurer’s business is diversified among several lines of insurance;

(3) The number and size of risks insured in each line of business;

(4) The extent of the geographical dispersion of the insurer’s insured risks;

(5) The nature and extent of the insurer’s reinsurance program;
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(6) The quality, diversification and liquidity of the insurer’s investment portfolio;

(7) The recent past and projected future trend in the size of the insurer’s investment portfolio;

(8) The surplus as regards policyholders maintained by other comparable insurers;

(9) The adequacy of the insurer’s reserves; and

(10) The quality and liquidity of investments in affiliates. The commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the judgment of the commissioner the investment so warrants.

Section 6. Examination

A. Power of Commissioner. Subject to the limitation contained in this section and in addition to the powers which the commissioner has under Sections [insert applicable sections] relating to the examination of insurers, the commissioner shall have the power to examine any insurer registered under Section 4 and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

B. Access to Books and Records.

(1) The commissioner may order any insurer registered under Section 4 to produce such records, books, or other information papers in the possession of the insurer or its affiliates as are reasonably necessary to determine compliance with this Chapter.

(2) To determine compliance with this Chapter, the commissioner may order any insurer registered under Section 4 to produce information not in the possession of the insurer if the insurer can obtain access to such information pursuant to contractual relationships, statutory obligations, or other method. In the event the insurer cannot obtain the information requested by the commissioner, the insurer shall provide the commissioner a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of information. Whenever it appears to the commissioner that the detailed explanation is without merit, the commissioner may require, after notice and hearing, the insurer to pay a penalty of $[insert amount] for each day’s delay, or may suspend or revoke the insurer’s license.

C. Use of Consultants. The commissioner may retain at the registered insurer’s expense such attorneys, actuaries, accountants and other experts not otherwise a part of the commissioner’s staff as shall be reasonably necessary to assist in the conduct of the examination under Subsection A above. Any persons so retained shall be under the direction and control of the commissioner and shall act in a purely advisory capacity.

D. Expenses. Each registered insurer producing for examination records, books and papers pursuant to Subsection A above shall be liable for and shall pay the expense of examination in accordance with Section [insert applicable section].

E. Compelling Production. In the event the insurer fails to comply with an order, the commissioner shall have the power to examine the affiliates to obtain the information. The commissioner shall also have the power to issue subpoenas, to administer oaths, and to examine under oath any person for purposes of determining compliance with this section. Upon the failure or refusal of any person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court. Every person shall be obliged to attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the state. He or she shall be entitled to the same fees and mileage, if claimed, as a witness in [insert appropriate statutory reference to trial-level court in that state], which fees, mileage, and actual expense, if any, necessarily incurred in securing the attendance of witnesses, and their testimony, shall be itemized and charged against, and be
Section 7. Supervisory Colleges

A. Power of Commissioner. With respect to any insurer registered under Section 4, and in accordance with Subsection C below, the commissioner shall also have the power to participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance by the insurer with this Chapter. The powers of the commissioner with respect to supervisory colleges include, but are not limited to, the following:

1. Initiating the establishment of a supervisory college;
2. Clarifying the membership and participation of other supervisors in the supervisory college;
3. Clarifying the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor;
4. Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and processes for information sharing; and
5. Establishing a crisis management plan.

B. Expenses. Each registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the commissioner’s participation in a supervisory college in accordance with Subsection C below, including reasonable travel expenses. For purposes of this section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates, and the commissioner may establish a regular assessment to the insurer for the payment of these expenses.

C. Supervisory College. In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management and governance processes, and as part of the examination of individual insurers in accordance with Section 6, the commissioner may participate in a supervisory college with other regulators charged with supervision of the insurer or its affiliates, including other state, federal and international regulatory agencies. The commissioner may enter into agreements in accordance with Section 8C providing the basis for cooperation between the commissioner and the other regulatory agencies, and the activities of the supervisory college. Nothing in this section shall delegate to the supervisory college the authority of the commissioner to regulate or supervise the insurer or its affiliates within its jurisdiction.

Section 7.1. Group-wide Supervision of Internationally Active Insurance Groups

A. The commissioner is authorized to act as the group-wide supervisor for any internationally active insurance group in accordance with the provisions of this section. However, the commissioner may otherwise acknowledge another regulatory official as the group-wide supervisor where the internationally active insurance group:

1. Does not have substantial insurance operations in the United States;
2. Has substantial insurance operations in the United States, but not in this state; or
3. Has substantial insurance operations in the United States and this state, but the commissioner has determined pursuant to the factors set forth in Subsections B and F that the other regulatory official is the appropriate group-wide supervisor.

An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the commissioner make a determination or acknowledgment as to a group-wide supervisor pursuant to this section.

B. In cooperation with other state, federal and international regulatory agencies, the commissioner will...
identify a single group-wide supervisor for an internationally active insurance group. The commissioner may determine that the commissioner is the appropriate group-wide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in this state. However, the commissioner may acknowledge that a regulatory official from another jurisdiction is the appropriate group-wide supervisor for the internationally active insurance group. The commissioner shall consider the following factors when making a determination or acknowledgment under this subsection:

1. The place of domicile of the insurers within the internationally active insurance group that hold the largest share of the group’s written premiums, assets or liabilities;
2. The place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group;
3. The location of the executive offices or largest operational offices of the internationally active insurance group;
4. Whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the commissioner determines to be:
   a. Substantially similar to the system of regulation provided under the laws of this state, or otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials; and
5. Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the commissioner with reasonably reciprocal recognition and cooperation.

However, a commissioner identified under this section as the group-wide supervisor may determine that it is appropriate to acknowledge another supervisor to serve as the group-wide supervisor. The acknowledgment of the group-wide supervisor shall be made after consideration of the factors listed in Paragraphs (1) through (5) above, and shall be made in cooperation with and subject to the acknowledgment of other regulatory officials involved with supervision of members of the internationally active insurance group, and in consultation with the internationally active insurance group.

C. Notwithstanding any other provision of law, when another regulatory official is acting as the group-wide supervisor of an internationally active insurance group, the commissioner shall acknowledge that regulatory official as the group-wide supervisor. However, in the event of a material change in the internationally active insurance group that results in:

1. The internationally active insurance group’s insurers domiciled in this state holding the largest share of the group’s premiums, assets or liabilities; or
2. This state being the place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group, the commissioner shall make a determination or acknowledgment as to the appropriate group-wide supervisor for such an internationally active insurance group pursuant to Subsection B.

D. Pursuant to Section 6, the commissioner is authorized to collect from any insurer registered pursuant to Section 4 all information necessary to determine whether the commissioner may act as the group-wide supervisor of an internationally active insurance group or if the commissioner may acknowledge another regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to group-wide supervision by the commissioner, the commissioner shall notify the insurer registered pursuant to Section 4 and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group shall have not less than thirty (30) days to provide the commissioner with additional information pertinent to the pending determination. The commissioner shall publish in the [insert name of state administrative record] and on its Internet website the identity of internationally active insurance groups that the commissioner has determined are subject to group-wide supervision by the commissioner.
E. If the commissioner is the group-wide supervisor for an internationally active insurance group, the commissioner is authorized to engage in any of the following group-wide supervision activities:

1. Assess the enterprise risks within the internationally active insurance group to ensure that:
   a. The material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management, and
   b. Reasonable and effective mitigation measures are in place;

2. Request, from any member of an internationally active insurance group subject to the commissioner’s supervision, information necessary and appropriate to assess enterprise risk, including, but not limited to, information about the members of the internationally active insurance group regarding:
   a. Governance, risk assessment and management,
   b. Capital adequacy, and
   c. Material intercompany transactions;

3. Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of such internationally active insurance group that are engaged in the business of insurance;

4. Communicate with other state, federal and international regulatory agencies for members within the internationally active insurance group and share relevant information subject to the confidentiality provisions of Section 8, through supervisory colleges as set forth in Section 7 or otherwise;

5. Enter into agreements with or obtain documentation from any insurer registered under Section 4, any member of the internationally active insurance group, and any other state, federal and international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the commissioner's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state; and

6. Other group-wide supervision activities, consistent with the authorities and purposes enumerated above, as considered necessary by the commissioner.

F. If the commissioner acknowledges that another regulatory official from a jurisdiction that is not accredited by the NAIC is the group-wide supervisor, the commissioner is authorized to reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor, provided that:

1. The commissioner's cooperation is in compliance with the laws of this state; and

2. The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the commissioner's activities as a group-wide supervisor for other internationally active insurance groups where applicable. Where such recognition and cooperation is not reasonably reciprocal, the commissioner is authorized to refuse recognition and cooperation.

G. The commissioner is authorized to enter into agreements with or obtain documentation from any insurer registered under Section 4, any affiliate of the insurer, and other state, federal and international regulatory
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agencies for members of the internationally active insurance group, that provide the basis for or otherwise clarify a regulatory official's role as group-wide supervisor.

H. The commissioner may promulgate regulations necessary for the administration of this section.

I. A registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the commissioner's participation in the administration of this section, including the engagement of attorneys, actuaries and any other professionals and all reasonable travel expenses.

Section 8. Confidential Treatment

A. Documents, materials or other information in the possession or control of the Department of Insurance that are obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to Section 6 and all information reported or provided to the Department of Insurance pursuant to Section 3B(12) and (13), Section 4, Section 5 and Section 7.1 are recognized by this state as being proprietary and to contain trade secrets, and shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer to which it pertains unless the commissioner, after giving the insurer and its affiliates who would be affected thereby notice and opportunity to be heard, determines that the interest of policyholders, shareholders or the public will be served by the publication thereof, in which event the commissioner may publish all or any part in such manner as may be deemed appropriate.

(1) For purposes of the information reported and provided to the Department of Insurance pursuant to Section 4L(2), the commissioner shall maintain the confidentiality of the group capital calculation and group capital ratio produced within the calculation and any group capital information received from an insurance holding company supervised by the Federal Reserve Board or any U.S. group wide supervisor.

(2) For purposes of the information reported and provided to the [Department of Insurance] pursuant to Section 4L(3), the commissioner shall maintain the confidentiality of the liquidity stress test results and supporting disclosures and any liquidity stress test information received from an insurance holding company supervised by the Federal Reserve Board and non-U.S. group wide supervisors.

Drafting note: This group capital calculation and group capital ratio includes confidential information and filings received from insurance holding companies supervised by the Federal Reserve Board. Similarly, the liquidity stress test may include confidential information and filings received from insurance holding companies supervised by the Federal Reserve Board. The confidential treatment afforded to group capital calculation filings includes any Federal Reserve Board group capital filings and information.

B. Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner or with whom such documents, materials or other information are shared pursuant to this Act shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to Subsection A.

C. In order to assist in the performance of the commissioner’s duties, the commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection A, including proprietary and trade secret documents and materials with other state, federal and international regulatory agencies, with the NAIC, and with any third-party consultants designated by the commissioner, with state, federal, and international law enforcement authorities, including members of any supervisory college described in Section 7, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material or other information, and has verified in writing the legal authority to maintain confidentiality.
(2) Notwithstanding paragraph (1) above, the commissioner may only share confidential and privileged documents, material, or information reported pursuant to Section 4L(1) with commissioners of states having statutes or regulations substantially similar to Subsection A and who have agreed in writing not to disclose such information.

(3) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, including propriety and trade-secret information from the NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(4) Shall enter into written agreements with the NAIC and any third-party consultant designated by the commissioner governing sharing and use of information provided pursuant to this Act consistent with this subsection that shall:

(a) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant designated by the commissioner pursuant to this Act, including procedures and protocols for sharing by the NAIC with other state, federal or international regulators. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the documents, materials or other information and has verified in writing the legal authority to maintain such confidentiality;

(b) Specify that ownership of information shared with the NAIC or a third party consultant pursuant to this Act remains with the commissioner and the NAIC’s or a third-party consultant’s, as designated by the commissioner, use of the information is subject to the direction of the commissioner;

(c) Excluding documents, material or information reported pursuant to Section 4L(3), prohibit the NAIC or third-party consultant designated by the commissioner from storing the information shared pursuant to this Act in a permanent database after the underlying analysis is completed;

(d) Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third-party consultant designated by the commissioner pursuant to this Act is subject to a request or subpoena to the NAIC or a third-party consultant designated by the commissioner for disclosure or production; and

(e) Require the NAIC or a third-party consultant designated by the commissioner to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant designated by the commissioner may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant designated by the commissioner pursuant to this Act.

(f) For documents, material or information reporting pursuant to Section 4L(3), in the case of an agreement involving a third-party consultant, provide for notification of the identity of the consultant to the applicable insurers.

D. The sharing of information by the commissioner pursuant to this Act shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution and enforcement of the provisions of this Act.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Subsection C.

F. Documents, materials or other information in the possession or control of the NAIC or a third-party...
consultant designated by the commissioner pursuant to this Act shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

G. The group capital calculation and resulting group capital ratio required under Section 4L(2) and the liquidity stress test along with its results and supporting disclosures required under Section 4L(3) are regulatory tools for assessing group risks and capital adequacy and group liquidity risks, respectively, and are not intended as a means to rank insurers or insurance holding company systems generally. Therefore, except as otherwise may be required under the provisions of this Act, the making, publishing, disseminating, circulating or placing before the public, or causing directly or indirectly to be made, published, disseminated, circulated or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station or any electronic means of communication available to the public, or in any other way as an advertisement, announcement or statement containing a representation or statement with regard to the group capital calculation, group capital ratio, the liquidity stress test results, or supporting disclosures for the liquidity stress test of any insurer or any insurer group, or of any component derived in the calculation by any insurer, broker, or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; provided, however, that if any materially false statement with respect to the group capital calculation, resulting group capital ratio, an inappropriate comparison of any amount to an insurer’s or insurance group’s group capital calculation or resulting group capital ratio, liquidity stress test result, supporting disclosures for the liquidity stress test, or an inappropriate comparison of any amount to an insurer’s or insurance group’s liquidity stress test result or supporting disclosures is published in any written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity of such statement or the inappropriateness, as the case may be, then the insurer may publish announcements in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

Drafting Note: In Section 8C(4) above, the exclusions in sub-items (ii), (iii) and (vi) are the result of the Liquidity Stress Test primary purpose, which is to be used as a tool for assessing macroprudential risks by the NAIC Financial Stability Task Force assisted by NAIC staff, including trend analysis over time. Provisions against the NAIC owning the information, databasing the results and disclosures, and obtaining written consent from the insurer when a consultant is involved were deemed inappropriate.

Section 9. Rules and Regulations

The commissioner may, upon notice and opportunity for all interested persons to be heard, issue such rules, regulations and orders as shall be necessary to carry out the provisions of this Act.

Section 10. Injunctions, Prohibitions Against Voting Securities, Sequestration of Voting Securities

A. Injunctions. Whenever it appears to the commissioner that any insurer or any director, officer, employee or agent thereof has committed or is about to commit a violation of this Act or of any rule, regulation or order issued by the commissioner hereunder, the commissioner may apply to the [insert title] Court for the county in which the principal officer of the insurer is located or if the insurer has no office in this state then to the [insert title] Court for [insert county] County for an order enjoining the insurer or director, officer, employee or agent thereof from violating or continuing to violate this Act or any rule, regulation or order, and for such other equitable relief as the nature of the case and the interest of the insurer’s policyholders, creditors and shareholders or the public may require.

B. Voting of Securities; When Prohibited. No security which is the subject of any agreement or arrangement regarding acquisition, or which is acquired or to be acquired, in contravention of the provisions of this Act or of any rule, regulation or order issued by the commissioner hereunder may be voted at any shareholder’s meeting, or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though the securities were not issued and outstanding; but no action taken at any such meeting shall be invalidated by the voting of the securities, unless the action would materially affect control of the insurer or unless the courts of this state have so ordered. If an insurer or the commissioner has reason to believe that any security of the insurer has been or is about to be acquired in contravention of the provisions of this Act or of any rule, regulation or order issued by the commissioner hereunder; the insurer or the commissioner may apply to the [insert title] Court for the
county in which the insurer has its principal place of business to enjoin any offer, request, invitation, agreement or acquisition made in contravention of Section 3 or any rule, regulation or order issued by the commissioner thereunder to enjoin the voting of any security so acquired, to void any vote of the security already cast at any meeting of shareholders and for such other equitable relief as the nature of the case and the interest of the insurer’s policyholders, creditor and shareholders or the public may require.

C. Sequestration of Voting Securities. In any case where a person has acquired or is proposing to acquire any voting securities in violation of this Act or any rule, regulation or order issued by the commissioner hereunder, the [insert title] Court for [insert county] County or the [insert title] Court for the county in which the insurer has its principal place of business may, on such notice as the court deems appropriate, upon the application of the insurer or the commissioner, seize or sequester any voting securities of the insurer owned directly or indirectly by the person, and issue such order as may be appropriate to effectuate the provisions of this Act.

Notwithstanding any other provisions of law, for the purposes of this Act the situs of the ownership of the securities of domestic insurers shall be deemed to be in this state.

Section 11. Sanctions

A. Any insurer failing, without just cause, to file any registration statement as required in this Act shall be required, after notice and hearing, to pay a penalty of $[insert amount] for each day’s delay, to be recovered by the commissioner of Insurance and the penalty so recovered shall be paid into the General Revenue Fund of this state. The maximum penalty under this section is $[insert amount]. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

B. Every director or officer of an insurance holding company system who knowingly violates, participates in, or assents to, or who knowingly shall permit any of the officers or agents of the insurer to engage in transactions or make investments which have not been properly reported or submitted pursuant to Section 4A, 5A(2), or 5B, or which violate this Act, shall pay, in their individual capacity, a civil forfeiture of not more than $[insert amount] per violation, after notice and hearing before the commissioner. In determining the amount of the civil forfeiture, the commissioner shall take into account the appropriateness of the forfeiture with respect to the gravity of the violation, the history of previous violations, and such other matters as justice may require.

C. Whenever it appears to the commissioner that any insurer subject to this Act or any director, officer, employee or agent thereof has engaged in any transaction or entered into a contract which is subject to Section 5 of this Act and which would not have been approved had the approval been requested, the commissioner may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and hearing the commissioner may also order the insurer to void any contracts and restore the status quo if the action is in the best interest of the policyholders, creditors or the public.

D. Whenever it appears to the commissioner that any insurer or any director, officer, employee or agent thereof has committed a willful violation of this Act, the commissioner may cause criminal proceedings to be instituted by the [insert title] Court for the county in which the principal office of the insurer is located or if the insurer has no office in this state, then by the [insert county] Court for [insert title] County against the insurer or the responsible director, officer, employee or agent thereof. Any insurer which willfully violates this Act may be fined not more than $[insert amount]. Any individual who willfully violates this Act may be fined in his or her individual capacity not more than $[insert amount] or be imprisoned for not more than one to three (3) years or both.

E. Any officer, director or employee of an insurance holding company system who willfully and knowingly subscribes to or makes or causes to be made any false statements or false reports or false filings with the intent to deceive the commissioner in the performance of his or her duties under this Act, upon conviction shall be imprisoned for not more than [insert amount] years or fined $[insert amount] or both. Any fines imposed shall be paid by the officer, director or employee in his or her individual capacity.

F. Whenever it appears to the commissioner that any person has committed a violation of Section 3 of this Act
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and which prevents the full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with [insert appropriate statutory reference related to orders of supervision.]

Section 12. Receivership

Whenever it appears to the commissioner that any person has committed a violation of this Act which so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, shareholders or the public, then the commissioner may proceed as provided in Section [insert applicable section] of this Chapter to take possession of the property of the domestic insurer and to conduct its business.

Section 13. Recovery

A. If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer, (i) from any parent corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions (other than distributions of shares of the same class of stock) paid by the insurer on its capital stock, or (ii) any payment in the form of a bonus, termination settlement or extraordinary lump sum salary adjustment made by the insurer or its subsidiary to a director, officer or employee, where the distribution or payment pursuant to (i) or (ii) is made at any time during the one year preceding the petition for liquidation, conservation or rehabilitation, as the case may be, subject to the limitations of Subsections B, C, and D of this section.

B. No distribution shall be recoverable if the parent or affiliate shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

C. Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time the distributions were paid shall be liable up to the amount of distributions or payments under Subsection A which the person received. Any person who otherwise controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions that would have been received if they had been paid immediately. If two (2) or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

D. The maximum amount recoverable under this section shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.

E. To the extent that any person liable under Subsection C of this section is insolvent or otherwise fails to pay claims due from it, its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from the parent corporation or holding company or person who otherwise controlled it.

Section 14. Revocation, Suspension, or Nonrenewal of Insurer’s License

Whenever it appears to the commissioner that any person has committed a violation of this Act which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the commissioner may, after giving notice and an opportunity to be heard, suspend, revoke or refuse to renew the insurer’s license or authority to do business in this state for such period as the commissioner finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusions of law.

Section 15. Judicial Review, Mandamus

A. Any person aggrieved by any act, determination, rule, regulation or order or any other action of the commissioner pursuant to this Act may appeal to the [insert title] Court for [insert county] County. The court shall conduct its review without a jury and by trial de novo, except that if all parties, including the commissioner, so stipulate, the review shall be confined to the record. Portions of the record may be
introduced by stipulation into evidence in a trial de novo as to those parties so stipulating.

B. The filing of an appeal pursuant to this section shall stay the application of any rule, regulation, order or other action of the commissioner to the appealing party unless the court, after giving the party notice and an opportunity to be heard, determines that a stay would be detrimental to the interest of policyholders, shareholders, creditors or the public.

C. Any person aggrieved by any failure of the commissioner to act or make a determination required by this Act may petition the [insert title] Court for [insert county] County for a writ in the nature of a mandamus or a peremptory mandamus directing the commissioner to act or make a determination.

Section 16. Conflict with Other Laws

All laws and parts of laws of this state inconsistent with this Act are hereby superseded with respect to matters covered by this Act.

Section 17. Separability of Provisions

If any provision of this Act or the application thereof to any person or circumstances is held invalid, the invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provisions or application, and for this purpose the provisions of this Act are separable.

Section 18. Effective Date

This Act shall take effect thirty (30) days from its passage.
Alternative Section 1. Findings

A. It is hereby found and declared that it may not be inconsistent with the public interest and the interest of policyholders and shareholders to permit insurers to:

1. Engage in activities which would enable them to make better use of management skills and facilities;

2. Diversify into new lines of business through acquisition or organization of subsidiaries;

3. Have free access to capital markets which could provide funds for insurers to use in diversification programs;

4. Implement sound tax planning conclusions; and

5. Serve the changing needs of the public and adapt to changing conditions of the social, economic and political environment, so that insurers are able to compete effectively and to meet the growing public demand for institutions capable of providing a comprehensive range of financial services.

B. It is further found and declared that the public interest and the interests of policyholders and shareholders are or may be adversely affected when:

1. Control of an insurer is sought by persons who would utilize such control adversely to the interests of policyholders or shareholders;

2. Acquisition of control of an insurer would substantially lessen competition or create a monopoly in the insurance business in this state;

3. An insurer which is part of an insurance holding company system is caused to enter into transactions or relationships with affiliated companies on terms which are not fair and reasonable; or

4. An insurer pays dividends to shareholders which jeopardize the financial condition of such insurers.

C. It is hereby declared that the policies and purposes of this Act are to promote the public interest by:

1. Facilitating the achievement of the objectives enumerated in Subsection A;

2. Requiring disclosure of pertinent information relating to changes in control of an insurer;

3. Requiring disclosure by an insurer of material transactions and relationships between the insurer and its affiliates, including certain dividends to shareholders paid by the insurer; and

4. Providing standards governing material transactions between the insurer and its affiliates.

D. It is further declared that it is desirable to prevent unnecessary multiple and conflicting regulation of insurers. Therefore, this state shall exercise regulatory authority over domestic insurers and unless otherwise provided in this Act, not over nondomestic insurers, with respect to the matters contained herein.
Alternative Section 2. Subsidiaries of Insurers

A. Authorization. Any domestic insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries engaged in the following kinds of business:

(1) Any kind of insurance business authorized by the jurisdiction in which it is incorporated;

(2) Acting as an insurance broker or as an insurance agent for its parent or for any of its parent’s insurer subsidiaries;

(3) Investing, reinvesting or trading in securities for its own account, that of its parent, a subsidiary of its parent, or an affiliate or subsidiary;

(4) Management of an investment company subject to or registered pursuant to the Investment Company Act of 1940, as amended, including related sales and services;

(5) Acting as a broker-dealer subject to or registered pursuant to the Securities Exchange Act of 1934, as amended;

(6) Rendering investment advice to governments, government agencies, corporations or other organizations or groups;

(7) Rendering other services related to the operations of an insurance business, such as actuarial, loss prevention, safety engineering, data processing, accounting, claims, appraisal and collection services;

(8) Ownership and management of assets which the parent corporation could itself own or manage;

Drafting Note: The aggregate investment by the insurer and its subsidiaries acquired or organized pursuant to this paragraph should not exceed the limitations applicable to such investments by the insurer.

(9) Acting as administrative agent for a governmental instrumentality that is performing an insurance function;

(10) Financing of insurance premiums, agents and other forms of consumer financing;

(11) Any other business activity determined by the commissioner to be reasonably ancillary to an insurance business; and

(12) Owning a corporation or corporations engaged or organized to engage exclusively in one or more of the businesses specified in this section.
INSURANCE HOLDING COMPANY SYSTEM MODEL REGULATION
WITH REPORTING FORMS AND INSTRUCTIONS

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Section 1. Authority

These regulations are promulgated pursuant to the authority granted by Sections [insert applicable sections] and [insert applicable section] of the Insurance Law.

Note: Optional for those states in which similar provisions are normally used.

Section 2. Purpose

The purpose of these regulations is to set forth rules and procedural requirements which the Commissioner deems necessary to carry out the provisions of the NAIC Insurance Holding Company System Regulatory Act [insert applicable sections] of the Insurance Code hereinafter referred to as “the Act.” The information called for by these regulations is hereby declared to be necessary and appropriate in the public interest and for the protection of the policyholders in this State.

Editor’s Note: Insert the title of the chief insurance regulatory official wherever the term “commissioner” appears.
Drafting Note: Optional for those states in which similar provisions are normally used.

Section 3. Severability Clause

If any provision of these regulations, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect other provisions or applications of these regulations which can be given effect without the invalid provision or application, and to that end the provisions of these regulations are severable.

Drafting Note: Optional for those states in which similar provisions are normally used.

Section 4. Forms - General Requirements

A. Forms A, B, C, D, E and F are intended to be guides in the preparation of the statements required by Sections 3, 3.1, 4, and 5 of the Act. They are not intended to be blank forms which are to be filled in. The statements filed shall contain the numbers and captions of all items, but the text of the items may be omitted provided the answers thereto are prepared in such a manner as to indicate clearly the scope and coverage of the items. All instructions, whether appearing under the items of the form or elsewhere therein, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable or the answer thereto is in the negative, an appropriate statement to that effect shall be made.

B. [Insert number] complete copies of each statement including exhibits and all other papers and documents filed as a part thereof, shall be filed with the Commissioner by personal delivery or mail addressed to: Insurance Commissioner of the State of [insert state and address], Attention: [insert name - title]. At least one of the copies shall be signed in the manner prescribed on the form. Unsigned copies shall be conformed. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of the power of attorney or other authority shall also be filed with the statement.

C. If an applicant requests a hearing on a consolidated basis under Section 3D(3) of the Act, in addition to filing the Form A with the commissioner, the applicant shall file a copy of Form A with the National Association of Insurance Commissioners (NAIC) in electronic form.

D. Statements should be prepared electronically. Statements shall be easily readable and suitable for review and reproduction. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies. Statements shall be in the English language and monetary values shall be stated in United States currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency normally shall be converted into United States currency.

Drafting Note: Section 4 may be omitted if it is included as instructions on Forms A, B, C, D, E and F.

Section 5. Forms - Incorporation by Reference, Summaries and Omissions

A. Information required by any item of Form A, Form B, Form D, Form E or Form F may be incorporated by reference in answer or partial answer to any other item. Information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority, or any other document may be incorporated by reference in answer or partial answer to any item of Form A, Form B, Form D, Form E or Form F provided the document is filed as an exhibit to the statement. Excerpts of documents may be filed as exhibits if the documents are extensive. Documents currently on file with the Commissioner which were filed within three (3) years need not be attached as exhibits. References to information contained in exhibits or in documents already on file shall clearly identify the material and shall specifically indicate that such material is to be incorporated by reference in answer to the item. Matter shall not be incorporated by reference in any case where the incorporation would render the statement incomplete, unclear or confusing.
B. Where an item requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the pertinent provisions of the document. In addition to the statement, the summary or outline may incorporate by reference particular parts of any exhibit or document currently on file with the Commissioner which was filed within three (3) years and may be qualified in its entirety by such reference. In any case where two (2) or more documents required to be filed as exhibits are substantially identical in all material respects except as to the parties thereto, the dates of execution, or other details, a copy of only one of the documents need be filed with a schedule identifying the omitted documents and setting forth the material details in which the documents differ from the documents, a copy of which is filed.

Drafting Note: Section 5 may be omitted if it is included as instructions on Forms A, B, D, E, and F.

Section 6. Forms-Information Unknown or Unavailable and Extension of Time to Furnish

If it is impractical to furnish any required information, document or report at the time it is required to be filed, there shall be filed with the Commissioner a separate document:

A. Identifying the information, document or report in question;
B. Stating why the filing thereof at the time required is impractical; and
C. Requesting an extension of time for filing the information, document or report to a specified date. The request for extension shall be deemed granted unless the Commissioner within [XX] days after receipt thereof enters an order denying the request.

Drafting Note: Section 6 may be omitted if it is included as instruction on Forms A, B, C, D, E, and F.

Section 7. Forms - Additional Information and Exhibits

In addition to the information expressly required to be included in Form A, Form B, Form C, Form D, Form E and Form F, the Commissioner may request such further material information, if any, as may be necessary to make the information contained therein not misleading. The person filing may also file such exhibits as it may desire in addition to those expressly required by the statement. The exhibits shall be so marked as to indicate clearly the subject matters to which they refer. Changes to Forms A, B, C, D, E or F shall include on the top of the cover page the phrase: “Change No. [insert number] to” and shall indicate the date of the change and not the date of the original filing.

Drafting Note: Section 7 may be omitted if it included as instructions on Forms A, B, C, D, E, and F.

Section 8. Definitions

A. “Executive officer” means chief executive officer, chief operating officer, chief financial officer, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers under whatever title.

B. “Ultimate controlling person” means that person which is not controlled by any other person.

C. Unless the context otherwise requires, other terms found in these regulations and in Section 1 of the Act are used as defined in the Act. Other nomenclature or terminology is according to the Insurance Code, or industry usage if not defined by the Code.

Drafting Note: If regulation Section 2 is not adopted by the state, the following definition should be added to this section:

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With Reporting Forms and Instructions

Section 9. Subsidiaries of Domestic Insurers

The authority to invest in subsidiaries under Section 2B of the Act is in addition to any authority to invest in subsidiaries which may be contained in any other provision of the Insurance Code.

Section 10. Acquisition of Control - Statement Filing

A person required to file a statement pursuant to Section 3 of the Act shall furnish the required information on Form A, hereby made a part of this regulation. Such person shall also furnish the required information on Form E, hereby made a part of this regulation and described in Section 13 of this regulation.

Section 11. Amendments to Form A

The applicant shall promptly advise the Commissioner of any changes in the information furnished on Form A arising subsequent to the date upon which the information was furnished but prior to the Commissioner’s disposition of the application.

Section 12. Acquisition of Section 3A(4) Insurers

A. If the person being acquired is deemed to be a “domestic insurer” solely because of the provisions of Section 3A(4) of the Act, the name of the domestic insurer on the cover page should be indicated as follows:

“ABC Insurance Company, a subsidiary of XYZ Holding Company.”

B. Where a Section 3A(4) insurer is being acquired, references to “the insurer” contained in Form A shall refer to both the domestic subsidiary insurer and the person being acquired.

Section 13. Pre-Acquisition Notification

If a domestic insurer, including any person controlling a domestic insurer, is proposing a merger or acquisition pursuant to Section 3A(1) of the Act, that person shall file a pre-acquisition notification form, Form E, which was developed pursuant to Section 3.1C(1) of the Act.

Additionally, if a non-domiciliary insurer licensed to do business in this state is proposing a merger or acquisition pursuant to Section 3.1 of the Act, that person shall file a pre-acquisition notification form, Form E. No pre-acquisition notification form need be filed if the acquisition is beyond the scope of Section 3.1 as set forth in Section 3.1B(2).

In addition to the information required by Form E, the Commissioner may wish to require an expert opinion as to the competitive impact of the proposed acquisition.

Section 14. Annual Registration of Insurers - Statement Filing

An insurer required to file an annual registration statement pursuant to Section 4 of the Act shall furnish the required information on Form B, hereby made a part of these regulations.

Section 15. Summary of Registration - Statement Filing

An insurer required to file an annual registration statement pursuant to Section 4 of the Act is also required to furnish information required on Form C, hereby made a part of these regulations.
Section 16. Amendments to Form B

A. An amendment to Form B shall be filed within fifteen (15) days after the end of any month in which there is a material change to the information provided in the annual registration statement.

B. Amendments shall be filed in the Form B format with only those items which are being amended reported. Each amendment shall include at the top of the cover page “Amendment No. [insert number] to Form B for [insert year]” and shall indicate the date of the change and not the date of the original filings.

Drafting Note: Section 16 may be omitted if Section 5A(2) of the Model Act has been adopted and amendments to the registration statement are therefore not required by the Act.

Section 17. Alternative and Consolidated Registrations

A. Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers which are required to register under Section 4 of the Act. A registration statement may include information not required by the Act regarding any insurer in the insurance holding company system even if the insurer is not authorized to do business in this State. In lieu of filing a registration statement on Form B, the authorized insurer may file a copy of the registration statement or similar report which it is required to file in its State of domicile, provided:

(1) The statement or report contains substantially similar information required to be furnished on Form B; and

(2) The filing insurer is the principal insurance company in the insurance holding company system.

B. The question of whether the filing insurer is the principal insurance company in the insurance holding company system is a question of fact and an insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer, shall set forth a brief statement of facts which will substantiate the filing insurer’s claim that it, in fact, is the principal insurer in the insurance holding company system.

C. With the prior approval of the Commissioner, an unauthorized insurer may follow any of the procedures which could be done by an authorized insurer under Subsection A above.

D. Any insurer may take advantage of the provisions of Section 4H or 4I of the Act without obtaining the prior approval of the Commissioner. The Commissioner, however, reserves the right to require individual filings if he or she deems such filings necessary in the interest of clarity, ease of administration or the public good.

Section 18. Disclaimers and Termination of Registration

A. A disclaimer of affiliation or a request for termination of registration claiming that a person does not, or will not upon the taking of some proposed action, control another person (hereinafter referred to as the “subject”) shall contain the following information:

(1) The number of authorized, issued and outstanding voting securities of the subject;

(2) With respect to the person whose control is denied and all affiliates of such person, the number and percentage of shares of the subject’s voting securities which are held of record or known to be beneficially owned, and the number of shares concerning which there is a right to acquire, directly or indirectly;

(3) All material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person;

(4) A statement explaining why the person should not be considered to control the subject.
B. A request for termination of registration shall be deemed to have been granted unless the Commissioner, within thirty (30) days after receipt of the request, notifies the registrant otherwise.

Section 19. Transactions Subject to Prior Notice - Notice Filing

A. An insurer required to give notice of a proposed transaction pursuant to Section 5 of the Act shall furnish the required information on Form D, hereby made a part of these regulations.

B. Agreements for cost sharing services and management services shall at a minimum and as applicable:

1. Identify the person providing services and the nature of such services;
2. Set forth the methods to allocate costs;
3. Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the Accounting Practices and Procedures Manual;
4. Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement;
5. State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance;
6. Define records and data of the insurer to include all records and data developed or maintained under or related to the agreement, that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records or similar records within the possession, custody or control of the affiliate; and

Drafting Note: The “at no additional cost to the insurer” language is not intended to prohibit recovery of the fair and reasonable cost associated with transferring records and data to the insurer. Since records and data of the insurer are the property of the insurer, the insurer should not pay a cost to segregate commingled records and data from other data of the affiliate.

7. Specify that all records and data of the insurer are and remain the property of the insurer, and:
   a. are subject to control of the insurer,
   b. are identifiable, and
   c. are segregated from all other persons’ records and data, or are readily capable of segregation at no additional cost to the insurer;

8. State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer;
9. Include standards for termination of the agreement with and without cause;
10. Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services and for any actions by the affiliate that violate provisions of the agreement required in Subsections 19B(11), 19B(12), 19B(13), 19B(14) and 19B(15) of this regulation;
11. Specify that if the insurer is placed in supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts],
   a. all of the rights of the insurer under the agreement extend to the receiver or commissioner to the extent permitted by [law of the state],
   b. all records and data of the insurer shall be identifiable and segregated from all other
persons’ records and data or readily capable of segregation at no additional cost to the receiver or the commissioner;

Drafting Note: The “at no additional cost to the receiver or the commissioner” language is not intended to prohibit recovery of the fair and reasonable cost associated with transferring records and data to the receiver or the commissioner. Since records and data of the insurer are the property of the insurer, the receiver or commissioner should not pay a cost to segregate commingled records and data from other data of the affiliate.

(c) a complete set of records and data of the insurer will immediately be made available to the receiver or the commissioner, shall be made available in a usable form, and shall be turned over to the receiver or commissioner immediately upon the receiver or the commissioner’s request, and the cost to transfer data to the receiver or the commissioner shall be fair and reasonable; and,

Drafting Note: The fair and reasonable cost to transfer data to the receiver or commissioner refers to the cost associated with physically or electronically transferring records and data files to the receiver or commissioner. This cost does not include costs to separate commingled data and records that should have been segregated or readily capable of segregation.

(d) The affiliated person(s) will make available all employees essential to the operations of the insurer and the services associated therewith for the immediate continued performance of the essential services ordered or directed by the receiver or commissioner;

(12) Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts];

(13) Specify that the affiliate will provide the essential services for a minimum period of time [specified in the agreement] after termination of the agreement, if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts], as ordered or directed by the receiver or commissioner. Performance of the essential services will continue to be provided without regard to pre-receivership unpaid fees, so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, commissioner or supervising court;

(14) Specify that the affiliate will continue to maintain any systems, programs or other infrastructure notwithstanding supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts], and will make them available to the receiver or commissioner as ordered or directed by the receiver or commissioner. Performance of the essential services will continue to be provided without regard to pre-receivership unpaid fees, so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, commissioner or supervising court;

(15) Specify that, in furtherance of the cooperation between the receiver and the affected guaranty association(s) and subject to the receiver’s authority over the insurer, if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts], and portions of the insurer’s policies or contracts are eligible for coverage by one or more guaranty associations, the affiliate’s commitments under Subsections 19B(11), 19B(12), 19B(13) and 19B(14) of this regulation will extend to such guaranty association(s).

Section 20. Enterprise Risk Report

The ultimate controlling person of an insurer required to file an enterprise risk report pursuant to Section 4L(1) of the Act shall furnish the required information on Form F, hereby made a part of these regulations.

Section 21. Group Capital Calculation

A. Where an insurance holding company system has previously filed the annual group capital calculation at least once, the lead state commissioner has the discretion to exempt the ultimate controlling person from filing the annual group capital calculation if the lead state commissioner makes a determination based upon that filing that the insurance holding company system meets all of the following criteria:
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(1) Has annual direct written and unaffiliated assumed premium (including international direct and assumed premium), but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than $1,000,000,000;

(2) Has no insurers within its holding company structure that are domiciled outside of the United States or one of its territories;

(3) Has no banking, depository or other financial entity that is subject to an identified regulatory capital framework within its holding company structure;

(4) The holding company system attests that there are no material changes in the transactions between insurers and non-insurers in the group that have occurred since the last filing of the annual group capital; and

(5) The non-insurers within the holding company system do not pose a material financial risk to the insurer’s ability to honor policyholder obligations.

B. Where an insurance holding company system has previously filed the annual group capital calculation at least once, the lead state commissioner has the discretion to accept in lieu of the group capital calculation a limited group capital filing if:

(1) The insurance holding company system has annual direct written and unaffiliated assumed premium (including international direct and assumed premium), but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than $1,000,000,000; and all of the following additional criteria are met:

(a) Has no insurers within its holding company structure that are domiciled outside of the United States or one of its territories;

(b) Does not include a banking, depository or other financial entity that is subject to an identified regulatory capital framework; and

(c) The holding company system attests that there are no material changes in transactions between insurers and non-insurers in the group that have occurred since the last filing of the report to the lead state commissioner and the non-insurers within the holding company system do not pose a material financial risk to the insurers ability to honor policyholder obligations.

C. For an insurance holding company that has previously met an exemption with respect to the group capital calculation pursuant Section 21A or 21B of this regulation, the lead state commissioner may require at any time the ultimate controlling person to file an annual group capital calculation, completed in accordance with the NAIC Group Capital Calculation Instructions, if any of the following criteria are met:

(1) Any insurer within the insurance holding company system is in a Risk-Based Capital action level event as set forth in [insert cross-reference to appropriate section of Risk-Based Capital (RBC) Model Act] or a similar standard for a non-U.S. insurer; or

(2) Any insurer within the insurance holding company system meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in [insert cross-reference to appropriate section of Model Regulation to Define Standards and Commissioner’s Authority for Companies Deemed to be in Hazardous Financial Condition]; or

(3) Any insurer within the insurance holding company system otherwise exhibits qualities of a troubled insurer as determined by the lead state commissioner based on unique circumstances including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests.

D. A non-U.S. jurisdiction is considered to “recognize and accept” the group capital calculation if it satisfies the following criteria:
(1) With respect to the [insert cross-reference to Section 4L(2)(d) of the Model Act]

(a) The non-U.S. jurisdiction recognizes the U.S. state regulatory approach to group supervision and group capital, by providing confirmation by a competent regulatory authority, in such jurisdiction, that insurers and insurance groups whose lead state is accredited by the NAIC under the NAIC Accreditation Program shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction; or

(b) Where no U.S. insurance groups operate in the non-U.S. jurisdiction, that non-U.S. jurisdiction indicates formally in writing to the lead state with a copy to the International Association of Insurance Supervisors that the group capital calculation is an acceptable international capital standard. This will serve as the documentation otherwise required in Section 21D(1)(a).

(2) The non-U.S. jurisdiction provides confirmation by a competent regulatory authority in such jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the lead state commissioner in accordance with a memorandum of understanding or similar document between the commissioner and such jurisdiction, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC. The commissioner shall determine, in consultation with the NAIC Committee Process, if the requirements of the information sharing agreements are in force.

E. A list of non-U.S. jurisdictions that “recognize and accept” the group capital calculation will be published through the NAIC Committee Process:

(1) A list of jurisdictions that “recognize and accept” the group capital calculation pursuant to [insert cross-reference to Sections 4L(2)(d)], is published through the NAIC Committee Process to assist the lead state commissioner in determining which insurers shall file an annual group capital calculation. The list will clarify those situations in which a jurisdiction is exempted from filing under [insert cross-reference to Sections 4L(2)(d)]. To assist with a determination under 4L(2)(e), the list will also identify whether a jurisdiction that is exempted under either [insert cross-reference to Sections 4L(2)(c) and 4L(2)(d)] requires a group capital filing for any U.S. based insurance group’s operations in that non-U.S. jurisdiction.

(2) For a non-U.S. jurisdiction where no U.S. insurance groups operate, the confirmation provided to meet the requirement of Section 21D(1)(b) will serve as support for recommendation to be published as a jurisdiction that “recognizes and accepts” the group capital calculation through the NAIC Committee Process.

(3) If the lead state commissioner makes a determination pursuant to Section 4L(2)(d) that differs from the NAIC List, the lead state commissioner shall provide thoroughly documented justification to the NAIC and other states.

(4) Upon determination by the lead state commissioner that a non-U.S. jurisdiction no longer meets one or more of the requirements to “recognize and accept” the group capital calculation, the lead state commissioner may provide a recommendation to the NAIC that the non-U.S. jurisdiction be removed from the list of jurisdictions that “recognize and accepts” the group capital calculation.

Section 22. Extraordinary Dividends and Other Distributions

A. Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders shall include the following:
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(1) The amount of the proposed dividend;

(2) The date established for payment of the dividend;

(3) A statement as to whether the dividend is to be in cash or other property and, if in property, a description thereof, its cost, and its fair market value together with an explanation of the basis for valuation;

(4) A copy of the calculations determining that the proposed dividend is extraordinary. The work paper shall include the following information:

   a) The amounts, dates and form of payment of all dividends or distributions (including regular dividends but excluding distributions of the insurer’s own securities) paid within the period of twelve (12) consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year;

   b) Surplus as regards policyholders (total capital and surplus) as of the 31st day of December next preceding;

   c) If the insurer is a life insurer, the net gain from operations for the 12-month period ending the 31st day of December next preceding;

   d) If the insurer is not a life insurer, the net income less realized capital gains for the 12-month period ending the 31st day of December next preceding and the two preceding 12-month periods; and

   e) If the insurer is not a life insurer, the dividends paid to stockholders excluding distributions of the insurer’s own securities in the preceding two (2) calendar years;

(5) A balance sheet and statement of income for the period intervening from the last annual statement filed with the Commissioner and the end of the month preceding the month in which the request for dividend approval is submitted; and

(6) A brief statement as to the effect of the proposed dividend upon the insurer’s surplus and the reasonableness of surplus in relation to the insurer’s outstanding liabilities and the adequacy of surplus relative to the insurer’s financial needs.

B. Subject to Section 5B of the Act, each registered insurer shall report to the Commissioner all dividends and other distributions to shareholders within fifteen (15) business days following the declaration thereof, including the same information required by Subsection A(4).

Section 23. Adequacy of Surplus

The factors set forth in Section 5D of the Act are not intended to be an exhaustive list. In determining the adequacy and reasonableness of an insurer’s surplus no single factor is necessarily controlling. The Commissioner instead will consider the net effect of all of these factors plus other factors bearing on the financial condition of the insurer. In comparing the surplus maintained by other insurers, the Commissioner will consider the extent to which each of these factors varies from company to company and in determining the quality and liquidity of investments in subsidiaries, the Commissioner will consider the individual subsidiary and may discount or disallow its valuation to the extent that the individual investments so warrant.
FORM A

STATEMENT REGARDING THE ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER

____________________________________
Name of Domestic Insurer

BY

____________________________________
Name of Acquiring Person (Applicant)

Filed with the Insurance Department of

_____________________________________________________
(State of domicile of insurer being acquired)

Dated:________________________, 20_____

Name, Title, address and telephone number of Individual to Whom Notices and Correspondence Concerning this Statement Should be Addressed:

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

ITEM 1. METHOD OF ACQUISITION

State the name and address of the domestic insurer to which this application relates and a brief description of how control is to be acquired.

ITEM 2. IDENTITY AND BACKGROUND OF THE APPLICANT

(a) State the name and address of the applicant seeking to acquire control over the insurer.

(b) If the applicant is not an individual, state the nature of its business operations for the past 5 years or for such lesser period as such person and any predecessors thereof shall have been in existence. Briefly describe the business intended to be done by the applicant and the applicant’s subsidiaries.

(c) Furnish a chart or listing clearly presenting the identities of the interrelationships among the applicant and all affiliates of the applicant. Indicate in such chart or listing the percentage of voting securities of each such person which is owned or controlled by the applicant or by any other such person. If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (e.g. corporation, trust, partnership) and the state or other jurisdiction of domicile. If court proceedings involving a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, nature of proceedings and the date when commenced.
ITEM 3. IDENTITY AND BACKGROUND OF INDIVIDUALS ASSOCIATED WITH THE APPLICANT

On the biographical affidavit, include a third party background check, and state the following with respect to (1) the applicant if (s)he is an individual or (2) all persons who are directors, executive officers or owners of 10% or more of the voting securities of the applicant if the applicant is not an individual.

(a) Name and business address.

(b) Present principal business activity, occupation or employment including position and office held and the name, principal business and address of any corporation or other organization in which such employment is carried on.

(c) Material occupations, positions, offices or employment during the last 5 years, giving the starting and ending dates of each and the name, principal business and address of any business corporation or other organization in which each such occupation, position, office or employment was carried on; if any such occupation, position, office or employment required licensing by or registration with any federal, state or municipal governmental agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension or disciplinary proceedings in connection therewith.

(d) Whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last 10 years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case.

ITEM 4. NATURE, SOURCE AND AMOUNT OF CONSIDERATION

(a) Describe the nature, source and amount of funds or other considerations used or to be used in effecting the merger or other acquisition of control. If any part of the same is represented or is to be represented by funds or other consideration borrowed or otherwise obtained for the purpose of acquiring, holding or trading securities, furnish a description of the transaction, the names of the parties thereto, the relationship, if any, between the borrower and the lender, the amounts borrowed or to be borrowed, and copies of all agreements, promissory notes and security arrangements relating thereto.

(b) Explain the criteria used in determining the nature and amount of such consideration.

(c) If the source of the consideration is a loan made in the lender’s ordinary course of business and if the applicant wishes the identity of the lender to remain confidential, he must specifically request that the identity be kept confidential.

ITEM 5. FUTURE PLANS OF INSURER

Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate the insurer, to sell its assets to or merge it with any person or persons or to make any other material change in its business operations or corporate structure or management.

ITEM 6. VOTING SECURITIES TO BE ACQUIRED

State the number of shares of the insurer’s voting securities which the applicant, its affiliates and any person listed in Item 3 plan to acquire, and the terms of the offer, request, invitation, agreement or acquisition, and a statement as to the method by which the fairness of the proposal was arrived at.

ITEM 7. OWNERSHIP OF VOTING SECURITIES

State the amount of each class of any voting security of the insurer which is beneficially owned or concerning which there is a right to acquire beneficial ownership by the applicant, its affiliates or any person listed in Item 3.
ITEM 8.  CONTRACTS, ARRANGEMENTS, OR UNDERSTANDINGS WITH RESPECT TO VOTING SECURITIES OF THE INSURER

Give a full description of any contracts, arrangements or understandings with respect to any voting security of the insurer in which the applicant, its affiliates or any person listed in Item 3 is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom the contracts, arrangements or understandings have been entered into.

ITEM 9.  RECENT PURCHASES OF VOTING SECURITIES

Describe any purchases of any voting securities of the insurer by the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement. Include in the description the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid therefor. State whether any shares so purchased are hypothecated.

ITEM 10.  RECENT RECOMMENDATIONS TO PURCHASE

Describe any recommendations to purchase any voting security of the insurer made by the applicant, its affiliates or any person listed in Item 3, or by anyone based upon interviews or at the suggestion of the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement.

ITEM 11.  AGREEMENTS WITH BROKER-DEALERS

Describe the terms of any agreement, contract or understanding made with any broker-dealer as to solicitation of voting securities of the insurer for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.

ITEM 12.  FINANCIAL STATEMENTS AND EXHIBITS

(a)  Financial statements, exhibits, and three-year financial projections of the insurer(s) shall be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b)  The financial statements shall include the annual financial statements of the persons identified in Item 2(c) for the preceding 5 fiscal years (or for such lesser period as such applicant and its affiliates and any predecessors thereof shall have been in existence), and similar information covering the period from the end of such person’s last fiscal year, if the information is available. The statements may be prepared on either an individual basis, or, unless the Commissioner otherwise requires, on a consolidated basis if consolidated statements are prepared in the usual course of business.

The annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the applicant is an insurer which is actively engaged in the business of insurance, the financial statements need not be certified, provided they are based on the Annual Statement of the person filed with the insurance department of the person’s domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of the state.

(c)  File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and (if distributed) of additional soliciting material relating thereto, any proposed employment, consultation, advisory or management contracts concerning the insurer, annual reports to the stockholders of the insurer and the applicant for the last two fiscal years, and any additional documents or papers required by Form A or regulation Sections 4 and 6.
ITEM 13. AGREEMENT REQUIREMENTS FOR ENTERPRISE RISK MANAGEMENT

Applicant agrees to provide, to the best of its knowledge and belief, the information required by Form F within fifteen (15) days after the end of the month in which the acquisition of control occurs.

ITEM 14. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of Section 3 of the Act ________________ has caused this application to be duly signed on its behalf in the City of ___________ and State of on the __________ day of __________, 20____.

(SEAL)

Name of Applicant

BY

(Name) (Title)

Attest:

____________________

(Signature of Officer)

____________________

(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated __________, 20____, for and on behalf of __________ (Name of Applicant); that (s)he is the __________ (Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with the instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

____________________

(Signature)

____________________

(Type or print name beneath)
FORM B

INSURANCE HOLDING COMPANY SYSTEM ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Department of the State of________________________

By

______________________________

Name of Registrant

On Behalf of Following Insurance Companies

Name  Address

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

Date:____________________, 20_____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

____________________________________________________________________________________________

____________________________________________________________________________________________

ITEM 1.  IDENTITY AND CONTROL OF REGISTRANT

Furnish the exact name of each insurer registering or being registered (hereinafter called “the Registrant”), the home office address and principal executive offices of each; the date on which each registrant became part of the insurance holding company system; and the method(s) by which control of each registrant was acquired and is maintained.

ITEM 2.  ORGANIZATIONAL CHART

Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of control. As to each person specified in the chart or listing indicate the type of organization (e.g., corporation, trust, partnership) and the state or other jurisdiction of domicile.

© 2021 National Association of Insurance Commissioners
ITEM 3. THE ULTIMATE CONTROLLING PERSON

As to the ultimate controlling person in the insurance holding company system furnish the following information:

(a) Name;
(b) Home office address;
(c) Principal executive office address;
(d) The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.;
(e) The principal business of the person;
(f) The name and address of any person who holds or owns 10% or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned; and
(g) If court proceedings involving a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.

ITEM 4. BIOGRAPHICAL INFORMATION

If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, furnish the following information for the directors and executive officers of the ultimate controlling person: the individual’s name and address, his or her principal occupation and all offices and positions held during the past 5 years, and any conviction of crimes other than minor traffic violations. If the ultimate controlling person is an individual, furnish the individual's name and address, his or her principal occupation and all offices and positions held during the past 5 years, and any conviction of crimes other than minor traffic violations.

ITEM 5. TRANSACTIONS AND AGREEMENTS

Briefly describe the following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between the registrant and its affiliates:

(a) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the Registrant or of the Registrant by its affiliates;
(b) Purchases, sales or exchanges of assets;
(c) Transactions not in the ordinary course of business;
(d) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant’s assets to liability, other than insurance contracts entered into in the ordinary course of the registrant’s business;
(e) All management agreements, service contracts and all cost-sharing arrangements;
(f) Reinsurance agreements;
(g) Dividends and other distributions to shareholders;
(h) Consolidated tax allocation agreements; and
(i) Any pledge of the registrant’s stock and/or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

No information need be disclosed if such information is not material for purposes of Section 4 of the Act.

Sales, purchases, exchanges, loans or extensions of credit, investments or guarantees involving one-half of 1% or less of the registrant’s admitted assets as of the 31st day of December next preceding shall not be deemed material.

**Drafting Note:** Commissioner may by rule, regulation or order provide otherwise.

The description shall be in a manner as to permit the proper evaluation thereof by the Commissioner, and shall include at least the following: the nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to the transaction, and relationship of the affiliated parties to the registrant.

**ITEM 6. LITIGATION OR ADMINISTRATIVE PROCEEDINGS**

A brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which the litigation or proceeding is or was pending:

(a) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and

(b) Proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations.

**ITEM 7. STATEMENT REGARDING PLAN OR SERIES OF TRANSACTIONS**

The insurer shall furnish a statement that transactions entered into since the filing of the prior year’s annual registration statement are not part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.

**ITEM 8. FINANCIAL STATEMENTS AND EXHIBITS**

(a) Financial statements and exhibits should be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, the financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person’s latest fiscal year.

If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis; or, unless the Commissioner otherwise requires, on a consolidated basis if consolidated statements are prepared in the usual course of business.

Other than with respect to the foregoing, such financial statement shall be filed in a standard form and format adopted by the National Association of Insurance Commissioners, unless an alternative form is accepted by the Commissioner. Documentation and financial statements filed with the Securities and Exchange Commission or audited GAAP financial statements shall be deemed to be an appropriate form and format.
Unless the Commissioner otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that the statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the Annual Statement of the insurer’s domiciliary state and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of that state.

Any ultimate controlling person who is an individual may file personal financial statements that are reviewed rather than audited by an independent public accountant. The review shall be conducted in accordance with standards for review of personal financial statements published in the Personal Financial Statements Guide by the American Institute of Certified Public Accountants. Personal financial statements shall be accompanied by the independent public accountant’s Standard Review Report stating that the accountant is not aware of any material modifications that should be made to the financial statements in order for the statements to be in conformity with generally accepted accounting principles.

(c) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or papers required by Form B or regulation Sections 4 and 6.

ITEM 9. FORM C REQUIRED

A Form C, Summary of Changes to Registration Statement, must be prepared and filed with this Form B.

ITEM 10. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of Section 4 of the Act, Registrant has caused this annual registration statement to be duly signed on its behalf of the City of _________________ and State of ______________ on the __________ day of ______________, 20 ___.

(SEAL)

Name of Applicant

BY __________________________________________

(Name) (Title)

Attest:

____________________________________

(Signature of Officer)

____________________________________

(Title)
CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached annual registration statement dated __________, 20____, for and on behalf of ___________________(Name of Applicant); that (s)he is the ______________ (Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature)________________________________________

(Type or print name beneath)________________________________________
FORM C

SUMMARY OF CHANGES TO REGISTRATION STATEMENT

Filed with the Insurance Department of the State of ______________________

By

____________________________________

Name of Registrant

On Behalf of Following Insurance Companies

Name  Address

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Date:_________________________, 20_____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

____________________________________________________________________________________________
____________________________________________________________________________________________

Furnish a brief description of all items in the current annual registration statement which represent changes from the prior year’s annual registration statement. The description shall be in a manner as to permit the proper evaluation thereof by the Commissioner, and shall include specific references to Item numbers in the annual registration statement and to the terms contained therein.

Changes occurring under Item 2 of Form B insofar as changes in the percentage of each class of voting securities held by each affiliate is concerned, need only be included where such changes are ones which result in ownership or holdings of 10% or more of voting securities, loss or transfer of control, or acquisition or loss of partnership interest.

Changes occurring under Item 4 of Form B need only be included where an individual is, for the first time, made a director or executive officer of the ultimate controlling person; a director or executive officer terminates his or her responsibilities with the ultimate controlling person; or in the event an individual is named president of the ultimate controlling person.

If a transaction disclosed on the prior year’s annual registration statement has been changed, the nature of such change shall be included. If a transaction disclosed on the prior year’s annual registration statement has been effectuated, furnish the mode of completion and any flow of funds between affiliates resulting from the transaction.

The insurer shall furnish a statement that transactions entered into since the filing of the prior year’s annual registration statement are not part of a plan or series of like transactions whose purpose it is to avoid statutory threshold amounts and the review that might otherwise occur.
SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

Pursuant to the requirements of Section 4 of the Act, Registrant has caused this annual registration statement to be duly signed on its behalf of the City of _______________ and State of ______________ on the __________ day of ____________, 20 ___.

(SEAL) ______________________________
Name of Applicant

BY ____________________________________________
(Name) (Title)

Attest:

____________________________
(Signature of Officer)

____________________________
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached annual registration statement dated ______________, 20 ___, for and on behalf of ________________________(Name of Applicant); that (s)he is the ________________________(Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) ______________________________

(Type or print name beneath) ______________________________
Insurance Holding Company System Model Regulation
With Reporting Forms and Instructions

FORM D

PRIOR NOTICE OF A TRANSACTION

Filed with the Insurance Department of the State of______________________

By

_____________________________________

Name of Registrant

On Behalf of Following Insurance Companies

Name            Address

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

Date:__________________________, 20_____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

ITEM 1.      IDENTITY OF PARTIES TO TRANSACTION

Furnish the following information for each of the parties to the transaction:

(a) Name;

(b) Home office address;

(c) Principal executive office address;

(d) The organizational structure, i.e. corporation, partnership, individual, trust, etc.;

(e) A description of the nature of the parties’ business operations;

(f) Relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties;

(g) Where the transaction is with a non-affiliate, the name(s) of the affiliate(s) which will receive, in whole or in substantial part, the proceeds of the transaction.
ITEM 2. DESCRIPTION OF THE TRANSACTION

Furnish the following information for each transaction for which notice is being given:

(a) A statement as to whether notice is being given under Section 5A(2)(a), (b), (c), (d), or (e) of the Act;

(b) A statement of the nature of the transaction;

c) A statement of how the transaction meets the ‘fair and reasonable’ standard of Section 5A(1)(a) of the Act; and

(d) The proposed effective date of the transaction.

ITEM 3. SALES, PURCHASES, EXCHANGES, LOANS, EXTENSIONS OF CREDIT, GUARANTEES OR INVESTMENTS

Furnish a brief description of the amount and source of funds, securities, property or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee, or investment, whether any provision exists for purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice, a description of the terms of any securities being received, if any, and a description of any other agreements relating to the transaction such as contracts or agreements for services, consulting agreements and the like. If the transaction involves other than cash, furnish a description of the consideration, its cost and its fair market value, together with an explanation of the basis for evaluation.

If the transaction involves a loan, extension of credit or a guarantee, furnish a description of the maximum amount which the insurer will be obligated to make available under such loan, extension of credit or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest.

If the transaction involves an investment, guarantee or other arrangement, state the time period during which the investment, guarantee or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees or arrangements. Furnish a brief statement as to the effect of the transaction upon the insurer’s surplus.

No notice need be given if the maximum amount which can at any time be outstanding or for which the insurer can be legally obligated under the loan, extension of credit or guarantee is less than (a) in the case of non-life insurers, the lesser of 3% of the insurer’s admitted assets or 25% of surplus as regards policyholders, or (b) in the case of life insurers, 3% of the insurer’s admitted assets, each as of the 31st day of December next preceding.

ITEM 4. LOANS OR EXTENSIONS OF CREDIT TO A NON-AFFILIATE

If the transaction involves a loan or extension of credit to any person who is not an affiliate, furnish a brief description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit, and specify in what manner the proceeds are to be used to loan to, extend credit to, purchase assets of or make investments in any affiliate. Describe the amount and source of funds, securities, property or other consideration for the loan or extension of credit and, if the transaction is one involving consideration other than cash, a description of its cost and its fair market value together with an explanation of the basis for evaluation. Furnish a brief statement as to the effect of the transaction upon the insurer’s surplus.

No notice need be given if the loan or extension of credit is one which equals less than, in the case of non-life insurers, the lesser of 3% of the insurer’s admitted assets or 25% of surplus as regards policyholders or, with respect to life insurers, 3% of the insurer’s admitted assets, each as of the 31st day of December next preceding.
ITEM 5. REINSURANCE

If the transaction is a reinsurance agreement or modification thereto, as described by Section 5A(2)(c)(ii) of the Act, or a reinsurance pooling agreement or modification thereto as described by Section 5A(2)(c)(i) of the Act, furnish a description of the known and/or estimated amount of liability to be ceded and/or assumed in each calendar year, the period of time during which the agreement will be in effect, and a statement whether an agreement or understanding exists between the insurer and non-affiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one or more of the insurer’s affiliates. Furnish a brief description of the consideration involved in the transaction, and a brief statement as to the effect of the transaction upon the insurer’s surplus.

No notice need be given for reinsurance agreements or modifications thereto if the reinsurance premium or a change in the insurer’s liabilities, or the projected reinsurance premium or change in the insurer’s liabilities in any of the next three years, in connection with the reinsurance agreement or modification thereto is less than 5% of the insurer’s surplus as regards policyholders, as of the 31st day of December next preceding. Notice shall be given for all reinsurance pooling agreements including modifications thereto.

ITEM 6. MANAGEMENT AGREEMENTS, SERVICE AGREEMENTS AND COST-SHARING ARRANGEMENTS.

For management and service agreements, furnish:

(a) A brief description of the managerial responsibilities, or services to be performed;

(b) A brief description of the agreement, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made.

For cost-sharing arrangements, furnish:

(a) A brief description of the purpose of the agreement;

(b) A description of the period of time during which the agreement is to be in effect;

(c) A brief description of each party’s expenses or costs covered by the agreement;

(d) A brief description of the accounting basis to be used in calculating each party’s costs under the agreement;

(e) A brief statement as to the effect of the transaction upon the insurer’s policyholder surplus;

(f) A statement regarding the cost allocation methods that specifies whether proposed charges are based on “cost or market.” If market based, rationale for using market instead of cost, including justification for the company’s determination that amounts are fair and reasonable; and

(g) A statement regarding compliance with the NAIC Accounting Practices and Procedure Manual regarding expense allocation.

ITEM 7. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:
SIGNATURE

Pursuant to the requirements of Section 5 of the Act, ______ has caused this application to be duly signed on its behalf in the City of ___________ and State of ___________ on the ___________ day of __________, 20 ___.

(SEAL)____________________________
Name of Applicant

BY______________________________
(Name) (Title)

Attest:

___________________________
(Signature of Officer)

___________________________
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated ___________, 20 ___, for and on behalf of _______________________(Name of Applicant); that (s)he is the _______________________(Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

______________________________
(Signature)

______________________________
(Type or print name beneath)
FORM E
PRE-ACQUISITION NOTIFICATION FORM
REGARDING THE POTENTIAL COMPETITIVE IMPACT
OF A PROPOSED MERGER OR ACQUISITION BY A
NON-DOMICILIARY INSURER DOING BUSINESS IN THIS
STATE OR BY A DOMESTIC INSURER

Name of Applicant

Name of Other Person
Involved in Merger or
Acquisition

Filed with the Insurance Department of

Dated: ________________________, 20 ____________

Name, title, address and telephone number of person completing this statement:

ITEM 1. NAME AND ADDRESS
State the names and addresses of the persons who hereby provide notice of their involvement in a pending acquisition or change in corporate control.

ITEM 2. NAME AND ADDRESSES OF AFFILIATED COMPANIES
State the names and addresses of the persons affiliated with those listed in Item 1. Describe their affiliations.

ITEM 3. NATURE AND PURPOSE OF THE PROPOSED MERGER OR ACQUISITION
State the nature and purpose of the proposed merger or acquisition.

ITEM 4. NATURE OF BUSINESS
State the nature of the business performed by each of the persons identified in response to Item 1 and Item 2.
ITEM 5. MARKET AND MARKET SHARE

State specifically what market and market share in each relevant insurance market the persons identified in Item 1 and Item 2 currently enjoy in this state. Provide historical market and market share data for each person identified in Item 1 and Item 2 for the past five years and identify the source of such data. Provide a determination as to whether the proposed acquisition or merger, if consummated, would violate the competitive standards of the state as stated in Section 3.1D of the Act. If the proposed acquisition or merger would violate competitive standards, provide justification of why the acquisition or merger would not substantially lessen competition or create a monopoly in the state.

For purposes of this question, market means direct written insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state.

Drafting Note: State Insurance Departments may additionally choose to make these calculations using their own data or data provided by the National Association of Insurance Commissioners.
FORM F

ENTERPRISE RISK REPORT

Filed with the Insurance Department of the State of ______________________

By

Name of Registrant/Applicant

On Behalf of/Related to Following Insurance Companies

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Date:______________, 20____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

ITEM 1. ENTERPRISE RISK

The Registrant/Applicant, to the best of its knowledge and belief, shall provide information regarding the following areas that could produce enterprise risk as defined in [insert cross reference to definition of Enterprise Risk in Section 1F of the Act], provided such information is not disclosed in the Insurance Holding Company System Annual Registration Statement filed on behalf of itself or another insurer for which it is the ultimate controlling person:

- Any material developments regarding strategy, internal audit findings, compliance or risk management affecting the insurance holding company system;
- Acquisition or disposal of insurance entities and reallocating of existing financial or insurance entities within the insurance holding company system;
- Any changes of shareholders of the insurance holding company system exceeding ten percent (10%) or more of voting securities;
- Developments in various investigations, regulatory activities or litigation that may have a significant bearing or impact on the insurance holding company system;
- Business plan of the insurance holding company system and summarized strategies for the next 12 months;
- Identification of material concerns of the insurance holding company system raised by supervisory college, if any, in the last year;
Identification of insurance holding company system capital resources and material distribution patterns;

Identification of any negative movement, or discussions with rating agencies which may have caused, or may cause, potential negative movement in the credit ratings and individual insurer financial strength ratings assessment of the insurance holding company system (including both the rating score and outlook);

Information on corporate or parental guarantees throughout the holding company and the expected source of liquidity should such guarantees be called upon; and

Identification of any material activity or development of the insurance holding company system that, in the opinion of senior management, could adversely affect the insurance holding company system.

The Registrant/Applicant may attach the appropriate form most recently filed with the U.S. Securities and Exchange Commission, provided the Registrant/Applicant includes specific references to those areas listed in Item 1 for which the form provides responsive information. If the Registrant/Applicant is not domiciled in the U.S., it may attach its most recent public audited financial statement filed in its country of domicile, provided the Registrant/Applicant includes specific references to those areas listed in Item 1 for which the financial statement provides responsive information.

ITEM 2: OBLIGATION TO REPORT.

If the Registrant/Applicant has not disclosed any information pursuant to Item 1, the Registrant/Applicant shall include a statement affirming that, to the best of its knowledge and belief, it has not identified enterprise risk subject to disclosure pursuant to Item 1.
The Receiver’s Handbook (E) Subgroup of the Receivership and Insolvency (E) Task Force met June 14, 2021. The following Subgroup members participated: Kevin Baldwin, Chair (IL); Toma Wilkerson, Vice Chair (FL); Joe Holloway (CA); Jared Kosky (CT); James Gerber (MI); Donna Wilson and Jamin Dawes (OK); Laura Lyon Slaymaker and Crystal McDonald (PA); and Brain Riewe (TX).

1. **Adopted its May 26 Minutes.**

The Subgroup met May 26 and took the following action: 1) discussed its charges; and 2) planned the review process for the *Receiver’s Handbook for Insurance Company Insolvencies* (Receiver’s Handbook). Mr. Baldwin noted that the minutes from the May meeting were in the meeting materials.

Mr. Gerber made a motion, seconded by Ms. Wilkerson, to adopt the Subgroup’s May 26 minutes (Attachment Two-A). The motion passed unanimously.

2. **Discussed the Drafting Group Volunteers and Process**

Mr. Baldwin thanked the volunteers that have agreed to participate in the drafting group and discussed the process for the drafting group. He said that the drafting group would have a primary drafter for specific pages of Chapter 1. The other group members would add comments and/or revisions to the Word document. The drafting group would schedule a meeting(s) to discuss the comments or revisions. Once completed, the drafting group would present the document to the Subgroup for public exposure. Once the document has been publicly exposed, the public comments received would be considered by the Subgroup and the document would be revised as warranted. After public exposure, the Subgroup would consider adoption of Chapter 1. This would be the same process for all the other chapters of the Receiver’s Handbook.

3. **Demonstrated SharePoint Collaboration Software for Drafting Groups**

Mr. Baldwin introduced Sherry Flippo (NAIC) and Amy Lopez (NAIC). They demonstrated the SharePoint website that would be used for collaboration among the drafting group members.

Having no further business, the Receiver’s Handbook (E) Subgroup adjourned.

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The Receiver’s Handbook (E) Subgroup of the Receivership and Insolvency (E) Task Force met May 26, 2021. The following Subgroup members participated: Kevin Baldwin, Chair (IL); Toma Wilkerson, Vice Chair (FL); Jared Kosky (CT); James Gerber (MI); Leatrice Geckler (NM); Donna Wilson and Jamin Dawes (OK); Laura Lyon Slaymaker and Crystal McDonald (PA); and Brain Riewe (TX).

1. **Reviewed its Charge**

   Mr. Baldwin reviewed the Subgroup’s charge to “Review the Receiver’s Handbook to identify areas where information is outdated, updates are required, or additional guidance is needed. Based on this review, draft and propose recommended edits to the Receiver’s Handbook.” He noted that the charge is to be completed by the 2022 Fall National Meeting.

2. **Reviewed the Chapters of the Receiver’s Handbook and Considered the Assignment of Drafting Groups**

   Mr. Baldwin reviewed the current chapters of the Receiver’s Handbook for Insurance Company Insolvencies (Receiver’s Handbook). After discussions concerning making the Receiver’s Handbook more user friendly and concise by the participants, he noted that the Subgroup would form two drafting groups. The drafting groups would perform the drafting, editing and writing of the first two chapters. Then, the draft of the chapters would be sent to the Subgroup for public exposure and comment. Mr. Baldwin invited Subgroup members, interested state insurance regulators, and interested parties to volunteer for any chapters in which they are interested by contacting Sherry Flippo (NAIC) or Erin Arscott (NAIC).

Having no further business, the Receiver’s Handbook (E) Subgroup adjourned.
The Receivership Law (E) Working Group of the Receivership and Insolvency (E) Task Force met May 4, 2021. The following Working Group members participated: Kevin Baldwin, Co-Chair (IL); Laura Lyon Slaymaker, Co-Chair (PA); Steve Uhrynnowycz (AR); Jack Hom (CA); Jared Kosky (CT); Toma Wilkerson (FL); Tom Travis (LA); Christopher Joyce (MA); Robert Wake (ME); James Gerber (MI); Shelley Forrest (MO); Justin Schrader (NE); James Kennedy (TX); and Melanie Anderson (WA).

1. **Adopted Amendments to Model #440 and Model #450**

   Ms. Slaymaker said on the Working Group’s March 5 meeting, additional revisions to Section 5A(1)(g) of the *Insurance Holding Company System Regulatory Act* (#440) were released for a 30-day public comment period ending April 9.

   Ms. Slaymaker said one comment letter was received from the American Council of Life Insurers (ACLI) (Attachment Three-A). Wayne Mehlman (ACLI) said the addition to the drafting note for Section 5A(1)(g) is to clarify that the section applies to managerial and support service agreements, and it does not apply to reinsurance or risk transfer. Ms. Slaymaker said she agrees with the ACLI’s suggested addition. Hearing no objection, she said the additional wording will be included in the amendments.

   Mr. Kennedy made a motion, seconded by Ms. Wilkerson, to adopt the amendments to Model #440 (see NAIC Proceedings – Summer 2021, Receivership and Insolvency (E) Task Force, Attachment One-A) and the *Insurance Holding Company System Regulation with Reporting Forms and Instructions* (#450) (see NAIC Proceedings – Summer 2021, Receivership and Insolvency (E) Task Force, Attachment One-B). The motion passed unanimously.

2. **Discussed Updating Related Regulatory Guidance**

   Mr. Baldwin said the original survey to gather ideas to address the issue of the continuation of services and issues with access to books and records, in addition to the model amendments, included two general recommendations to update pre-receivership analysis, examination guidance, and guidance in the *Receiver’s Handbook for Insurance Company Insolvencies* (Handbook).

   Mr. Baldwin said as analysis and examination guidance is outside the scope of this Working Group, after the NAIC has adopted the Model #440 and Model #450 amendments, the appropriate NAIC groups can address related updates to pre-receivership analysis and examination guidance.

   Mr. Baldwin said at the 2020 Spring National Meeting, the NAIC adopted charges to form the Receiver’s Handbook (E) Subgroup, which will review and draft updates to the Handbook. He said he will serve as the Subgroup’s chair, and Ms. Wilkerson will serve as vice chair. He said the Subgroup will review the existing guidance, including aspects of service agreements and the books and records of the estate. He said he recommends that the Subgroup address aligning Handbook guidance to the Model #440 and Model #450 amendments, once adopted, as part of the normal process of completing its charge. Ms. Wilkerson and Mr. Kosky agreed. Hearing no objection, Mr. Baldwin said guidance will be drafted by the Subgroup under its charge to update the Handbook.

Having no further business, the Receivership Law (E) Working Group adjourned.
Wayne Mehlman
Senior Counsel
(202) 624-2135
waynemehlman@acli.com

April 6, 2021

Dear Co-Chairs Baldwin and Slaymaker:

The American Council of Life Insurers (“ACLI”)\(^1\) appreciates this opportunity to provide comments to the Receivership Law Working Group on Section 5.A.(1)(g) of Model #440. We respectfully suggest that the following underlined language be added to that subsection’s Drafting Note.

**Drafting Note:** This section is intended to apply to a broad range of affiliate managerial and support service contracts including, for example, general managerial services, financial accounting and actuarial services, data management, investment portfolio management and support and policy and policyholder services. (Performance collateralization for reinsurance and other risk transfer or financial contracts with affiliates is typically addressed in the underlying contractual agreements and is beyond the scope of these deposit/bond requirements.) The intent of the deposit or bond is to ensure the affiliated services provided under the contract(s) are fulfilled. In determining appropriate circumstances when a commissioner may require a deposit or bond, to be determined by the insurer, and in specifying an amount, the

\(^1\) The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 95 percent of industry assets in the United States. Learn more at [www.acli.com](http://www.acli.com).
commissioner should evaluate and consider whether an insurer subject to this act is in a hazardous financial condition or a condition that would be grounds for substantial regulatory action, including supervision, conservation or a delinquency proceeding. If it is, the deposit or bond requirement would be available as an additional regulatory remedy at the discretion of the commissioner. Note, the commissioner should consider whether the affiliated person is already required to post a deposit or bond under applicable laws regulating third-party administrators.

Thanks again for this opportunity to provide comments. If you have any questions, feel free to contact me at waynemehlman@acli.com or 202-624-2135.

Sincerely,

Wayne A. Mehlman
Senior Counsel, Insurance Regulation
2022 Proposed Charges

Receivership and Insolvency (E) Task Force

The mission of the Receivership and Insolvency (E) Task Force shall be administrative and substantive as it relates to issues concerning insurer insolvencies and insolvency guarantees. Such duties include, without limitation, monitoring the effectiveness and performance of state administration of receiverships and the state guaranty fund system; coordinating cooperation and communication among regulators, receivers and guaranty funds; monitoring ongoing receiverships and reporting on such receiverships to NAIC members; developing and providing educational and training programs in the area of insurer insolvencies and insolvency guarantees to regulators, professionals and consumers; developing and monitoring relevant model laws, guidelines and products; and providing resources for regulators and professionals to promote efficient operations of receiverships and guaranty funds.

The Receivership and Insolvency (E) Task Force will:

A. Monitor and promote efficient operations of insurance receiverships and guaranty associations.
B. Monitor and promote state adoption of insurance receivership and guaranty association model acts and regulations, and monitor other legislation related to insurance receiverships and guaranty associations.
C. Provide input and comments to the International Association of Insurance Supervisors (IAIS), the Financial Stability Board (FSB) or other related groups on issues regarding international resolution authority.
D. Monitor, review and provide input on federal rulemaking and studies related to insurance receiverships.
F. Monitor the work of other NAIC committees, task forces and working groups to identify and address any issues that affect receivership law and/or regulatory guidance.
G. Perform additional work as directed by the Financial Condition (E) Committee and/or received through referral by other groups.

The Receivership Financial Analysis (E) Working Group will:

1. Monitor receiverships involving nationally significant insurers/groups to support, encourage, promote and coordinate multistate efforts in addressing problems.
2. Interact with the Financial Analysis (E) Working Group, domiciliary regulators, and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods and/or action(s) regarding potential or pending receiverships.

The Receivership Law (E) Working Group will:

1. Review and provide recommendations on any issues identified that may affect states’ receivership and guaranty association laws (e.g., any issues that arise as a result of market conditions; insurer insolvencies; federal rulemaking and studies; international resolution initiatives; or as a result of the work performed by or referred from other NAIC committees, task forces and/or working groups).
2. Discuss significant cases that may impact the administration of receiverships.
The Receiver’s Handbook (E) Subgroup of the Receivership and Insolvency (E) Task Force will:

1. Review the Receiver’s Handbook to identify areas where information is outdated, updates are required, or additional guidance is needed. Based on this review, draft and propose recommended edits to the Receiver’s Handbook. Complete by the 2022 Fall National Meeting.

Deleted: Complete work as assigned from the Receivership and Insolvency (E) Task Force to address recommendations from the Financial Stability (E) Task Force’s Macroprudential Initiative (MPI) referral:

- Complete work related to qualified financial contracts (QFCs), including: 1) explore if bridge institutions could be implemented under regulatory oversight pre-receivership to address an early termination of QFCs and, if appropriate, develop applicable guidance; 2) develop enhancements to the Receiver’s Handbook guidance on QFCs; and 3) identify related pre-receivership considerations related to QFCs and, if necessary, make referrals to other relevant groups to enhance pre-receivership planning, examination and analysis guidance.

- Review and provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including non-regulated entities. Among other solutions, this will encompass a review of the Insurance Holding Company System Regulatory Act (0440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (0450) to provide proposed revisions to address the continuation of essential services through affiliated intercompany agreements in a receivership.

- Consult with and/or make referrals to other NAIC working groups, as deemed necessary, as the topic relates to affiliated intercompany agreements and pre-receivership considerations. Complete by the 2021 Fall National Meeting.
REINSURANCE (E) TASK FORCE

Reinsurance (E) Task Force July 27, 2021, Minutes ........................................................................................................ 10-1161
Reinsurance (E) Task Force 2022 Proposed Charges (Attachment One)................................................................. 10-1164
Comment Letters Regarding Draft Revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions (Attachment Two) ........................................................................................................ 10-1165
Updated Draft Revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions, Including
Revisions from the Federal Insurance Office (FIO) (Attachment Three)........................................................................ 10-1175
Draft Revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions, Including All Revisions
Made Since the Initial Public Exposure on March 23, 2021 (Attachment Four).......................................................... 10-1177
Draft ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers
(Attachment Five)...................................................................................................................................................... 10-1207
Comment Letters Regarding the Draft ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers (Attachment Six) .......................................................................................... 10-1219
May 27, 2021 (Attachment Seven)............................................................................................................................. 10-1238
Comment Letter from the American Property Casualty Insurance Association (APCIA) Regarding the Republic of Korea Final Evaluation Report (Attachment Eight) ................................................................. 10-1243
Maps Showing Implementation of the 2019 Revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) as of July 16, 2021 (Attachment Nine) .......... 10-1245
Map Showing Implementation of the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) as of June 22, 2021 (Attachment Ten)...................................................................................... 10-1247
The Reinsurance (E) Task Force met July 27, 2021. The following Task Force members participated: Chlora Lindley-Myers, Chair, represented by John Rehagen (MO); Raymond G. Farmer, Vice Chair, represented by Daniel Morris (SC); Lori K. Wing-Heier represented by David Phifer (AK); Jim L. Ridling represented by Richard Ford (AL); Ricardo Lara represented by Monica Macaluso (CA); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Kathy Belfi (CT); Trinidad Navarro represented by Dave Lonchar (DE); David Altmaier represented by Robert Ridenour (FL); Doug Ommen represented by Kevin Clark (IA); Dana Popish Severinghaus represented by Eric Moser and Susan Berry (IL); Amy L. Beard represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Russell Coy and Rodney Hugle (KY); James J. Donelon represented by Stewart Guerin (LA); Gary D. Anderson represented by Christopher Joyce (MA); Eric A. Cioppa represented by Robert Wake (ME); Mike Causey represented by Monique Smith (NC); Jon Godfried represented by Matt Fischer (ND); Eric Dunning represented by Lindsay Crawford (NE); Chris Nicolopoulos represented by Doug Bartlett (NH); Marlene Caride represented by John Tirado (NJ); Russell Toal (NM); Linda A. Lacewell represented by Michael Campanelli (NY); Judith L. French represented by Dale Bruggeman (OH); Glen Mulready represented by Eli Snowbarger (OK); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Doug Slape represented by Jamie Walker (TX); Jonathan T. Pike represented by Natasha Robinson (UT); Scott A. White represented by David Smith and Doug Stolte (VA); Michael S. Pieciak represented by David Provost (VT); and Mark Afable represented by Randy Milquet (WI).

1. **Adopted its Spring National Meeting Minutes**

Superintendent Toal made a motion, seconded by Ms. Crawford, to adopt the Task Force’s March 23 minutes (see NAIC Proceedings – Spring 2021, Reinsurance (E) Task Force). The motion passed unanimously.

2. **Adopted its 2022 Proposed Charges**

Superintendent Toal made a motion, seconded by Ms. Smith, to adopt the 2022 proposed charges of the Task Force and the Reinsurance Financial Analysis (E) Working Group (Attachment One). The motion passed unanimously. Mr. Rehagen noted that the Qualified Jurisdiction (E) Working Group was renamed to be the Mutual Recognition of Jurisdictions (E) Working Group and now reports directly to the Financial Condition (E) Committee.


Mr. Kaumann provided the report of the Reinsurance Financial Analysis (E) Working Group. He stated that the Working Group met April 13 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss proposed revisions to the Reinsurance Financial Analysis (E) Working Group Procedures Manual (ReFAWG Manual). He noted that the ReFAWG Manual is a regulator-only document that is being updated to reflect the 2019 revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786). He noted that the Working Group also plans to meet several more times during 2021 to complete the reviews of the certified reinsurers and to discuss any new applications.

Mr. Kaumann made a motion, seconded by Ms. Macaluso, to adopt the Working Group’s report. The motion passed unanimously.

4. **Adopted the Draft Revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions**

Mr. Rehagen stated that the draft revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions incorporate provisions for terminating the status of a qualified jurisdiction or reciprocal jurisdiction and create a passporting process for reciprocal jurisdictions. He noted that these revisions were discussed on March 17 by the Qualified Jurisdiction (E) Working Group in regulator-only session and were exposed for a 30-day public comment period on March 23, and four comment letters (Attachment Two) were received.

Mr. Rehagen stated that the renamed Mutual Recognition of Jurisdictions (E) Working Group then met on May 27 and incorporated the suggested revisions from the comment letters and made some minor revisions related to the name change. He
noted that NAIC staff met with the Federal Insurance Office (FIO), which provided several suggested revisions that were included in an additional handout sent out before this meeting (Attachment Three). Mr. Wake provided a summary of the revisions and recommended that the Task Force adopt the updated *Process for Evaluating Qualified and Reciprocal Jurisdictions*, with the FIO suggested revisions. Dan Schelp (NAIC) noted that these revisions are nonsubstantive in nature and are consistent with the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement) and the “Bilateral Agreement the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (UK Covered Agreement), as well as with Model #785 and Model #786. Ms. Macaluso and Mr. Kaumann stated that they agree with Mr. Schelp.

Mr. Wake made a motion, seconded by Superintendent Toal, to adopt the revisions to the *Process for Evaluating Qualified and Reciprocal Jurisdictions* (Attachment Four), with the additional revisions included in Attachment Three. The motion passed unanimously.

5. Discussed the Draft ReFAWG Review Process

Mr. Rehagen stated that the ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers (ReFAWG Review Process) (Attachment Five) was created to aid in the implementation process of the 2019 revisions to Model #785 and Model #786 and intends to clarify the processes for the passporting of certified reinsurers and reciprocal jurisdiction reinsurers. He noted that the document was released for initial exposure on June 17 for 30 days, and six comment letters (Attachment Six) were received. Mr. Rehagen noted that because of the comments received, the Task Force will refer the document to the Working Group, which will evaluate the comments and recommend any revisions back to the Task Force.

Suzanne Williams-Charles (Association of Bermuda Insurers and Reinsurers—ABIR) stated she supports the passporting processes and recommends updating the ReFAWG Review Process to eliminate the need for duplicate information for reciprocal jurisdiction reinsurers that are also certified reinsurers. She also recommended consistent filing dates for both reciprocal jurisdiction reinsurers and certified reinsurers and suggested permitting reciprocal jurisdiction reinsurers to submit evidence of their minimum capital and surplus and minimum solvency or capital ratio requirement status directly to state insurance regulators on behalf of their supervisory regulators.

Thomas Dawson (on behalf of the International Underwriting Association of London—IUA) stated that he agrees with Ms. Williams-Charles’ statements and emphasized the importance of a consistent filing date and requirements for both certified and reciprocal jurisdiction reinsurers. He noted that some reinsurers will have a different lead state for its certified reinsurer status and its reciprocal jurisdiction reinsurer status.

Steve Clayburn (American Council of Life Insurers—ACLI) recommended that the process use efficiencies for situations where the certified reinsurer status and reciprocal jurisdiction reinsurer status have overlapping requirements.

Karalee Morrell (Reinsurance Association of America—RAA) stated that she would like the process document to clarify which aspects of the process applied to certified reinsurers, which applied to reciprocal jurisdiction reinsurers, and which applied to both types. She also recommended revising the process document to clarify between the requirements imposed by a lead state and those imposed by a state where an applicant is seeking to do business, and she added that she supports the passporting process.

6. Discussed the Republic of Korea Application to Become a Qualified Jurisdiction

Mr. Rehagen stated that on May 27, the Mutual Recognition of Jurisdictions (E) Working Group recommended the Republic of Korea be approved as a qualified jurisdiction and exposed the *Republic of Korea: Final Evaluation Report* (Attachment Seven) for a 30-day public comment period. He noted that one comment letter (Attachment Eight) was received from the American Property Casualty Insurance Association (APCIA) and the ACLI that noted an issue with Korea requiring localization of data that may create extra obstacles for U.S. reinsurers looking to do business in Korea. Mr. Rehagen referred this issue back to the Mutual Recognition of Jurisdictions (E) Working Group to further evaluate and remediate this issue, and to report back to the Task Force.

7. Received a Status Report on the States’ Implementation of the 2019 Revisions to Model #785 and Model #786

Mr. Rehagen stated that as of July 16, 42 U.S. jurisdictions have adopted the 2019 revisions to Model #785, while four jurisdictions have action under consideration. He noted that 15 states have adopted the revisions to Model #786, and seven
jurisdictions currently have action under consideration. He stated that the maps showing the adoption of the 2019 revisions to Model #785 and Model #786 were included in the meeting materials (Attachment Nine).

Mr. Rehagen stated that the 2019 revisions to the models must be adopted by the states prior to Sept. 1, 2022, which is the date at which the FIO must complete its federal preemption reviews under the EU Covered Agreement. He stated that the Task Force will provide support to the states to meet this deadline, and it will communicate with the U.S. Department of the Treasury (Treasury Department) and the FIO as necessary. He noted that there have not been any specific conversations with either the FIO or the European Union (EU) about extending this deadline, but there have been some preliminary discussions with the FIO on the status of state adoptions. Mr. Rehagen recommended that all states and jurisdictions adopt the 2019 revisions to Model #785 and Model #786 as soon as possible and no later than July 1, 2022, in order to give the FIO time for its federal preemption analysis.

Mr. Rehagen stated that the current adoption maps can be found on the Task Force’s web page. He noted that Mr. Schelp and Jake Stultz (NAIC) can answer any technical questions during the legislative process, and Holly Weatherford (NAIC) is working directly with the states on the adoption of the 2019 revisions to Model #785 and Model #786.

8. Received a Status Report on the States’ Implementation of Model #787

Mr. Rehagen stated that the *Term and Universal Life Insurance Reserve Financing Model Regulation* (#787) becomes an accreditation standard on Sept. 1, 2022, with enforcement beginning on Jan. 1, 2023. He noted that as of June 22, five jurisdictions have adopted Model #787, with another six jurisdictions with action under consideration. He stated that the map showing the current adoption status for Model #787 was included in the meeting materials (Attachment Ten) and added that the adoption of Model #787 is unrelated to the covered agreements and is not potentially subject to federal preemption. Mr. Schelp noted that Model #787 mirrors *Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation* (AG 48), and that under the accreditation standards, a state may meet the requirements through an administrative practice, such as an actuarial guideline, and that AG 48 would likely be considered to be substantially similar to Model #787. Mr. Schelp noted that if a state adopts Model #787, it also will need to adopt Section 5B(4) of Model #785.

Mr. Clayburn asked if a state may adopt Section 5B(4) of Model #785 into its state’s regulation, and Mr. Schelp stated that such an approach should be acceptable.

9. Discussed Other Matters

John Huff (Association of Bermuda Insurers and Reinsurers—ABIR) stated that the Bermuda Monetary Authority (BMA) had announced on July 26 that Bermuda reinsurers had provided up to $2.7 billion worth of support to the Texas insurers because of the widespread winter storm in early 2021.

Having no further business, the Reinsurance (E) Task Force adjourned.
Proposed 2022 Charges of the
Reinsurance (E) Task Force

2022 Charges

The **Reinsurance (E) Task Force** will:

A. Provide a forum for the consideration of reinsurance-related issues of public policy.


C. Monitor the implementation of the 2011, 2016 and 2019 revisions to the Credit for Reinsurance Model Law (#785); and the 2011 and 2019 revisions to the Credit for Reinsurance Model Regulation (#786) and the Term and Universal Life Insurance Reserve Financing Model Regulation (#787).

D. Communicate and coordinate with the Federal Insurance Office (FIO), other federal authorities, and international regulators and authorities on matters pertaining to reinsurance.

E. Consider any other issues related to the revised Model #785, Model #786 and Model #787.

F. Monitor the development of international principles, standards and guidance with respect to reinsurance. This includes, but is not limited to, monitoring the activities of various groups within the International Association of Insurance Supervisors (IAIS), including the Reinsurance and Other Forms of Risk Transfer Subcommittee, the Reinsurance Mutual Recognition Subgroup and the Reinsurance Transparency Group.

G. Consider the impact of reinsurance-related federal legislation, including, but not limited to, the federal Nonadmitted and Reinsurance Reform Act (NRRA) and the Federal Insurance Office Act, and coordinate any appropriate NAIC action.

H. Continue to monitor the impact of reinsurance-related international agreements, including the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement) and the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (UK Covered Agreement).

The **Reinsurance Financial Analysis (E) Working Group** will:

A. Operate in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings and operate in open session when discussing certified reinsurance topics and policy issues, such as amendments to the Uniform Application for Certified Reinsurers.

B. Provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.

C. Provide a forum for discussion among NAIC jurisdictions of reinsurance issues related to specific companies, entities or individuals.

D. Support, encourage, promote and coordinate multistate efforts in addressing issues related to certified reinsurers, including, but not limited to, multistate recognition of certified reinsurers.

E. Provide analytical expertise and support to the states with respect to certified reinsurers and applicants for certification.

F. Provide advisory support with respect to issues related to the determination of qualified jurisdictions.

G. Ensure the public passporting website remains current.

H. For reinsurers domiciled in Reciprocal Jurisdictions, determine the best and most effective approaches for the financial solvency surveillance to assist the states in their work to protect the interests of policyholders.
April 23, 2021

Ms. Chlora Lindley-Myers
Chair
NAIC Reinsurance (E) Task Force

Sent via email: jstutz@naic.org and dschelp@naic.org

RE: Updated Process for Evaluating Qualified and Reciprocal Jurisdictions

Greetings:

The American Council of Life Insurers (ACLI) appreciates the opportunity to comment on the updated Process for Evaluating Qualified and Reciprocal Jurisdictions document.

During our review, we did not notice any new additional language that seemed to be incorrect or caused confusion in reading. We do note that throughout the document that “Qualified Jurisdiction Working Group” is utilized. With that working group being renamed to “Mutual Recognition of Jurisdictions Working Group”, we would suggest updating the document with the new name of the working group.

Sincerely,

Steven Clayburn

cc: Jake Stultz, Senior Accounting and Reinsurance Policy Advisor
    Dan Schelp, Chief Counsel, Regulatory Affairs
NAIC Consultation on Qualified & Reciprocal Jurisdiction Process

The Association of Bermuda Insurers and Reinsurers ("ABIR") kindly thanks the National Association of Insurance Commissioners ("NAIC") for the opportunity to comment on its consultation on revisions to the Qualified and Reciprocal Jurisdiction Process. ABIR represents the public policy interests of Bermuda’s leading insurers and reinsurers and make up over 35% of the global reinsurance market based on property & casualty net premiums earned. ABIR members employ over 43,000 Americans in the U.S. and protect consumers around the world by providing affordable and accessible insurance protection and peace of mind. From our review of the revised draft, the changes appear to be focused on two areas, which are new procedures for termination of the status of a qualified and/or reciprocal jurisdictions and the passporting process for reciprocal jurisdictions. The following are ABIR’s comments.

Termination of Status as Qualified ("QJ") and/or Reciprocal ("RJ") Jurisdiction

If a QJ is found to be out of compliance with the requirements to be a QJ, the QJ Working Group will report the details of the non-compliance to the Task Force and ultimately, the QJ may then be placed on probation or have its designation suspended or revoked. The process is the same for a RJ except for those RJs entitled to automatic recognition. The revised process notes that it is intended that compliance with the covered agreement for an RJ will ultimately be determined by the Joint Committee established under the covered agreement, or through termination of the covered agreement by the parties to the covered agreement.

If a QJ or RJ’s status is revoked by a state, then those Certified Reinsurers and/or Reciprocal Jurisdiction Reinsurers domiciled in that jurisdiction must post within three months of this determination one hundred percent (100%) collateral on all their liabilities assumed from ceding insurers domiciled in that state. Due to the potential significant financial impact to a reinsurer of this change in status, ABIR is concerned that the proposed three-month time frame to establish the required collateral in the event of the revocation of a jurisdiction’s status, may not be reasonable.

Additionally, the revision notes “Both Qualified Jurisdictions and Reciprocal Jurisdictions that are not subject to a covered agreement are obligated to provide notice to the Qualified Jurisdiction Working Group of any applicable changes to their reinsurance supervisory system” or any adverse developments with respect to enforcement of final U.S. judgments. States and U.S. ceding insurers may also provide notice of such changes to the Working Group. ABIR would like additional information on this process, highlighting the potential for unintended consequences of allowing ceding insurers to report changes to a jurisdiction’s reinsurance supervisory systems.

Passporting Process for Reciprocal Jurisdiction

The proposed revisions describe the NAIC process called “passporting” under which the commissioner has the discretion to defer to another state’s determination with respect to the requirements for both Certified
Reinsurers and Reciprocal Jurisdiction Reinsurers. It notes that passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process.

ABIR supports a process to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the States. In addition, we would recommend that states are strongly encouraged to collaborate to facilitate uniformity, reduce friction and increase efficiency.

I am willing to make myself available, if you wish to discuss any of these matters further.

Kind regards
Suzanne Williams-Charles
April 23, 2021

VIA ELECTRONIC MAIL

Mr. Jake Stultz
Senior Accounting and Reinsurance Policy Advisor
National Association of Insurance Commissioners
1100 Walnut Street Suite 1500
Kansas City, MO 64106-2197
E-mail: jstultz@naic.org

Mr. Daniel Schelp
Chief Counsel, Regulatory Affairs
National Association of Insurance Commissioners
1100 Walnut Street Suite 1500
Kansas City, MO 64106-2197
E-mail: dschelp@naic.org

Re: Proposed Revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions

Dear Mr. Stultz and Mr. Schelp:

We are writing on behalf of the International Underwriting Association of London (“IUA”), a trade association that represents international insurers and reinsurers operating in the London Insurance Market. A number of IUA members are currently registered as certified reinsurers and it is anticipated that those companies, and perhaps additional IUA members, will seek reciprocal jurisdiction reinsurer status in the future.

We greatly appreciate the opportunity to comment on the proposed revisions to the Process for Evaluating Qualified and Reciprocal Jurisdictions.

Proposed Revisions to New Section III, Paragraph 15

Section 9C(7) of the Credit for Reinsurance Model Regulation (#786) requires the supervisory authority of an assuming insurer domiciled in a Reciprocal Jurisdiction (a “Reciprocal Reinsurer”) to confirm on an annual basis to the relevant state insurance regulator that such Reciprocal Reinsurer complies with the minimum capital and surplus and minimum solvency or capital ratio requirements set forth in the Credit for Reinsurance Model Regulation (#786). To that end, the new Section III, Paragraph 15 of the Process for Evaluating Qualified and Reciprocal Jurisdictions creates a process for Reciprocal Jurisdictions to make annual filings of the relevant financial information.
To make such a filing, the supervisory authority in a Reciprocal Jurisdiction would need to: (1) track on an annual basis which Reciprocal Reinsurers domiciled in their jurisdiction had obtained such status and file the required information on behalf of multiple reinsurers in potentially1 multiple states; (2) collect the relevant financial information from the Reciprocal Reinsurers domiciled in their jurisdiction; and (3) develop a system for filing such information with U.S. insurance regulators. This filing process would clearly impose considerable burdens on Reciprocal Jurisdictions. The process, however, could be streamlined by adding as an option allowing individual Reciprocal Reinsurers to file the required financial information directly with U.S. insurance regulators.

A Reciprocal Jurisdiction should be permitted to either make an annual filing as reflected in the proposed draft or, alternatively, issue a document to the Reciprocal Reinsurers confirming the information required by Section 9C(7) of the Credit for Reinsurance Model Regulation (#786), similar to a certificate of good standing, which the Reciprocal Reinsurers would then annually file directly with state insurance regulators (e.g., as part of a Reciprocal Reinsurer’s application for or renewal of status as a Reciprocal Reinsurer).

Given that the Reciprocal Reinsurers are more likely to already have developed systems of making filings with supervisory authorities in general, allowing those Reciprocal Reinsurers to make the required filings with U.S. insurance regulators directly would likely be more efficient than asking supervisory authorities in Reciprocal Jurisdictions to establish whole new systems and procedures for making financial filings on behalf of the Reciprocal Reinsurers domiciled in those Reciprocal Jurisdictions.

Attached hereto as Appendix A are proposed revisions to the new Section III, Paragraph 15 of the Process for Evaluating Qualified and Reciprocal Jurisdictions that would allow for a more streamlined approach. Specifically, with respect to the changes reflected in the attached document:

1. The first proposed change to paragraph 15.c. is to permit a Reciprocal Jurisdiction to satisfy the requirements of Section 9C(7) of the Credit for Reinsurance Model Regulation (#786) by either making a filing itself or providing to a Reciprocal Reinsurer domiciled in that Reciprocal Jurisdiction a document confirming the required information, which the assuming insurer would then file with relevant state insurance regulators.

2. The second proposed change to paragraph 15.c. is to address the fact that Reciprocal Jurisdictions do not do business in the U.S. and in many cases, neither do the Reciprocal Reinsurers from those Reciprocal Jurisdictions. Therefore, we propose that filings of financial information be required in those states where the Reciprocal Reinsurer has reinsured ceding

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1 We say potentially because, although the hope is that states adopt the passporting process, states are not required to follow the passporting process, and so such filings may be required in multiple states.
insurers domiciled in such states, subject to the alternative options of making the filings with its Lead State or the NAIC.

* * *

**Additional Comments on Procedures Related to Reciprocal Jurisdiction Designation**

We would like to offer some additional comments on how this new designation of a Reciprocal Reinsurer will be used.

Once this process is adopted and implemented, the Reinsurance Financial Analysis (E) Working Group (“ReFAWG”) will be evaluating two kinds of reinsurers – Certified Reinsurers and Reciprocal Reinsurers. Generally, these two categories of reinsurers are similar and differ mainly based on the status of the regulatory authority where they are domiciled. For example, both types of reinsurers are required to have minimum capital and surplus of $250 million.

Given the similarity of the standards to be considered by individual states and ReFAWG with respect to both types of reinsurers, it would make the process more efficient for everyone if the evaluation of Reciprocal Reinsurers were treated in a similar manner to Certified Reinsurers. More specifically, to simplify the process and ensure consistent application of standards, we recommend the following:

1. There should be uniform timing for the application and renewal dates for Certified Reinsurer and Reciprocal Reinsurer status – we suggest June 30th, a date that is currently commonly used by states.

2. The effect of obtaining Certified Reinsurer and Reciprocal Reinsurer status is prospective (i.e., only applies to new business written). Therefore, even after the application and renewal process for Reciprocal Reinsurer status is established, some reinsurers may have designations as a Certified Reinsurer for some business and a Reciprocal Reinsurer for other business. Such reinsurers would have status renewal obligations with respect to both designations. Given the similarity of the financial standards, as discussed above, we recommend that in the case where a reinsurer has both statuses in a given state, such reinsurer should only be obligated to file one set of information to renew both statuses.

3. We strongly support the proposed passporting process for Reciprocal Jurisdictions and Reciprocal Reinsurers.

We ask that the ReFAWG consider these suggestions when the ReFAWG Manual is revised.
Thank you once again for the opportunity to share these comments, which we would be happy to discuss further at your request.

Sincerely,

John Finston

JFF/yf

cc: Helen Dalziel, International Underwriting Association
    Thomas M. Dawson, McDermott Will & Emery LLP
    Yuliya Feldman, McDermott Will & Emery LLP
APPENDIX A

Proposed Revisions to Section III, Paragraph 15 of the Process for Evaluating Qualified and Reciprocal Jurisdictions

15. Passporting Process for Reciprocal Jurisdictions

a. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting” under which the commissioner has the discretion to defer to another state’s determination with respect to the requirements for both Certified Reinsurers and Reciprocal Jurisdiction Reinsurers. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings.

b. The passporting process is facilitated through the Reinsurance Financial Analysis (E) Working Group (ReFAWG). It is intended that ReFAWG will help facilitate multi-state recognition of Certified Reinsurers and Reciprocal Jurisdiction Reinsurers and address issues of uniformity among the states, both with respect to initial application and subsequent changes in rating or status. The ReFAWG Review Process is set forth in the ReFAWG Procedures Manual.

c. Section 9C(7) of the Credit for Reinsurance Model Regulation (#786) provides that the “assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis that the assuming insurer complies with the requirements set forth in Paragraphs (2) [i.e., minimum capital and surplus of no less than $250] and (3) [i.e., minimum solvency or capital ratio] of this subsection.” Section 9E(1) of Model #786 then provides that “The commissioner may accept financial documentation filed with another NAIC accredited jurisdiction or with the NAIC in satisfaction of the requirements of Subsection C.” A Reciprocal Jurisdiction may satisfy the requirements of Section 9C(7) of Model #786 by either providing the information required by Section 9C(7) itself, or by providing to an assuming insurer domiciled in that Reciprocal Jurisdiction a document confirming the required information, which the assuming insurer would file annually. With respect to either filing method, the required information would be filed with each state in which such assuming insurer has reinsured a ceding insurer domiciled in that state it is doing business, or with the Lead State or the NAIC, which will share this documentation with the other states through the ReFAWG Review Process. Each state may accept financial documentation filed with the Lead State or with the NAIC.
April 23, 2021

Director Chlora Lindley-Myers, Chair
Reinsurance (E) Task Force
National Association of Insurance Commissioners
c/o Mr. Dan Schelp and Mr. Jake Stultz
Via e-mail dschelp@naic.org, jstultz@naic.org

Re: NAIC Request for Comments on Draft Process for Evaluating Qualified and Reciprocal Jurisdictions

Dear Director Lindley-Myers:

The Reinsurance Association of America (RAA) appreciates the opportunity to submit comments on the NAIC’s exposure draft of its revised Process for Evaluating Qualified and Reciprocal Jurisdictions. The Reinsurance Association of America (RAA) is a national trade association representing reinsurance companies doing business in the United States. RAA membership is diverse, including reinsurance underwriters and intermediaries licensed in the U.S. and those that conduct business on a cross-border basis. The RAA also has life reinsurance affiliates.

We appreciate the Reinsurance Task Force’s continued thoughtful engagement with respect to implementation of its 2019 revisions to the NAIC Credit for Reinsurance Model Law and Model Regulation, including its continued work on the draft of its Process for Evaluating Qualified and Reciprocal Jurisdictions. This is another important step in the implementation process for the U.S./EU and U.S./UK covered agreements and in the NAIC’s expressed goal to revise the credit for reinsurance framework in the U.S. to create an equal playing field for all reinsurers that meet the legal requirements and commitments from the new category of “Reciprocal Jurisdictions.” The Process for Evaluating Qualified and Reciprocal Jurisdictions provides the framework through which U.S. and non-U.S. jurisdictions will be evaluated as Reciprocal Jurisdictions, principles for that evaluation and a structure for review of Reciprocal Jurisdiction status.

Termination of Status as a Qualified and/or Reciprocal Jurisdiction

We appreciate the changes to provide a process for termination of status as a Qualified and/or Reciprocal Jurisdiction. Having a clear process for termination or re-evaluation of a jurisdiction’s status is critical. In addition, we appreciate the inclusion of the clarification that a U.S. ceding insurer may provide notice to the Qualified Jurisdiction Working Group if they receive notice of any material change in the applicable reinsurance supervisory system or any adverse developments with respect to enforcement of final U.S. judgments. Active engagement with companies in addition to regulators will help to enhance timely and effective review, if needed. We also appreciate the specificity with respect to the process for reinstatement of a Reciprocal Jurisdiction. The Task Force may wish to include a provision that the Qualified Jurisdiction Working Group affirmatively survey those U.S. companies doing business in the relevant jurisdiction about their
experience there or to have a clearer process through which issues experienced by U.S. companies can be handled.

Passporting Process for Reciprocal Jurisdictions

We also welcome the additional clarity with respect to the passporting process for Reciprocal Jurisdictions, including recognition between U.S. jurisdictions. In addition to the process set forth in the framework, we urge the Task Force and NAIC staff to work with those states that already have passed the 2019 Model Law and Regulation to communicate publicly when they are prepared to accept applications for reinsurers from Reciprocal Jurisdictions.

Conclusion

Thank you for your continued work and engagement with us in this important process. We would be happy to answer any questions or discuss any concerns.

Sincerely,

Karalee C. Morell
SVP and General Counsel
Reinsurance Association of America
II. Principles for the Evaluation of Non-U.S. Jurisdictions

6. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the List of Reciprocal Jurisdictions. A state must consider this list in its determination of Reciprocal Jurisdiction status, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Reciprocal Jurisdictions contained in the Credit for Reinsurance Models. Under the Credit for Reinsurance Model Law (as adopted by a state) the state must recognize the Reciprocal Jurisdiction status of jurisdictions subject to an in-force Covered Agreement.

8. Both Qualified Jurisdictions and Reciprocal Jurisdictions have agreed to share specific information and cooperate with the state with respect to all applicable reinsurers domiciled within that jurisdiction, in accordance with the Credit for Reinsurance Models, as adopted by the state. Critical factors in the evaluation process include but are not limited to the history of performance by assuming insurers in the applicant jurisdiction and any documented evidence of substantial problems with the enforcement of final U.S. judgments in the applicant jurisdiction. A jurisdiction will not be a Qualified Jurisdiction if the commissioner has determined that it does not adequately and promptly enforce final U.S. judgments or arbitration awards.

III. Procedure for Evaluation of Non-U.S. Jurisdictions

14. Termination of Status as Qualified and/or Reciprocal Jurisdiction

a. If the Mutual Recognition of Jurisdictions (E) Working Group finds a Qualified Jurisdiction to be out of compliance at any time with the requirements to be a Qualified Jurisdiction, the specific reasons will be documented in a report to the jurisdiction under review. The Mutual Recognition of Jurisdictions (E) Working Group would then report any concerns to the Reinsurance (E) Task Force for further discussion and communication with appropriate federal and/or international authorities. The status as a Qualified Jurisdiction may be placed on probation, suspended or revoked by the NAIC. If a Qualified Jurisdiction is also a Reciprocal Jurisdiction subject to a Covered Agreement, the Mutual Recognition of Jurisdictions (E) Working Group and the NAIC will initiate communications and consult with FIO, USTR and any other relevant federal and/or international authorities before any action is taken with respect to that Qualified Jurisdiction’s status.

b. Except for Reciprocal Jurisdictions entitled to automatic recognition, a jurisdiction’s status as a Reciprocal Jurisdiction may be placed on probation, suspended or revoked for good cause in the same manner as provided for Qualified Jurisdictions. If cause is found to question the
fitness of a Reciprocal Jurisdiction that is subject to an in-force Covered Agreement, or its compliance with applicable requirements of the covered agreement, the Mutual Recognition of Jurisdictions (E) Working Group would report any concerns to the Reinsurance (E) Task Force for further discussion and communication with appropriate federal and/or international authorities. It is intended that compliance with the covered agreement will be addressed through the Joint Committee process established under the covered agreement, or through termination of the covered agreement by the parties to the covered agreement. The NAIC, individual state regulators and interested parties may raise these issues directly with FIO, USTR or other relevant federal authorities.
Note: The draft revisions to the *Process for Evaluating Qualified and Reciprocal Jurisdictions* were originally exposed at the Reinsurance (E) Task Force’s March 23 meeting, and four comment letters were received. The Mutual Recognition of Jurisdictions (E) Working Group then discussed this document and the comment letters on its May 27 regulator-only call and revised the document accordingly. All revisions that were made after the initial public exposure on March 23 are included in this document and are tracked with yellow highlights.

Process for Evaluating Qualified and Reciprocal Jurisdictions
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I. Preamble

Purpose

The revised Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (collectively, the Credit for Reinsurance Models) require an assuming insurer to be licensed and domiciled in a “Qualified Jurisdiction” in order to be eligible for certification by a state as a certified reinsurer for reinsurance collateral reduction purposes. In 2012, the NAIC Reinsurance (E) Task Force was charged to develop an NAIC process to evaluate the reinsurance supervisory systems of non-U.S. jurisdictions, for the purposes of developing and maintaining a list of jurisdictions recommended for recognition by the states as Qualified Jurisdictions. This charge was extended in 2019 to encompass the recognition of Reciprocal Jurisdictions in accordance with the 2019 amendments to the Credit for Reinsurance Models, including the maintenance of a list of recommended Reciprocal Jurisdictions. The purpose of the Process for Evaluating Qualified and Reciprocal Jurisdictions is to provide a documented evaluation process for creating and maintaining these NAIC lists.

Background

On November 6, 2011, the NAIC Executive (EX) Committee and Plenary adopted revisions to the Credit for Reinsurance Models. These revisions serve to reduce reinsurance collateral requirements for certified reinsurers that are licensed and domiciled in Qualified Jurisdictions. Under the previous version of the Credit for Reinsurance Models, in order for U.S. ceding insurers to receive reinsurance credit, the reinsurance was required to be ceded to U.S.-licensed reinsurers or secured by collateral representing 100% of U.S. liabilities for which the credit is recorded. When considering revisions to the Credit for Reinsurance Models, the Reinsurance (E) Task Force contemplated establishing an accreditation-like process, modeled on the current NAIC Financial Regulation Standards and Accreditation Program, to review the reinsurance supervisory systems of non-U.S. jurisdictions. Under the revised Credit for Reinsurance Models, the approval of Qualified Jurisdictions is left to the authority of the states; however, the models provide that a list of Qualified Jurisdictions will be created through the NAIC committee process, and that individual states must consider this list when approving jurisdictions.

The enactment in 2010 of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) enacted in 2010. Further, the Dodd-Frank Act authorizes the U.S. Treasury Secretary and the U.S. Trade Representative (USTR), jointly, to negotiate and enter into “covered agreements” on behalf of the United States. These are bilateral or multilateral agreements with foreign governments, authorities or regulators relating to insurance prudential measures, which can preempt contrary state insurance laws or regulatory measures. The Dodd-Frank Act also created the Federal Insurance Office (FIO), which has the following authority: (1) coordinate federal efforts and develop federal policy on prudential aspects of international insurance matters; (2) assist the Secretary of the U.S. Department of the Treasury in negotiating covered agreements (as defined in the Dodd-Frank Act); (3) determine whether the states’ insurance measures are preempted by covered agreements; and (4) consult with the states (including state insurance regulators) regarding insurance matters of national importance and prudential insurance matters of international importance. Further, the Dodd-Frank Act authorizes the U.S. Treasury Secretary and the U.S. Trade Representative (USTR), jointly, to negotiate and enter into covered agreements on behalf of the United States. It is the NAIC’s intention to communicate and coordinate with the FIO and related federal authorities as appropriate with respect to the evaluation of the reinsurance supervisory systems of non-U.S. jurisdictions.

On September 22, 2017, the United States and the European Union (EU) entered into the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and
Reinsurance.” A similar agreement with the United Kingdom (UK) was signed on December 18, 2018. Both agreements (collectively referred to as the “Covered Agreements”) will require the states to eliminate reinsurance collateral requirements for reinsurers licensed and domiciled in these jurisdictions within 60 months (five years) after signing or face potential federal preemption by the Federal Insurance Office (FIO) under the Dodd-Frank Act.

Reciprocal Jurisdictions

On June 25, 2019, the NAIC Executive (EX) Committee and Plenary adopted revisions to the Credit for Reinsurance Models. These revisions were intended to conform the Models to the relevant provisions of the Covered Agreements. The Covered Agreements would eliminate reinsurance collateral requirements for EU and UK reinsurers that maintain a minimum amount of own funds equivalent to $250 million and a solvency capital requirement (SCR) of 100% under Solvency II, among other conditions. Conversely, U.S. reinsurers that maintain capital and surplus equivalent to 226 million euros with a risk-based capital (RBC) of 300% of authorized control level would not be required to maintain a local presence in order to do business in the EU or UK or post reinsurance collateral. Under the revised Credit for Reinsurance Models, jurisdictions that are subject to in-force Covered Agreements are considered to be Reciprocal Jurisdictions, and reinsurers that have their head office or are domiciled in a Reciprocal Jurisdiction are not required to post reinsurance collateral if they meet all of the requirements of the Credit for Reinsurance Models.

Under the revised Credit for Reinsurance Models, not only are jurisdictions that are subject to Covered Agreements treated as Reciprocal Jurisdictions for reinsurance collateral purposes, but any other Qualified Jurisdictions can also has a pathway to qualify for collateral elimination as a Reciprocal Jurisdictions States that meet the requirements of the NAIC Financial Standards and Accreditation Program are also considered to be Reciprocal Jurisdictions.

The NAIC has updated and revised this Process for Evaluating Qualified and Reciprocal Jurisdictions to specify how Qualified Jurisdictions that recognize key NAIC solvency initiatives, including group supervision and group capital standards, and also meet the other requirements under the revised Credit for Reinsurance Models, will be recognized as Reciprocal Jurisdictions and receive similar treatment as that provided under the EU and UK Covered Agreements, including the elimination of reinsurance collateral and local presence requirements by the states.

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1 The hypothetical possibility that a future covered agreement might not relate to reinsurance is addressed in Section 2P(1)(a)(i) of Model #785, which limits automatic Reciprocal Jurisdiction status to a covered agreement that “addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance.”
II. Principles for the Evaluation of Non-U.S. Jurisdictions

1. The NAIC model revisions applicable to certified reinsurers are intended to facilitate cross-border reinsurance transactions and enhance competition within the U.S. market, while ensuring that U.S. insurers and policyholders are adequately protected against the risk of insolvency. To be eligible for certification, a reinsurer must be domiciled and licensed in a Qualified Jurisdiction as determined by the domestic regulator of the ceding insurer. A Qualified Jurisdiction not subject to an in-force Covered Agreement under the Dodd-Frank Act may also be determined to be a Reciprocal Jurisdiction, and reinsurers that have their head office or are domiciled in any such Reciprocal Jurisdiction will not be required to post reinsurance collateral, provided they meet the minimum capital and financial strength requirements and comply with the other requirements of the Credit for Reinsurance Models.

2. The evaluation of non-U.S. jurisdictions as Qualified Jurisdictions and Reciprocal Jurisdictions will be conducted in accordance with the provisions of the Credit for Reinsurance Models and any other relevant guidance developed by the NAIC.

3. The evaluation of non-U.S. jurisdictions as Qualified Jurisdictions is intended as an outcomes-based comparison to financial solvency regulation under the NAIC Financial Regulation Standards and Accreditation Program (Accreditation Program), adherence to international supervisory standards, and relevant international guidance for recognition of reinsurance supervision. It is not intended as a prescriptive comparison to the NAIC Accreditation Program. In order for a Qualified Jurisdiction that is not subject to an in-force Covered Agreement to be evaluated as a Reciprocal Jurisdiction, that Qualified Jurisdiction must agree to recognize the states’ approach to group supervision, including group capital, and other such requirements as provided under the Credit for Reinsurance Models.

4. The states shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system within the Qualified Jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the jurisdiction to reinsurers licensed and domiciled in the U.S. The determination of Qualified Jurisdiction status is based on the effectiveness of the entire reinsurance supervisory system within the jurisdiction.

5. Each state may evaluate a non-U.S. jurisdiction to determine if it is a Qualified Jurisdiction. A list of Qualified Jurisdictions will be published through the NAIC committee process. A state must consider this list in its determination of Qualified Jurisdictions, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Qualified Jurisdictions contained in the Credit for Reinsurance Models. The creation of this list does not constitute a delegation of regulatory authority to the NAIC. The regulatory authority to recognize a Qualified Jurisdiction resides solely in each state and the NAIC List of Qualified Jurisdictions is not binding on the states.

6. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the List of Reciprocal Jurisdictions. A state must consider this list in its determination of Reciprocal Jurisdiction status, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Reciprocal Jurisdictions contained in the Credit for Reinsurance Models.

7. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting,” as discussed more fully below in paragraph 15 of Section...
III-under which the commissioner has the discretion to defer to another state’s determination that a jurisdiction is a Qualified or Reciprocal Jurisdiction. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings. The NAIC Lists of Qualified and Reciprocal Jurisdictions are intended to facilitate the passporting process.

8. Both Qualified Jurisdictions and Reciprocal Jurisdictions must agree to share information and cooperate with the state with respect to all applicable reinsurers domiciled within that jurisdiction. Critical factors in the evaluation process include but are not limited to the history of performance by assuming insurers in the applicant jurisdiction and any documented evidence of substantial problems with the enforcement of final U.S. judgments in the applicant jurisdiction. A jurisdiction will not be a Qualified Jurisdiction if the commissioner has determined that it does not adequately and promptly enforce final U.S. judgments or arbitration awards.

9. The determination of Qualified Jurisdiction status can only be made with respect to the reinsurance supervisory system in existence and applied by a non-U.S. jurisdiction at the time of the evaluation.

10. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to the evaluation of the reinsurance supervisory systems of non-U.S. jurisdictions.
III. Procedure for Evaluation of Non-U.S. Jurisdictions

   a. Priority will be given to requests from the states and from those jurisdictions specifically requesting an evaluation by the NAIC.
   b. Formal notification of the NAIC’s intent to initiate the evaluation process will be sent by the NAIC to the reinsurance supervisory authority in the jurisdiction selected, with copies to the FIO and other relevant federal authorities as appropriate. The NAIC will issue public notice on the NAIC website upon confirmation that the jurisdiction is willing to participate in the evaluation process. The NAIC will at this time request public comments with respect to consideration of the jurisdiction as a Qualified Jurisdiction. The process of evaluation and all related documentation are private and confidential matters between the NAIC and the applicant jurisdiction, unless otherwise provided in this document, subject to a preliminary confidentiality and information sharing agreement between the NAIC, relevant states and the applicant jurisdiction.
   c. Relevant U.S. state and federal authorities will be notified of the NAIC’s decision to evaluate a jurisdiction.

2. Evaluation of Jurisdiction
   a. Evaluation Materials. The Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group will initiate evaluation of a jurisdiction’s regulatory system by using the information identified in Section A through Section G of the Evaluation Methodology (Evaluation Materials). The Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group will begin by undertaking a review of the most recent Financial Sector Assessment Program (FSAP) Report prepared by the International Monetary Fund (IMF), including the Technical Note on Insurance Sector Supervision, and any other publicly available information regarding the laws, regulations, practices and procedures applicable to the reinsurance supervisory system. The Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group will also invite each jurisdiction or its designee to provide information relative to Section A through Section G of the Evaluation Methodology in order to update, complete or supplement publicly available information. The Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group may also request or accept relevant information from reinsurers domiciled in the jurisdiction under review.
   b. The Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group will notify the jurisdiction of any information upon which the Working Group is relying. In that communication, the NAIC will invite the supervisory authority to compare the materials identified by the NAIC to the materials described in Appendix A and Appendix B, and provide information required to update the identified public information or supplement the public information, as required, to address the topics identified in Section A through Section G of the Evaluation Methodology. The use of publicly available information (e.g., the FSAP Report and/or the Insurance Sector Technical Note) is intended to lessen the burden on applicant jurisdictions by requiring the production of information that is readily available, while still addressing substantive areas of inquiry detailed in the Evaluation Methodology. The Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group’s review at this stage will be focused on how the jurisdiction’s laws, regulations, administrative practices and procedures, and regulatory authorities regulate the financial solvency of its domestic reinsurers in comparison to key
principles underlying the U.S. financial solvency framework\(^2\) and other factors set forth in the Evaluation Methodology.

c. After reviewing the Evaluation Materials, the **Qualified Jurisdiction Working Group**\(^2\) may request that the applicant jurisdiction submit supplemental information as necessary to determine whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. The Working Group will address specific questions directly with the jurisdiction related to items detailed in the Evaluation Methodology that are not otherwise addressed in the Evaluation Materials.

d. The NAIC will request that all responses from the jurisdiction being evaluated be provided in English. Any responses submitted with respect to a jurisdiction’s laws and regulations should be provided by a person qualified in that jurisdiction to provide such analyses and, in the case of statutory analysis, qualified to provide such legal interpretations, to ensure that the jurisdiction is providing an accurate description.

e. The NAIC does not intend to review confidential company-specific information in this process, and has focused the procedure on reviewing publicly available information. No confidential company-specific information shall be disclosed or disseminated during the course of the jurisdiction’s evaluation unless specifically requested, subject to appropriate confidentiality safeguards addressed in a preliminary confidentiality and information-sharing agreement. If no such agreement is executed or the jurisdiction is unable to enter into such an agreement under its regulatory authority, the NAIC will not accept any confidential company-specific information.

3. **NAIC Review of Evaluation Materials**

a. NAIC staff and/or outside consultants with the appropriate knowledge, experience and expertise will review the jurisdiction’s Evaluation Materials.

b. Expenses with respect to the evaluations will be absorbed within the NAIC budget. This will be periodically reviewed.

c. Timeline for review. A project management approach will be developed with respect to the overall timeline applicable to each evaluation.

d. Upon completing its review of the Evaluation Materials, the internal reviewer(s) will report initial findings to the **Qualified Jurisdiction Working Group**\(^2\), including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation. Copies of the initial findings may also be made available to FIO and other relevant federal authorities subject to appropriate confidentiality and information-sharing agreements being in place.

4. **Discretionary On-site Review**

a. The NAIC may ask the jurisdiction under consideration for the opportunity to perform an on-site review of the jurisdiction’s reinsurance supervisory system. Factors that the **Qualified Jurisdiction Working Group**\(^2\) will consider in determining whether an on-site review is appropriate include the completeness of the information provided by the jurisdiction under

\(^2\) The U.S. financial solvency framework is understood to refer to the key elements provided in the NAIC Financial Regulation Standards and Accreditation Program. Appendix A and Appendix B are derived from this framework.
review, the general familiarity of the jurisdiction by the NAIC staff or other state regulators participating in the review based on prior conduct or dealings with the jurisdiction, and the results of other evaluations performed by other regulatory or supervisory organizations. If the review is performed, it will be coordinated through the NAIC, utilizing personnel with the appropriate knowledge, experience and expertise. Individual states may also request that representatives from their state be added to the review team.

b. The review team will communicate with the supervisory authority in advance of the on-site visit to clearly identify the objectives, expectations and procedures with respect to the review, as well as any significant issues or concerns identified within the review of the Evaluation Materials. Information to be considered during the on-site review includes, but is not limited to, the following:
   i. Interviews with supervisory authority personnel.
   ii. Review of organizational and personnel practices.
   iii. Any additional information beneficial to gaining an understanding of document and communication flows.

c. Upon completing the on-site review, the reviewer(s) will report initial findings to the Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation.

5. Standard of Review

The evaluation is intended as an outcomes-based comparison to financial solvency regulation under the NAIC Accreditation Program, adherence to international supervisory standards and relevant international guidance for recognition of reinsurance supervision. The standard for qualification of a jurisdiction is that the NAIC must reasonably conclude that the jurisdiction’s reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction, that the jurisdiction’s demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system, and that the jurisdiction’s laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

6. Additional Information to be Considered as Part of Evaluation

The NAIC may also consider information from sources other than the jurisdiction under review. This information includes:
   a. Documents, reports and information from appropriate international, U.S. federal and U.S. state authorities.
   b. Public comments from interested parties.
   c. Rating agency information.
   d. Any other relevant information.

8.7 Preliminary Evaluation Report

   a. NAIC staff and/or outside consultants will prepare a Preliminary Evaluation Report for review by the Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group. This
preliminary report will be private and confidential (i.e., may only be reviewed by Working Group members, designated NAIC staff, consultants, the states, the FIO and other relevant federal authorities that specifically request to be kept apprised of this information, provided that such entities have entered into a preliminary confidentiality and information-sharing agreement with the foreign jurisdiction. Any outside consultants retained by the NAIC will be required to enter into a confidentiality and nondisclosure agreement.).

b. The report will be prepared in a consistent style and format to be developed by NAIC staff. It will contain detailed advisory information and recommendations with respect to the evaluation of the jurisdiction’s reinsurance supervisory system and the documented practices and procedures thereunder. The report will contain a recommendation as to whether the NAIC should recognize the jurisdiction as a Qualified Jurisdiction.

c. All workpapers and reports, including supporting documentation and data, produced as part of the evaluation process are the property of the NAIC and shall be maintained at the NAIC Central Office. In the event that the NAIC shall come into possession of any confidential information, the information shall be held subject to a confidentiality and information-sharing agreement, which will outline the appropriate actions necessary to protect the confidentiality of such information.

a. The Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group’s review of the Preliminary Evaluation Report will be held in regulator-to-regulator session in accordance with the NAIC Policy Statement on Open Meetings.

b. The Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group will make a preliminary determination as to whether the jurisdiction under consideration satisfies the Standard of Review and is deemed acceptable to be included on the NAIC List of Qualified Jurisdictions. If the preliminary determination is that the jurisdiction should not be included on the NAIC List of Qualified Jurisdictions, the Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group will set forth its specific findings and identify those areas of concern with respect to this determination.

c. The results of the Preliminary Evaluation Report will be immediately communicated in written form to the supervisory authority of the jurisdiction under review.

10.9. Opportunity to Respond to Preliminary Evaluation Report
a. Upon receipt of the Preliminary Evaluation Report, the supervisory authority will have an opportunity to respond to the initial findings and determination. This is not intended to be a formal appeals process that would initiate U.S. state administrative due process requirements.

b. The Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group will consider any response, and will proceed to prepare its Final Evaluation Report. The Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group will consider the Final Evaluation Report for approval in regulator-to-regulator session in accordance with the NAIC Policy Statement on Open Meetings. This report will be approved upon an affirmative vote of a majority of the members in attendance at this meeting.

c. Upon approval of the Final Evaluation Report, the Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group will issue a public statement and a summary of its findings
with respect to its determination. At this time, the Working Group will release the summary for public comment. The detailed report will be a confidential, regulator-only document. The report may be shared with any state indicating that it is considering relying on the NAIC List of Qualified Jurisdictions and has entered into a preliminary confidentiality and information-sharing agreement with the foreign jurisdiction.

11.10. NAIC Determination Regarding List of Qualified Jurisdictions

a. Once the Qualified Jurisdiction Working Group has adopted its Final Evaluation Report, it will submit the summary of its findings and its recommendation to the Reinsurance (E) Task Force at an open meeting. Upon approval by the Reinsurance (E) Task Force, the summary and recommendation will be submitted to the Executive (EX) Committee and Plenary, as well as to the FIO, USTR and other relevant federal authorities for consultation purposes. Upon approval as a Qualified Jurisdiction by the Executive (EX) Committee and Plenary, the jurisdiction will be added to the NAIC List of Qualified Jurisdictions. The NAIC will maintain the List of Qualified Jurisdictions on its public website and in other appropriate NAIC publications.

b. In the event that a jurisdiction is not approved as a Qualified Jurisdiction, the supervisory authority will be eligible for reapplication at the discretion of the NAIC.

c. Upon final adoption of the Qualified Jurisdiction Working Group’s determination with respect to a jurisdiction, the Final Evaluation Report will be made available to individual U.S. state insurance regulators upon request and confirmation that the information contained therein will remain confidential.

12.11. Memorandum of Understanding (MOU)

a. A Qualified Jurisdiction must agree to share information and cooperate on a confidential basis with the U.S. state insurance regulatory authority with respect to all certified reinsurers domiciled within that jurisdiction.

b. The International Association of Insurance Supervisors (IAIS) Multilateral Memorandum of Understanding (MMoU) is the recommended method under which a Qualified Jurisdiction will agree to share information and cooperate with U.S. state insurance regulatory authorities. However, until such time as a state has been approved as a signatory to the MMoU by the IAIS, the state may rely on an MOU entered into by a “Lead State” designated by the NAIC. This Lead State will act as a conduit for information between the Qualified Jurisdiction and other states that have certified a reinsurer domiciled and licensed in that jurisdiction, and will share information with these states consistent with the terms governing the further sharing of information included in the NAIC Master Information Sharing and Confidentiality Agreement, and, as applicable, in the applicable IAIS MMoU, or in a bilateral MOU between the Lead State and the Qualified Jurisdiction, and pursuant to the NAIC Master Information Sharing and Confidentiality Agreement. The jurisdiction must also confirm in writing that it is willing to permit this Lead State to act as the contact for purposes of obtaining information concerning its certified reinsurers, provided the Lead State share that information with the other states requesting the information only in a manner consistent with the terms governing the further sharing of information included as in the applicable, in the IAIS MMoU or bilateral MOU between the Lead State and the Qualified Jurisdiction.
c. If a Qualified Jurisdiction has not been approved by the IAIS for use as a party to the MMoU, it must enter into an MOU with a Lead State. The MOU must provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions.

d. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to this process.


a. The process for determining whether a non-U.S. jurisdiction is a Qualified Jurisdiction is ongoing and subject to periodic review. The Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group will perform a yearly review of Qualified Jurisdictions to determine whether there have been any significant changes over the prior year that might affect their status as Qualified Jurisdictions. This yearly review shall follow such abbreviated process as may be determined by the Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group to be appropriate. It shall include a review of the jurisdiction’s status as a Reciprocal Jurisdiction if the jurisdiction has been recognized by the NAIC as a Reciprocal Jurisdiction through the process established in paragraph 13.

b. Qualified Jurisdictions must provide the Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group with notice of any material change in the applicable reinsurance supervisory system that may affect the status of the Qualified Jurisdiction. A U.S. jurisdiction should also notify the Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group if it receives notice of any material change in the applicable reinsurance supervisory system, or any adverse developments with respect to enforcement of final U.S. judgments, that may affect the status of the Qualified Jurisdiction. U.S. ceding insurers may also initiate notice to the Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group if they receive notice of any material change in the applicable reinsurance supervisory system or any adverse developments with respect to enforcement of final U.S. judgments. Upon receipt of any such notice, the Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group will consider whether it is necessary to re-evaluate the status of the Qualified Jurisdiction. Any review will be conducted in accordance with the procedure set forth in paragraph 14.

c. If the Qualified Jurisdiction Working Group finds the jurisdiction to be out of compliance at any time with the requirements to be a Qualified Jurisdiction, the specific reasons will be documented in a report to the jurisdiction under review, and the status as a Qualified Jurisdiction may be placed on probation, suspended or revoked.

d. The Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group will monitor those jurisdictions that have been approved as Qualified or Reciprocal Jurisdictions by individual states, but are not included on the applicable NAIC List of Qualified Jurisdictions.

14.13. Review of Qualified Jurisdictions as Potential Reciprocal Jurisdictions

a. In undertaking the evaluation of whether to designate a Qualified Jurisdiction as a Reciprocal Jurisdiction, the Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group shall utilize such processes and procedures as outlined in the immediately-preceding paragraphs 1 – 12 of Section

b. A Qualified Jurisdiction may not be reviewed for inclusion on the NAIC List of Reciprocal Jurisdictions, unless it has undergone the Evaluation Methodology outlined in Section IV, and remains in good standing with the NAIC as a Qualified Jurisdiction. The Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group may, if it determines an extended review period to be appropriate after its initial approval of a new Qualified Jurisdiction, defer consideration of that jurisdiction as a possible Reciprocal Jurisdiction until there has been sufficient United States experience with that jurisdiction and its Certified Reinsurers that the Working Group believes it is appropriate to progress from collateral reduction to collateral elimination. Nothing in this process requires a finding that a Qualified Jurisdiction meets the standards for recognition as a Reciprocal Jurisdiction, and the Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group may base its determination on all relevant information, which may include factors not specifically included in this Process for Evaluating Qualified and Reciprocal Jurisdictions.

c. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the NAIC List of Reciprocal Jurisdictions. In making its recommendation with respect to whether a Qualified Jurisdiction that is not automatically designated as a Reciprocal Jurisdiction should be added to the NAIC List of Reciprocal Jurisdictions, the Qualified Jurisdiction Working Group shall undertake the following analysis in making its evaluation:

i. The Qualified Jurisdiction must confirm that an insurer which has its head office or is domiciled in that jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as the same insurer would receive credit for reinsurance assumed by an assuming insurers domiciled in that jurisdiction is received by United States ceding insurers;

ii. The Qualified Jurisdiction must confirm that it does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by that jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

iii. The Qualified Jurisdiction must recognize the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by its competent regulatory authority that insurance groups that are domiciled or maintain their worldwide headquarters in
The Qualified Jurisdiction must provide written confirmation by its competent regulatory authority that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the Qualified Jurisdiction, including but not limited to the IAIS MMoU or other multilateral memoranda of understanding coordinated by the NAIC. This requirement may be satisfied by an MOU with a Lead State, which shall provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions, similar to the MOU requirement outlined in paragraph 11 of this section III; and

v. The Qualified Jurisdiction must confirm that it will provide to the states on an annual basis confirmation that each eligible assuming insurer that is domiciled in the Qualified Jurisdiction continues to comply with the requirements set forth in in Section 9C(2) and (3) of Model #786; i.e., must maintain, on an ongoing basis, minimum capital and surplus of no less than $250,000,000, and maintains on an ongoing basis the required minimum solvency or capital ratio, as applicable.

d. In order to satisfy the requirements of subsection (c) above, the chief insurance supervisor of the Qualified Jurisdiction being evaluated as a Reciprocal Jurisdiction may provide the NAIC with a written letter confirming, as follows:

[Jurisdiction] is a Qualified Jurisdiction under the NAIC Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786), and is currently in good standing on the NAIC List of Qualified Jurisdictions. As the lead insurance regulatory supervisor for [Jurisdiction], I hereby confirm to the National Association of Insurance Commissioners (NAIC) and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories the following:

- An insurer which has its head office or is domiciled in [Jurisdiction] shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit would be granted for reinsurance assumed by insurers domiciled in [Jurisdiction]. [Jurisdiction] does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by [Jurisdiction] or as a condition to allow the ceding insurer to recognize credit for such reinsurance.

- [Jurisdiction] recognizes the U.S. state regulatory approach to group supervision and group capital, and confirms that insurance groups that are domiciled or maintain their worldwide headquarters in jurisdictions accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision including
worldwide group governance, solvency and capital, and reporting, as applicable, and will
not be subject to group supervision at the level of the worldwide parent undertaking of the
insurance or reinsurance group by the [Jurisdiction].

- [Jurisdiction] confirms that information regarding insurers and their parent, subsidiary, or
affiliated entities, if applicable, shall be provided to the states in accordance with a
memorandum of understanding or similar document between a state and the [Jurisdiction].

- [Jurisdiction] will annually provide to the states confirmation that applicable assuming
insurers domiciled in [Jurisdiction] maintain minimum capital and surplus of no less than
$250,000,000, and maintain on an ongoing basis the required minimum solvency or capital
ratio, as applicable.

- Finally, I confirm that [Jurisdiction] will immediately notify the NAIC upon any changes
to the assurances provided in this letter.

e. The Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group
will perform a due diligence review of available public and confidential documents to confirm that to the best
of its determination, the representations in the letter are true and accurate, and will prepare for the review
by the Reinsurance Task Force a Summary of Findings and Determination recommending that the Qualified
Jurisdiction be recognized as a Reciprocal Jurisdiction. Upon approval by the Task Force, the Summary of
Findings and Determination must be adopted by the NAIC Executive (EX) Committee and Plenary for inclusion on the List of Reciprocal Jurisdictions.

f. The Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group,
working in coordination with the Qualified Jurisdiction and the Reinsurance Financial Analysis (E)
Working Group, must make a determination on a minimum solvency or capital ratio under which reinsurers
licensed and domiciled in the Qualified Jurisdiction may assume insurance from U.S. ceding companies
without posting reinsurance collateral. The applicable minimum solvency or capital ratio must be an
effective measure of solvency, comparable to either an NAIC risk-based capital (RBC) ratio of three
hundred percent (300%) of the authorized control level, or one hundred percent (100%) of the solvency
capital requirement (SCR) as calculated under the Solvency II Directive issued by the European Union,
giving due consideration to any applicable equivalency assessment conducted by the European Insurance
and Occupational Pensions Authority (EIOPA) on the Qualified Jurisdiction with respect to Solvency II.

14. Termination of Status as Qualified and/or Reciprocal Jurisdiction

a. If the Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group finds
the Qualified Jurisdiction to be out of compliance at any time with the requirements to be a Qualified
Jurisdiction, the specific reasons will be documented in a report to the jurisdiction under review. The
Qualified Jurisdiction Working Group Mutual Recognition of Jurisdictions (E) Working Group would then
report any concerns to its parent the Reinsurance (E) Task Force for further discussion and communication
with appropriate federal and/or international authorities, and the status as a Qualified Jurisdiction may be
placed on probation, suspended or revoked by the NAIC.
b. Except for Reciprocal Jurisdictions entitled to automatic recognition, a jurisdiction’s status as a Reciprocal Jurisdiction may be placed on probation, suspended or revoked for good cause in the same manner as provided for Qualified Jurisdictions under paragraph 12. If cause is found to question the fitness of a Reciprocal Jurisdiction that is subject to an in-force Covered Agreement, or its compliance with applicable requirements of the covered agreement, the Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group would report any concerns to its parent the Reinsurance (E) Task Force for further discussion and communication with appropriate federal and/or international authorities. It is intended that compliance with the covered agreement will ultimately be determined by the Joint Committee established under the covered agreement, or through termination of the covered agreement by the parties to the covered agreement.

c. Both Qualified Jurisdictions and Reciprocal Jurisdictions that are not subject to a covered agreement are obligated to provide notice to the Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group of any applicable changes to their reinsurance supervisory system or changes to the assurances provided in the letter set forth in paragraph 13. States and U.S. ceding insurers may also provide notice of such changes to the Working Group. Upon notice of any such material changes, the Working Group will meet in regulator-only session to determine if these changes are in fact material to continuing recognition by the NAIC as either a Qualified or Reciprocal Jurisdiction. The Working Group will work directly with the jurisdiction to address any issues that have been identified. If these issues cannot be resolved through this regulator-only dialogue, then the Working Group will report its recommendation to the Reinsurance Task Force, which will consider a suspension of the jurisdiction’s status as a Qualified or Reciprocal Jurisdiction in open session. The Task Force will then make a recommendation to the NAIC Plenary on the action, if any, to be taken, which may include placing the Qualified or Reciprocal Jurisdiction’s status on probation, or suspending or revoking its status.

d. If a Qualified or Reciprocal Jurisdiction’s status is placed on probation by the NAIC, the material change will be noted in an update to its Summary of Finding and Determination in order to provide notice to the states and U.S. ceding insurers of this material change. If the NAIC decides to suspend or revoke its status, the jurisdiction may be given a reasonable time period, no more than 18 months, to rectify its noncompliance with the standards and return it to good standing. Once the NAIC’s suspension or revocation takes effect, it is expected that the same action will be taken by the respective states that have recognized the jurisdiction as a Qualified or Reciprocal Jurisdiction.

e. There is no administrative right to appeal the decision of the NAIC with respect to the revocation of status as a Qualified or Reciprocal Jurisdiction, but the jurisdiction can apply for reinstatement after a one-year period.

b.f. During the period in which a Qualified or Reciprocal Jurisdiction’s status has been suspended by a state, any new reinsurance assumed by a reinsurer domiciled in that jurisdiction from a ceding insurer domiciled in that state will not be eligible for credit unless the transaction qualifies for credit on the basis of security posted by the ceding insurer or some other basis that does not depend on recognition of the jurisdiction as a Qualified or Reciprocal Jurisdiction. However, suspension does not affect credit for reinsurance that was already in force.
g. If a Qualified or Reciprocal Jurisdiction’s status is revoked by a state, then those Certified Reinsurers and/or Reciprocal Jurisdiction Reinsurers domiciled in that jurisdiction no longer qualify for that status, which generally must obligates them to post within three months of this determination one hundred percent (100%) collateral on all their liabilities assumed from ceding insurers domiciled in that state. The state has the option to suspend a reinsurer’s certification indefinitely, in lieu of revocation, in which case the obligation to post collateral applies prospectively to all new, renewed and amended reinsurance agreements. If the reinsurer’s eligibility is revoked, it must be granted at least three months after the effective date of the revocation to cure any deficiency in collateral, unless exceptional circumstances make a shorter period is necessary for policyholder and other consumer protection.

h. The factors used in the evaluation of Reciprocal Jurisdictions are not the same as are utilized in the evaluation of Qualified Jurisdictions. A Qualified Jurisdiction that has been approved by the NAIC as a Reciprocal Jurisdiction may have its status as a Reciprocal Jurisdiction either suspended or revoked but still meet the requirements to be a Qualified Jurisdiction. However, if a Reciprocal Jurisdiction that is not subject to a covered agreement has its status as a Qualified Jurisdiction revoked, it cannot maintain its status as a Reciprocal Jurisdiction, because it must be a Qualified Jurisdiction to meet the requirements of a Reciprocal Jurisdiction.

15. Passorting Process for Certified and Reciprocal Jurisdiction Reinsurers

a. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting” under which the commissioner has the discretion to defer to another state’s determination with respect to the requirements for both Certified Reinsurers and Reciprocal Jurisdiction Reinsurers. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings.

b. The passporting process is facilitated through the Reinsurance Financial Analysis (E) Working Group (ReFAWG). It is intended that ReFAWG will help facilitate multi-state recognition of Certified Reinsurers and Reciprocal Jurisdiction Reinsurers and address issues of uniformity among the states, both with respect to initial application and subsequent changes in rating or status. The ReFAWG Review Process is set forth in the ReFAWG Procedures Manual.

c. Section 9C(7) of the Credit for Reinsurance Model Regulation (#786) provides that the “assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis that the assuming insurer complies with the requirements set forth in Paragraphs (2) [i.e., minimum capital and surplus of no less than $250 million] and (3) [i.e., minimum solvency or capital ratio] of this subsection.” Section 9E(1) of Model #786 then provides that “The commissioner may accept financial documentation filed with another NAIC accredited jurisdiction or with the NAIC in satisfaction of the requirements of Subsection C.” A Reciprocal Jurisdiction may satisfy the requirements of Section 9C(7) of Model #786 either by providing the information required by Section 9C(7) itself, or by providing an assuming insurer domiciled in that Reciprocal Jurisdiction with a document confirming the required information, which the assuming insurer would file annually, annually filing. With either filing method, in lieu of filing the required information directly with the domiciliary states of each of the reinsurer’s U.S. ceding companies, the information
may be filed with each state in which such assuming insurer has reinsured a ceding insurer domiciled in that state it is doing business, or with either its Lead State or the NAIC, which will share this documentation with the other states through the ReFAWG Review Process in satisfaction of their respective filing requirements. Each state may accept financial documentation filed with the Lead State or with the NAIC.
IV. Evaluation Methodology

The Evaluation Methodology was developed to be consistent with the provisions of the NAIC Credit for Reinsurance Models. It is intended to provide an outcomes-based comparison to financial solvency regulation under the NAIC Accreditation Program, adherence to international supervisory standards and relevant international guidance for recognition of reinsurance supervision. Although the methodology includes a comparison of the jurisdiction’s supervisory system to a number of key elements from the NAIC Accreditation Program, it is not intended as a prescriptive assessment under the NAIC Accreditation Program. Rather, the NAIC Accreditation Program simply provide the framework for the outcomes-based analysis. The NAIC will evaluate the appropriateness and effectiveness of the reinsurance supervisory system within the jurisdiction and consider the rights, benefits and the extent of reciprocal recognition afforded by the jurisdiction to reinsurers licensed and domiciled in the U.S. The determination of a Qualified Jurisdiction is based on the effectiveness of the entire reinsurance supervisory system within the jurisdiction.

The Evaluation Methodology consists of the following:

- Section A: Laws and Regulations
- Section B: Regulatory Practices and Procedures
- Section C: Jurisdiction’s Requirements Applicable to U.S.-Domiciled Reinsurers
- Section D: Regulatory Cooperation and Information Sharing
- Section E: History of Performance of Domestic Reinsurers
- Section F: Enforcement of Final U.S. Judgments
- Section G: Solvent Schemes of Arrangement

This information will be the basis for the Final Evaluation Report and the determination of whether the jurisdiction will be included on the NAIC List of Qualified Jurisdictions.
Section A: Laws and Regulations

The NAIC will review publicly available information, as well as information provided by an applicant jurisdiction with respect to its laws and regulations, in an effort to evaluate whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. This will include a review of elements believed to be basic building blocks for sound insurance/reinsurance regulation. A jurisdiction’s effectiveness under Section A may be demonstrated through law, regulation or established practice that implements the general authority granted to the jurisdiction, or any combination of laws, regulations or practices that meet the objective.

The Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group will initiate evaluation of a jurisdiction’s regulatory system by gathering and undertaking a review of the most recent FSAP Report, ROSC and any other publicly available information regarding the laws, regulations, practices and procedures applicable to the reinsurance supervisory system. The Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group will simultaneously invite each jurisdiction (or its designee) to provide information relative to Section A (and other sections, as relevant) to assist the NAIC in evaluating its laws and regulations. The NAIC will review this information in conjunction with Appendix A, which provides more detailed guidance with respect to elements the NAIC intends to consider on an outcomes basis in the evaluation under this section. Appendix A is not intended as a prescriptive checklist of requirements a jurisdiction must meet in order to be a Qualified Jurisdiction. Rather, it is provided in an effort to facilitate an outcomes-based comparison to financial solvency regulation under the NAIC Accreditation Program. An applicant jurisdiction is requested to address the following information, which the NAIC will consider, at a minimum, in determining whether the outcomes achieved by the jurisdiction’s laws and regulations meet an acceptable level of effectiveness for the jurisdiction to be included on the NAIC List of Qualified Jurisdictions:

1. Confirmation of the jurisdiction’s most recent FSAP Report, including relevant updates with respect to descriptions or elements of the FSAP Report in which changes have occurred since the assessment or where information might otherwise be outdated.

2. Confirmation of the jurisdiction’s ROSC, including relevant updates with respect to descriptions or elements of the ROSC in which changes have occurred since the report was completed or where information might otherwise be outdated.

3. If materials responsive to the topics under review have been provided in response to information exchanges between the jurisdiction under review and the NAIC, such prior responses may be cross-referenced provided updates are submitted, if required to address changes in laws or procedures.

4. Any other information, descriptions or responses the jurisdiction believes would be beneficial to the NAIC’s evaluation process in order to address, on an outcomes basis, the key elements described within Appendix A.

The NAIC will review the information provided by the applicant jurisdiction and determine whether it is adequate to reasonably conclude whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in

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3 The basic considerations under this section are derived from Model #786, Section 8C(2), which include: (a) the framework under which the assuming reinsurer is regulated; (b) the structure and authority of the jurisdiction’s reinsurance supervisory authority with regard to solvency regulation requirements and financial surveillance; (c) the substance of financial and operating standards for reinsurers domiciled in the jurisdiction; and (d) the form and substance of financial reports required to be filed or made publicly available by reinsurers domiciled in the jurisdiction and the accounting principles used.

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an effective manner. After reviewing the initial submission, the NAIC may request that the applicant jurisdiction submit supplemental information as necessary in order to make this determination. An applicant jurisdiction is strongly encouraged to provide thorough, detailed and current information in its initial submission in order to minimize the number and extent of supplemental information requests from the NAIC with respect to Section A of this Evaluation Methodology. The NAIC will provide a complete description in the Final Evaluation Report of the information provided in the Evaluation Materials, and any updates or other information that have been provided by the applicant jurisdiction.

Section B: Regulatory Practices and Procedures

Section B is intended to facilitate an evaluation of whether the jurisdiction effectively employs baseline regulatory practices and procedures to supplement and support enforcement of the jurisdiction’s financial solvency laws and regulations described in Section A. This evaluation methodology recognizes that variation may exist in practices and procedures across jurisdictions due to the unique situations each jurisdiction faces. Jurisdictions differ with respect to staff and technology resources that are available, as well as the characteristics of the domestic industry regulated. A determination of effectiveness may be achieved using various financial solvency oversight practices and procedures. This evaluation is not intended to be prescriptive in nature.

The NAIC will utilize the information provided by the jurisdiction as outlined under Section A in completing this section of the evaluation. The NAIC will review this information in conjunction with Appendix B, which provides more detailed guidance with respect to elements the NAIC intends to consider on an outcomes basis in the evaluation under this section. Appendix B is not intended as a prescriptive checklist of requirements a jurisdiction must meet in order to be a Qualified Jurisdiction. Rather, it is provided in an effort to facilitate an outcomes-based comparison to financial solvency regulation under the NAIC Accreditation Program. An applicant jurisdiction should also provide any other information, descriptions or responses the jurisdiction believes would be beneficial to the NAIC’s evaluation process in order to address, on an outcomes basis, the key elements described within Appendix B.

Section C: Jurisdiction’s Requirements Applicable to U.S. Domiciled Reinsurers

The jurisdiction is requested to describe and explain the rights, benefits and the extent of reciprocal recognition afforded by the non-U.S. supervisory authority to reinsurers licensed and domiciled in the U.S.

Section D: Regulatory Cooperation and Information-Sharing

The Credit for Reinsurance Models require the supervisory authority to share information and cooperate with the U.S. state insurance regulators with respect to all certified reinsurers domiciled within their jurisdiction. The jurisdiction is requested to provide an explanation of the supervisory authority’s ability to cooperate, share information and enter into an MOU with U.S. state insurance regulators and confirm that they are willing to enter into an MOU. This should include information with respect to any existing MOU with U.S. state and/or federal authorities that pertain to reinsurance. Both the jurisdiction and the states may rely on the IAIS MMoU to satisfy this requirement, and any states that have not yet been approved by the IAIS as a signatory to the MMoU may rely on an MOU entered into by a Lead State with the jurisdiction until such time that the state has been approved as a signatory to the IAIS MMoU. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to this process.
Section E: History of Performance of Domestic Reinsurers

The jurisdiction is requested to provide a general description with respect to the historical performance of reinsurers domiciled in the jurisdiction. The NAIC does not intend to review confidential company-specific information under this section. Rather, it is intended that any information provided would be publicly available, unless specifically addressed with the jurisdiction under review. This discussion should address, at a minimum, the following information:

a. Number of reinsurers domiciled in the jurisdiction, and a list of any reinsurers domiciled in the jurisdiction that have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, of no less than $250,000,000.

b. Up to a 10-year history of any regulatory actions taken against specific reinsurers.

c. Up to a 10-year history listing any reinsurers that have gone through insolvency proceedings, including the size of each insolvency and a description of the related outcomes (e.g., reinsurer rehabilitated or liquidated, payout percentage of claims to priority classes, payout percentage of claims to domestic and foreign claimants).

d. Up to a 10-year history of any significant industry-wide fluctuations in capital or profitability with respect to domestic reinsurers.

Drafting Note: The NAIC will determine the appropriate time period for review on a case-by-case basis with respect to this information.

Section F: Enforcement of Final U.S. Judgments

The NAIC has previously collected information from a number of jurisdictions with respect to enforcement of final U.S. judgments. The jurisdiction is also requested to provide a current description or explanation of any restrictions with respect to the enforcement of final foreign judgments in the jurisdiction. Based on the foregoing information, the NAIC will make an assessment of the effectiveness of the ability to enforce final U.S. judgments in the jurisdiction. This will include a review of the status, interpretations, application and enforcement of various treaties, conventions and international agreements with respect to final judgments, arbitration and choice of law. The Qualified Jurisdiction Working GroupMutual Recognition of Jurisdictions (E) Working Group will monitor the enforcement of final U.S. judgments and the Qualified Jurisdiction is requested to notify the NAIC of any developments in this area.

Section G: Solvent Schemes of Arrangement

The jurisdiction is requested to provide a description of any legal framework that allows reinsurers domiciled in the jurisdiction to propose or participate in any solvent scheme of arrangement or similar procedure. In addition, the jurisdiction is requested to provide a description of any solvent scheme of arrangement or similar procedure that a domestic reinsurer has proposed or participated in and the outcome of such procedure.
V. Appendices: Specific Guidance with Respect to Section A and Section B

It is important to note that Part IV, Section A: Laws and Regulations, and Part IV, Section B: Regulatory Practices and Procedures, are derived from the NAIC Financial Regulation Standards and Accreditation Program, which is intended to establish and maintain standards to promote sound insurance company financial solvency regulation among the U.S. states. As such, the NAIC Accreditation Program requires the states to employ laws, regulations and administrative policies and procedures substantially similar to the NAIC accreditation standards in order to be considered an accredited state.

However, it is not the intent of the Evaluation Methodology to require applicant jurisdictions to meet the standards required by the NAIC for accreditation. Instead, Section A and Section B (and their corresponding appendices) are intended to provide a framework to facilitate an outcomes-based evaluation by the NAIC and state insurance regulators of the effectiveness of the jurisdiction’s supervisory authority. This framework consists of a description of the jurisdiction’s laws, regulations, practices and procedures applicable to the supervision of its domestic reinsurers. The amount of detail provided within these appendices should not be interpreted as specific requirements that must be met by the applicant jurisdiction. Rather, the information is intended to provide direction to the applicant jurisdiction in an effort to facilitate a complete response and increase the efficiency and timeliness of the evaluation process.
Appendix A: Laws and Regulations

1. **Examination Authority**

   Does the jurisdiction have the authority to examine its domestic reinsurers? This description should address the following:
   
   a. Frequency and timing of examinations and reports.
   
   b. Guidelines for examination.
   
   c. Whether the jurisdiction has the authority to examine reinsurers whenever it is deemed necessary.
   
   d. Whether the jurisdiction has the authority to have complete access to the reinsurer’s books and records and, if necessary, the records of any affiliated company.
   
   e. Whether the jurisdiction has the authority to examine officers, employees and agents of the reinsurer when necessary with respect to transactions directly or indirectly related to the reinsurer under examination.
   
   f. Whether the jurisdiction has the authority to share confidential information with U.S. state insurance regulatory authorities, provided that the recipients are required, under their law, to maintain its confidentiality.

2. **Capital and Surplus Requirement**

   Does the jurisdiction have the authority to require domestic reinsurers to maintain a minimum level of capital and surplus to transact business? This description should address the following:
   
   a. Whether the jurisdiction has the authority to require reinsurers to maintain minimum capital and surplus, including a description of such minimum amounts.
   
   b. Whether the jurisdiction has the authority to require additional capital and surplus based on the type, volume and nature of reinsurance business transacted.
   
   c. Capital requirements for reinsurers, including reports and a description of any specific levels of regulatory intervention.

3. **Accounting Practices and Procedures**

   Does the jurisdiction have the authority to require domestic reinsurers to file appropriate financial statements and other financial information? This description should address the following:
   
   a. Description of the accounting and reporting practices and procedures.
   
   b. Description of any standard financial statement blank/reporting template, including description of content/disclosure requirements and corresponding instructions.

4. **Corrective Action**

   Does the jurisdiction have the authority to order a reinsurer to take corrective action or cease and desist certain practices that, if not corrected or terminated, could place the reinsurer in a hazardous financial condition? This description should address the following:
   
   a. Identification of specific standards which may be considered to determine whether the continued operation of the reinsurer might be hazardous to the general public.
   
   b. Whether the jurisdiction has the authority to issue an order requiring the reinsurer to take corrective action when it has been determined to be in hazardous financial condition.
5. **Regulation and Valuation of Investments**

What authority does the jurisdiction have with respect to regulation and valuation of investments? This description should address the following:

a. Whether the jurisdiction has the authority to require a diversified investment portfolio for all domestic reinsurers as to type, issue and liquidity.

b. Whether the jurisdiction has the authority to establish acceptable practices and procedures under which investments owned by reinsurers must be valued, including standards under which reinsurers are required to value securities/investments.

6. **Holding Company Systems**

Does the jurisdiction have laws or regulations with respect to supervision of the group holding company systems of reinsurers? This description should address the following:

a. Whether the jurisdiction has access to information via the parent or other regulated group entities about activities or transactions within the group involving other regulated or non-regulated entities that could have a material impact on the operations of the reinsurer.

b. Whether the jurisdiction has access to consolidated financial information of a reinsurer’s ultimate controlling person.

c. Whether the jurisdiction has the authority to review integrity and competency of management.

d. Whether the jurisdiction has approval and intervention powers for material transactions and events involving reinsurers.

e. Whether the jurisdiction has authority to monitor, or has prior approval authority over:
   
   i. Change in control of domestic reinsurers.

   ii. Dividends and other distributions to shareholders of the reinsurer.

   iii. Material transactions with affiliates.

7. **Risk Management**

Does the jurisdiction have the authority to require its domestic reinsurers to maintain an effective risk-management function and practices? This description should address the following:

a. Whether the jurisdiction has Own Risk and Solvency Assessment (ORSA) requirements and reporting.

b. Any requirements regarding the maximum net amount of risk to be retained by a reinsurer for an individual risk based on the reinsurer’s capital and surplus.

c. Whether the jurisdiction has authority to monitor enterprise risk, including any activity, circumstance, event (or series of events) involving one or more affiliates of a reinsurer that, if not remedied promptly, is likely to have a material adverse effect on the financial condition or liquidity of the reinsurer or its insurance holding company system as a whole.

d. Whether the jurisdiction has corporate governance requirements for reinsurers.
8. **Liabilities and Reserves**

Does the jurisdiction have standards for the establishment of liabilities and reserves (technical provisions) resulting from reinsurance contracts? This description should address the following:

a. Liabilities incurred under reinsurance contracts for policy reserves, unearned premium, claims and losses unpaid, and incurred but not reported (IBNR) claims (including whether discounting is allowed for reserve calculation/reporting).

b. Liabilities related to catastrophic occurrences.

c. Whether the jurisdiction requires an opinion on reserves and loss and loss adjustment expense reserves by a qualified actuary or specialist for all domestic reinsurers, and the frequency of such reports.

9. **Reinsurance Ceded**

What are the jurisdiction’s requirements with respect to the financial statement credit allowed for reinsurance retroceded by its domestic reinsurers? This description should address the following:

a. Credit for reinsurance requirements applicable to reinsurance retroceded to domestic and non-domestic reinsurers.

b. Collateral requirements applicable to reinsurance contracts.

c. Whether the jurisdiction requires a reinsurance agreement to provide for insurance risk transfer (i.e., transfer of both underwriting and timing risk).

d. Requirements applicable to special purpose reinsurance vehicles and insurance securitizations.

e. Affiliated reinsurance transactions and concentration risk.

f. Disclosure requirements specific to reinsurance transactions, agreements and counterparties, if such information is not provided under another item.

10. **Independent Audits**

Does the jurisdiction require annual audits of domestic reinsurers by independent certified public accountants or similar accounting/auditing professional recognized in the applicant jurisdiction? This description should address the following:

a. Requirements for the filing of audited financial statements prepared in conformity with accounting practices prescribed or permitted by the supervisory authority.

b. Contents of annual audited financial reports.

c. Requirements for selection of auditor.

d. Allowance of audited consolidated or combined financial statements.

e. Notification of material misstatements of financial condition.

f. Supervisor’s access to auditor’s workpapers.

g. Audit committee requirements.

h. Requirements for reporting of internal control-related matters.

11. **Receivership**

Does the jurisdiction have a receivership scheme for the administration of reinsurers found to be insolvent? This should include a description of any liquidation priority afforded to policyholders and the liquidation priority of
reinsurance obligations to domestic and non-domestic ceding insurers in the context of an insolvency proceeding of a reinsurer.

12. Filings with Supervisory Authority

Does the jurisdiction require the filing of annual and interim financial statements with the supervisory authority? This description should address the following:
   a. The use of standardized financial reporting in the financial statements, and the frequency of relevant updates.
   b. The use of supplemental data to address concerns with specific companies or issues.
   c. Filing format (e.g., electronic data capture).
   d. The extent to which financial reports and information are public records.

13. Reinsurance Intermediaries

Does the jurisdiction have a regulatory framework for the regulation of reinsurance intermediaries?

14. Other Regulatory Requirements with respect to Reinsurers

Any other information necessary to adequately describe the effectiveness of the jurisdiction’s laws and regulations with respect to its reinsurance supervisory system.
Appendix B: Regulatory Practices and Procedures

1. Financial Analysis

What are the jurisdiction’s practices and procedures with respect to the financial analysis of its domestic reinsurers? Such description should address the following:

   a. **Qualified Staff and Resources**
      The resources employed to effectively review the financial condition of all domestic reinsurers, including a description of the educational and experience requirements for staff responsible for financial analysis.

   b. **Communication of Relevant Information to/from Financial Analysis Staff**
      The process under which relevant information and data received by the supervisory authority are provided to the financial analysis staff and the process under which the findings of the financial analysis staff are communicated to the appropriate person(s).

   c. **Supervisory Review**
      How the jurisdiction’s internal financial analysis process provides for supervisory review and comment.

   d. **Priority-Based Analysis**
      How the jurisdiction’s financial analysis procedures are prioritized in order to ensure that potential problem reinsurers are reviewed promptly.

   e. **Depth of Review**
      How the jurisdiction’s financial analysis procedures ensure that domestic reinsurers receive an appropriate level or depth of review commensurate with their financial strength and position.

   f. **Analysis Procedures**
      How the jurisdiction has documented its financial analysis procedures and/or guidelines to provide for consistency and continuity in the process and to ensure that appropriate analysis procedures are being performed on each domestic reinsurer.

   g. **Reporting of Material Adverse Findings**
      The process for reporting material adverse indications, including the determination and implementation of appropriate regulatory action.

   h. **Early Warning System/Stress Testing**
      Whether the jurisdiction has an early warning system and/or stress testing methodology that is utilized with respect to its domestic reinsurers.

2. Financial Examinations

What are the jurisdiction’s practices and procedures with respect to the financial examinations of its domestic reinsurers? Such description should address the following:

   a. **Qualified Staff and Resources**
      The resources employed to effectively examine all domestic reinsurers. This should include whether the jurisdiction prioritizes examination scheduling and resource allocation commensurate with the financial strength and position of each reinsurer, and a description of the educational and experience requirements for staff responsible for financial examinations.
b. **Communication of Relevant Information to/from Examination Staff**
   The process under which relevant information and data received by the supervisory authority are provided to the examination staff and the process under which the findings of the examination staff are communicated to the appropriate person(s).

c. **Use of Specialists**
   Whether the supervisory authority’s examination staff includes specialists with appropriate training and/or experience or whether the supervisory authority otherwise has available qualified specialists that will permit the supervisory authority to effectively examine any reinsurer.

d. **Supervisory Review**
   Whether the supervisory authority’s procedures for examinations provide for supervisory review.

e. **Examination Guidelines and Procedures**
   Description of the policies and procedures the supervisory authority employs for the conduct of examinations, including whether variations in methods and scope are commensurate with the financial strength and position of the reinsurer.

f. **Risk-Focused Examinations**
   Does the supervisory authority perform and document risk-focused examinations and, if so, what guidance is utilized in conducting the examinations? Are variations in method and scope commensurate with the financial strength and position of the reinsurer?

g. **Scheduling of Examinations**
   Whether the supervisory authority’s procedures provide for the periodic examination of all domestic reinsurers, including how the system prioritizes reinsurers that exhibit adverse financial trends or otherwise demonstrate a need for examination.

h. **Examination Reports**
   Description of the format in which the supervisory authority’s reports of examinations are prepared, and how the reports are shared with other jurisdictions under information-sharing agreements.

i. **Action on Material Adverse Findings**
   What are the jurisdiction’s procedures regarding supervisory action in response to the reporting of any material adverse findings.

3. **Information Sharing**

   Does the jurisdiction have a process for the sharing of otherwise confidential documents, materials, information, administrative or judicial orders, or other actions with U.S. state regulatory officials, provided that the recipients are required, under their law, to maintain its confidentiality?

4. **Procedures for Troubled Reinsurers**

   What procedures does the jurisdiction follow with respect to troubled reinsurers?

5. **Organization, Licensing and Change of Control of Reinsurers**

   What processes does the supervisory authority use to identify unlicensed or fraudulent activities? The description should address the following:
a. **Licensing Procedure**
   Whether the supervisory authority has documented licensing procedures that include a review and/or analysis of key pieces of information included in a primary licensure application.

b. **Staff and Resources**
   The educational and experience requirements for staff responsible for evaluating company licensing.

c. **Change in Control of a Domestic Reinsurer**
   Procedures for the review of key pieces of information included in filings with respect to a change in control of a domestic reinsurer.
ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers

Reinsurance Financial Analysis (E) Working Group
ReFAWG Review Process for Passporting
Certified and Reciprocal Jurisdiction Reinsurers
(“ReFAWG Review Process”)

1. ReFAWG Review Process

The Reinsurance Financial Analysis (E) Working Group (ReFAWG) normally operates in Executive Session, in accordance with the NAIC Policy Statement on Open Meetings and in open session when addressing policy issues. The authority of the Working Group is limited to that of an advisory body. This authority is derived from the 2011 Preface to Credit for Reinsurance Models, which provided that the purpose of the Working Group is “to provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.”

a. In November 2011, the NAIC adopted revisions to its Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) which reduce the prior reinsurance collateral requirements for non-U.S. licensed reinsurers that are licensed and domiciled in Qualified Jurisdictions and establish a certification process for reinsurers under which a Certified Reinsurer is eligible for collateral reduction with respect to contracts entered into or renewed subsequent to certification. The authority to issue individual ratings of certified reinsurers is reserved to the NAIC member jurisdictions under their respective statutes and regulations. While this forum is intended to strengthen state regulation and prevent regulatory arbitrage, it is not within the authority of the Working Group to assign collateral requirements for individual reinsurers.

b. On June 25, 2019, the NAIC adopted further revisions to the models, which implement the reinsurance collateral provisions of the Covered Agreements with the European Union (EU) and the United Kingdom (UK). These revisions create a new type of jurisdiction, which is called a Reciprocal Jurisdiction and eliminates reinsurance collateral requirements and local presence requirements for EU and UK reinsurers that maintain a minimum amount of own-funds equivalent to $250 million USD and a solvency capital requirement (SCR) of 100% under Solvency II. The revisions also provide Reciprocal Jurisdiction status for accredited U.S. jurisdictions and Qualified Jurisdictions if they meet certain requirements in the credit for reinsurance models. ReFAWG has also been given additional responsibilities with respect to these “Reciprocal Jurisdiction Reinsurers.” ReFAWG will coordinate its efforts with the Mutual Recognition of Jurisdictions (E) Working Group (formerly known as the Qualified Jurisdictions (E) Working Group).

c. Issues upon which the Working Group may provide advisory support and assistance include but are not limited to:

i. Provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.

ii. Provide a forum for discussion, among NAIC jurisdictions, of reinsurance issues related to specific companies, entities or individuals.
iii. Support, encourage, promote and coordinate multi-state efforts in addressing issues related to
certified reinsurers, including but not limited to multi-state recognition of certified reinsurers.
iv. Provide analytical expertise and support to the states with respect to certified reinsurers and
applicants for certification.
v. Interact with domiciliary regulators of ceding insurers and certifying states to assist and advise on
the most appropriate regulatory strategies, methods and actions with respect to certified reinsurers.
vi. Provide advisory support with respect to issues related to the determination of qualified
jurisdictions.
vii. Ensure the public passporting website remains current.
viii. For reinsurers domiciled in Reciprocal Jurisdictions, determine the best and most effective
approaches for the financial solvency surveillance to assist the states in their work to protect the
interests of policyholders.

2. **Lead States and Passporting Process**

   a. A reinsurer seeking recognition as either a Certified Reinsurer or a Reciprocal Jurisdiction Reinsurer must
      submit certain information to the state in which it seeks such recognition. Under the ReFAWG Review
      Process, ReFAWG will assist the states with the initial review of this information and provide guidance to
      the states in making their review of the reinsurer to determine whether it has met the regulatory requirements
      to be recognized as a Certified Reinsurer and/or a Reciprocal Jurisdiction Reinsurer.

   b. In addition to this assistance to individual states, ReFAWG will also assist with a passporting process for
      the states. “Passporting” refers to the process under which a state has the discretion to defer to the
      certification of a reinsurer (and the rating assigned to that certified reinsurer) by another state. Under this
      process, a reinsurer will apply to an initial state for certification, referred to as the “Lead State,” which will
      begin its analysis of the reinsurer and notify ReFAWG of the application. The Lead State will complete its
      initial analysis and will submit filing information and other documentation to ReFAWG for a peer review.
      Upon completion of the confidential peer review process, ReFAWG will make its recommendation
      concerning both the certified status of the reinsurer and its rating. The Lead State then makes the final
determination regarding certification, upon which the Lead State notifies ReFAWG and the certified
      reinsurer is eligible to apply for passporting into other states.

   c. A similar Passporting Process is in place with respect to Reciprocal Jurisdiction Reinsurers. In order to
      facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the
      NAIC has initiated a process called “passporting” under which the commissioner has the discretion to defer
      to another state’s determination with respect to compliance with this section. Passporting is based upon
      individual state regulatory authority, and states are encouraged to act in a uniform manner in order to
      facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the
      amount of documentation filed with the states and reduce duplicate filings.

   d. If an NAIC accredited jurisdiction has determined that the conditions set forth for recognition as a
      Reciprocal Jurisdiction Reinsurer have been met, the commissioner has the discretion to defer to that
      jurisdiction’s determination and add such assuming insurer to the list of assuming insurers to which cessions
      shall be granted credit. The commissioner may accept financial documentation filed with the Lead State or
      with the NAIC. ReFAWG and the Mutual Recognition of Jurisdictions (E) Working Group will coordinate
efforts to obtain and disseminate to the states financial information regarding both Certified Reinsurers and Reciprocal Jurisdiction Reinsurers.

e. The ReFAWG Review Process is designed to facilitate communication of relevant information with respect to individual reinsurers or reinsurance related issues by allowing interested state insurance regulators the opportunity to monitor the ReFAWG meetings and discussion. It should be noted that the process for engaging ReFAWG in the consideration of an application is intended to be flexible. Specific circumstances may necessitate discussion between ReFAWG and any states that have received any application in order to determine an appropriate lead state on a case-by-case basis.

f. Change of Lead State - The Lead State may change based upon mutual agreement between the current lead state and any other state where the reinsurer is certified, with input to be provided by ReFAWG. Upon a change in lead state, NAIC staff will provide timely notification to all states. In order to facilitate a change of lead state from one state to another, both states should discuss the rationale for the change during a regulator-only ReFAWG meeting. NAIC Staff will update the lead state and note such change on NAIC systems and send notice to ReFAWG and interested regulators.

3. ReFAWG Review Process for Certified Reinsurers

ReFAWG makes available to the states a Uniform Application Checklist for Certified Reinsurers (Exhibit 1) for certification of reinsurers based upon the requirements of the Credit for Reinsurance Model Law and Regulation. It is intended that the checklist be used by lead states for the initial/renewal application review and by ReFAWG in its review of Passporting requests.

The following provide a timeline for filings:

<table>
<thead>
<tr>
<th>Timeline Event</th>
<th>Required Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required Documents Filed with Lead State</td>
<td>June 30</td>
</tr>
<tr>
<td>Required Passporting Documents Uploaded to NAIC ReFAWG Database</td>
<td>August 31</td>
</tr>
<tr>
<td>NAIC Staff Re-Certification Review Process and Conference Calls</td>
<td>September 1 – November 30</td>
</tr>
<tr>
<td>All Passporting Re-Certifications Completed</td>
<td>December 1</td>
</tr>
<tr>
<td>Effective Date of Passporting Re-Certification</td>
<td>1/1/xx to 12/31/xx (Next Calendar Year)</td>
</tr>
<tr>
<td>Applications for Passporting</td>
<td>1/1/xx to 12/31/xx</td>
</tr>
</tbody>
</table>

In order to be eligible for certification, the assuming insurer shall meet the following requirements:

a. **Qualified Jurisdiction** - The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a Qualified Jurisdiction. The applicant must be in good standing and provide a copy of the certificate of authority or license to transact insurance and/or reinsurance business.

b. **Capital and Surplus** - The assuming insurer must maintain capital and surplus of no less than $250,000,000 as reported within its audited financial statement. This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital
and surplus equivalents (net of liabilities) of at least $250,000,000 and a central fund containing a balance of at least $250,000,000.

c. **Financial Strength Ratings** - The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the commissioner. These ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. The applicant must provide the rating agency report. If the rating is a group rating, the rationale for the group rating must be provided. Initial or Affirmed financial strength rating dates must be within 15 months of the application date/renewal filing date. Acceptable rating agencies include: A.M. Best, Fitch Ratings, Moody’s, Standard & Poor’s or any other Nationally Recognized Statistical Rating Organization by the SEC. Kroll is not recognized as an acceptable rating organization in Model #786 but has been recognized as an acceptable rating organization by the Reinsurance (E) Task Force.

d. The following table outlines the necessary ratings needed to meet a secure level:

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Collateral Required</th>
<th>A.M. Best</th>
<th>Standard &amp; Poor’s</th>
<th>Moody’s</th>
<th>Fitch</th>
<th>Kroll</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure – 1</td>
<td>0%</td>
<td>A++</td>
<td>AAA</td>
<td>Aaa</td>
<td>AAA</td>
<td>AAA</td>
</tr>
<tr>
<td>Secure – 2</td>
<td>10%</td>
<td>A</td>
<td>AA+, AA, AA-</td>
<td>Aa1, Aa2, Aa3</td>
<td>AA+, AA, AA-</td>
<td>AA+, AA, AA-</td>
</tr>
<tr>
<td>Secure – 3</td>
<td>20%</td>
<td>A</td>
<td>A+, A</td>
<td>A1, A2</td>
<td>A+, A</td>
<td>A+, A</td>
</tr>
<tr>
<td>Secure – 4</td>
<td>50%</td>
<td>A-</td>
<td>A-</td>
<td>A3</td>
<td>A-</td>
<td>A-</td>
</tr>
<tr>
<td>Secure – 5</td>
<td>75%</td>
<td>B++, B+</td>
<td>BBB+, BBB, BBB-</td>
<td>Baa1, Baa2, Baa3</td>
<td>BBB+, BBB, BBB-</td>
<td>BBB+, BBB, BBB-</td>
</tr>
</tbody>
</table>

e. **Protocol for Considering a Group Rating** - Section 8B(4) of the Credit for Reinsurance Model Regulation (#786) provides, in relevant part: “Each certified reinsurer shall be rated on a legal entity basis, with due consideration being given to the group rating where appropriate.” Understanding the rating agency basis for utilizing a group rating is a key factor in determining whether an applicant’s group rating may be considered appropriate. The recommended protocol for understanding the rationale involves one or more of the following protocol steps:
i. For reasons set forth in the rating agency report or its published ratings standards or guidelines, the rating agency utilizes the group rating as a consequence of finding that the company had sufficient interconnectivity with the group;

ii. For reasons set forth in the rating agency report or its published ratings standards or guidelines, the rating agency enhances the group rating due to the subsidiary’s potential benefit of capital support from one or more affiliated companies;

iii. The group rating was utilized because the subsidiary derives benefit from its inclusion within a financially strong and well-capitalized insurance group;

iv. The lead state has contacted the rating agency and was provided a written explanation for the use of the group rating;

v. Other factors deemed appropriate by the Reinsurance Financial Analysis (E) Working Group; or

vi. To assist the Lead State in the assessment of the appropriateness of the use of a group rating, applicants are encouraged to provide their rational for the use of a group rating.

f. Changes in Ratings

Section 8(B)(7)(a) of Model #786 provides that a certified reinsurer is required to notify the Commissioner of a certifying state within 10 days of any regulatory actions taken against the certified reinsurer, any change in the provisions of its domiciliary license or any change in rating by an approved rating agency, including a statement describing such changes and the reasons. Upon receipt of any such notification, a certifying state should immediately notify ReFAWG in order to facilitate communication of the information to other states. ReFAWG will subsequently send notification to all applicable regulators and may coordinate an interim meeting as deemed appropriate in order to discuss the issue(s).

Changes requiring action by a certifying state in accordance with statute and/or regulation may include but are not limited to: deterioration in financial condition; downgrade in a financial strength rating; change in the status of its domiciliary license; change in the qualification status of its domestic jurisdiction; and the triggering of certain thresholds with respect to reinsurance obligations to U.S. ceding insurers that are past due (in accordance with Section 8(B) of Model #786). While such changes may require action under statute or regulation, the ReFAWG process is intended to facilitate communication and coordination with respect to the date upon which changes in a certified reinsurer’s rating/status are effective, as well as discussion of any other relevant issues.

As part of the ongoing review process, other information may come to the attention of a certifying state and/or ReFAWG that warrants consideration with respect to a certified reinsurer’s rating/status. While ReFAWG cannot require a state to delay any action with respect to a certified reinsurer’s rating/status, certifying states are strongly encouraged to notify ReFAWG prior to taking any related action, as the ReFAWG process will serve to provide a proactive regulatory mechanism for communication of such information, discussion among regulators with respect to changes being considered on the basis of subjective rating criteria, and possible coordination of applicable effective dates if such changes are enacted. Upon receipt of any such information, ReFAWG will send notification to the NAIC Chief
Financial Regulators listing and may coordinate an interim meeting as deemed appropriate in order to discuss the issue(s).

g. **Schedule F/S (Ceded Reinsurance)** – Applicants domiciled in the U.S. must provide the most recent NAIC Annual Statement Blank Schedule F (property/casualty) and/or Schedule S (life and health). Applicants domiciled outside the U.S. must provide Form CR-F (property/casualty) and/or Form CR-S (life and health), completed in accordance with the instructions.

h. **Disputed and/or Overdue Reinsurance Claims** - The applicant must provide a detailed explanation regarding reinsurance obligations to U.S. cedents that are in dispute and/or more than 90 days past due that exceed 5% of its total reinsurance obligations to U.S. cedents as of the end of its prior financial reporting year or reinsurance obligations to any of the top 10 U.S. cedents (based on the amount of outstanding reinsurance obligations as of the end of its prior financial reporting year) that are in dispute and/or more than 90 days past due exceed 10% of its reinsurance obligations to that U.S. cedent. The applicant must then provide a description of its business practices in dealing with U.S. ceding insurers and a statement that the applicant commits to comply with all contractual requirements applicable to reinsurance contracts with U.S. ceding insurers.

i. **Mechanisms Used to Secure Obligations Incurred as a Certified Reinsurer** - The applicant must specify the mechanisms it will use to secure obligations incurred as a Certified Reinsurer. Use of multi-beneficiary trust must include: (1) approval from the domiciliary regulator; (2) the form of the trust that will be used as a certified reinsurer; and (3) the form of the trust that will be used to secure obligations incurred outside of the applicant’s certified reinsurer status (if applicable).

j. **Regulatory Actions** – The applicant must provide a description of any regulatory actions taken against the applicant. Include details on all regulatory actions, fines, and penalties. Further, a description of any changes in with respect to the provisions of the applicant’s domiciliary license should be provided.

k. **Audited Financial Report and Actuarial Opinion** – As filed with its non-U.S. jurisdiction supervisor, with a translation into English, the applicant must file audited financial statement for the current and prior year and an actuarial opinion (must be stand-alone, or the functional equivalent under the Supervisor’s applicable Actuarial Function Holder Regime).

l. **Solvent Schemes of Arrangement** - The applicant must provide a description of any past, present, or proposed future participation in any solvent scheme of arrangement, or similar procedure, involving U.S. ceding insurers.

m. **Form CR-1** - The applicant must provide a state lead state specific Form CR-1, which must be properly executed by an officer authorized to bind the applicant to the commitments set forth in the form.

n. **Other Requirements** - The applicant must commit to comply with other reasonable requirements deemed necessary for certification by the certifying state. Further, the applicant must provide a statement that it agrees to post 100% security upon the entry of an order of rehabilitation or conservation against the ceding insurer or its estate.
o. **Public Notice** - The commissioner is required to post notice on the insurance department’s website promptly upon receipt of any application for certification, including instructions on how members of the public may respond to the application. The commissioner may not take final action on the application until at least 30 days after posting such notice. The commissioner will consider any comments received during the public notice period with respect to this application.

4. **Certified Reinsurers – Certified by Another NAIC Accredited Jurisdiction**

If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the state has the discretion to defer to that jurisdiction’s certification and assigned rating (i.e., passporting) as provided in the Uniform Application Checklist for Certified Reinsurers (Exhibit 1). To assist in the determination to defer to another jurisdiction’s certification the following documents are required:

a. **Qualified Jurisdiction** - The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a Qualified Jurisdiction.

b. **Verification of Certification Issued by an NAIC Accredited Jurisdiction** – The applicant must provide a copy of the approval letter or other documentation provided to the applicant by the NAIC accredited jurisdiction. The letter should include the state, rating and collateral percentage assigned, effective date, lines of business, and the applicant’s statement on compliance.

c. **Mechanisms Used to Secure Obligations Incurred as a Certified Reinsurer** - The applicant must specify the mechanisms it will use to secure obligations incurred as a Certified Reinsurer. Use of multi-beneficiary trust must include: (1) approval from the domiciliary regulator; (2) the form of the trust that will be used as a certified reinsurer; and (3) the form of the trust that will be used to secure obligations incurred outside of the applicant’s certified reinsurer status (if applicable).

d. **Form CR-1** - The applicant must provide a state lead state specific Form CR-1, which must be properly executed by an officer authorized to bind the applicant to the commitments set forth in the form.

e. **Other Requirements** - The applicant must commit to comply with other reasonable requirements deemed necessary for certification by the certifying state. Further, they must provide a statement that they agree to post 100% security upon the entry of an order of rehabilitation or conservation against the ceding insurer or its estate.

f. **Public Notice** - The commissioner is required to post notice on the insurance department’s website promptly upon receipt of any application for certification, including instructions on how members of the public may respond to the application. The commissioner may not take final action on the application until at least 30 days after posting such notice. The commissioner will consider any comments received during the public notice period with respect to this application.
5. **Reciprocal Jurisdiction Process - Initial Application to Lead State**

Pursuant to the *Uniform Checklist for Reciprocal Jurisdiction Reinsurers* (Exhibit 2), the “Lead State” will uniformly require assuming insurers to provide the following documentation so that other states may rely upon the Lead State’s determination:

a. **Status of Reciprocal Jurisdiction** - The assuming insurer must be licensed to write reinsurance by, and has its head office or is domiciled in, a Reciprocal Jurisdiction that is listed on the *NAIC List of Reciprocal Jurisdictions*: (1) a non-U.S. jurisdiction that is subject to an in-force Covered Agreement with the United States; (2) a U.S. jurisdiction that meets the requirements for accreditation under the NAIC Financial Standards and Accreditation Program; or (3) a Qualified Jurisdiction that has been determined by the commissioner to meet all applicable requirements to be a Reciprocal Jurisdiction.

b. **Minimum Capital and Surplus** - The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the Reciprocal Jurisdiction: no less than $250,000,000 (USD); or if the assuming insurer is an association, including incorporated and individual unincorporated underwriters: minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least $250,000,000 (USD); and a central fund containing a balance of the equivalent of at least $250,000,000 (USD). The assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis according to the methodology of its domiciliary jurisdiction that the assuming insurer complies with this requirement. The Mutual Recognition of Jurisdictions (E) Working Group will coordinate the confirmations of the domiciliary jurisdictions with ReFAWG with respect to individual Reciprocal Jurisdiction Reinsurers.

c. **Minimum Solvency or Capital Ratio** - The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio. The ratio specified in the applicable in-force Covered Agreement where the assuming insurer has its head office or is domiciled; or if the assuming insurer is domiciled in an accredited state, a risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, calculated in accordance with the formula developed by the NAIC; or if the assuming insurer is domiciled in a Reciprocal Jurisdiction that is a Qualified Jurisdiction, such solvency or capital ratio as the commissioner determines to be an effective measure of solvency. The assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis that the assuming insurer complies with this requirement. The Mutual Recognition of Jurisdictions (E) Working Group will coordinate the confirmations of the domiciliary jurisdictions with ReFAWG with respect to individual Reciprocal Jurisdiction Reinsurers.

d. **Form RJ-1** - The assuming insurer must agree to and provide a signed Form RJ-1, which must be properly executed by an officer of the assuming insurer.

e. **Audited Financial Report** - The assuming insurer’s annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report as provided under Section 9C(5)(a) of Model #786.
f. **Solvency and Financial Condition Report or Actuarial Opinion** – The applicant must submit a solvency and financial condition report or actuarial opinion, if filed with the assuming insurer’s supervisor as provided under Section 9C(5)(b) of Model #786.

g. **Overdue Reinsurance Claims** – The applicant must submit a list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States as provided under Section 9C(5)(c) of Model #786.

h. **Assumed and Ceded Reinsurance Schedules** – The applicant must submit information regarding the assuming insurer’s assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer as provided under Section 9C(5)(d) of Model #786. Applicants domiciled in the U.S. must provide the most recent NAIC Annual Statement Blank Schedule F (property/casualty) and/or Schedule S (life and health). Applicants domiciled outside the U.S. may provide this information using Form CR-F (property/casualty) and/or Form CR-S (life and health), which ReFAWG considers sufficient to meet this requirement. This is for purposes of evaluating Prompt Payment of Claims.

i. **Prompt Payment of Claims** - The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment will be evidenced if any of the following criteria is met: (1) more than fifteen percent (15%) of the reinsurance recoverables from the assuming insurer are overdue and in dispute as reported to the commissioner; (2) more than fifteen percent (15%) of the assuming insurer’s ceding insurers or reinsurers have overdue reinsurance recoverable on paid losses of 90 days or more which are not in dispute and which exceed for each ceding insurer $100,000, or as otherwise specified in a Covered Agreement; or (3) the aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by 90 days or more, exceeds $50,000,000, or as otherwise specified in a Covered Agreement.

6. **Reciprocal Jurisdiction Process – Passporing States**

Per the *Uniform Checklist for Reciprocal Jurisdiction Reinsurers* (Exhibit 2), if an NAIC accredited jurisdiction has determined that the conditions set forth under the *Filing Requirements for Lead States* have been met, the commissioner has the discretion to defer to that jurisdiction’s determination and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit. The commissioner may accept financial documentation filed with the Lead State or with the NAIC. The following document is required to be filed with the state:

a. **Form RJ-1** - The assuming insurer must agree to and provide a signed Form RJ-1, which must be properly executed by an officer of the assuming insurer.

b. **Verification of Determination Issued by an NAIC Accredited Jurisdiction** – The applicant must provide a copy of the approval letter or other documentation provided to the applicant by the NAIC accredited jurisdiction. The letter should include the state, effective date, and lines of business.
7. **NAIC Staff Review of Reinsurers**

The reinsurer will file this information with the initial reviewing state and such Lead State will submit the information to ReFAWG in accordance with the applicable information sharing process. This submission by the Lead State will also facilitate other states’ access to the information. NAIC staff shall prepare a report for review by ReFAWG intended to provide information regarding whether the Lead State’s submission meets the requirements of the ReFAWG Review Process, and to determine whether there are any deficiencies in the application. This report will be considered confidential but may be made available to states through the NAIC’s information sharing process.

NAIC Staff will assist in the review of the filings and in monitoring the ongoing condition of the reinsurers. If during the review process or during an interim period ReFAWG determines that a reinsurer’s assigned rating or status may warrant reconsideration, notice will be sent to the Lead State. The specific issues identified will be presented for discussion during the next ReFAWG meeting.

8. **Process for Ongoing Monitoring of Certified Reinsurers**

Certified and reciprocal reinsurers are required to file specific information to a certifying state on an ongoing basis. NAIC Staff and ReFAWG will review this information in an effort to assist states with the ongoing monitoring of the reinsurers. All information submitted by reinsurers which is not otherwise public information subject to disclosure shall be exempted from disclosure under the state’s law equivalent of its Freedom of Information Act and shall be withheld from public disclosure.

9. **Withdrawal/Termination of a Certified or Reciprocal Jurisdiction Reinsurer**

When a reinsurer requests to withdraw its status or the lead state terminates the reinsurer’s status as a certified or reciprocal reinsurer, notice of this action should be promptly conveyed to the appropriate NAIC Staff. Once NAIC Staff receives notification of withdrawal or termination, the Passported Certified Reinsurers List(s) will be updated to reflect this status change. The Passported reinsurer will follow the lead state’s laws regarding its withdrawal or termination regarding any active reinsurance contracts.

10. **Interaction Between Certified Reinsurers and Reciprocal Jurisdiction Reinsurers**

   a. Under Section 8A(5) Model #786, credit for reinsurance shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer with respect to Certified Reinsurers. Under Section 2F(7) of the *Credit for Reinsurance Model Law* (#785), credit shall be taken with respect to Reciprocal Jurisdiction Reinsurers only for reinsurance agreements entered into, amended, or renewed on or after the effective date of the statute adding this subsection, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements to be designated a Reciprocal Jurisdiction Reinsurer, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal.

   b. It is expected that certain assuming insurers may be considered to be Certified Reinsurers for purposes of in-force business and Reciprocal Jurisdiction Reinsurers with respect to reinsurance agreements entered into, amended, or renewed on or after the effective date. In addition, these same reinsurers may also have
c. With respect to those reinsurers that are currently Certified Reinsurers but are seeking recognition by ReFAWG as Reciprocal Jurisdiction Reinsurers for passporting purposes, the same process as outlined in paragraphs 3-6 of this ReFAWG Review Process must be followed. A Form RJ-1 must be filed with each state in which the reinsurer seeks recognition as a Reciprocal Jurisdiction Reinsurer, and the reinsurer must meet all other applicable requirements. However, states may share this information with other states through the NAIC and the ReFAWG Review Process, and previously filed information used in the review of the reinsurer as a Certified Reinsurer may also be utilized in its review as a Reciprocal Jurisdiction Reinsurer. ReFAWG will take full advantage of the passporting process, with the intent of reducing the amount of documentation filed with the states and reduce duplicate filings.

11. Commissioner Shall Create and Publish Lists

Section 2E(3) of Model #785 and Section 8C(1) of Model #786 require the commissioner to publish a list of Qualified Jurisdictions, while Section 2E(4) of Model #785 and Section 8B(2) of Model #786 require the commissioner to publish a list of all Certified Reinsurers and their ratings. Section 2F(2) & (3) of Model #785 and Section 9D and E of Model #786 require the commissioner to (a) timely create and publish a list of Reciprocal Jurisdictions; and (b) timely create and publish a list of Reciprocal Jurisdiction Reinsurers. It is expected that the commissioner will publish these respective lists on the insurance department’s website, along with special instructions or other guidance as to how Certified Reinsurers and Reciprocal Jurisdiction Reinsurers may meet the applicable filing requirements under the models. There currently are no specific requirements as to the format in which these lists must be published, but ReFAWG and NAIC staff will assist the states with questions on the publication of these lists. In addition, ReFAWG will maintain links on its NAIC webpage to the lists published on the insurance departments’ webpages.
July 19, 2021

Mr. John Rehagen
Chair Representative, NAIC Reinsurance Task Force
Via-email to jstultz@naic.org; dschelp@naic.org

Re: ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdictions

Dear Mr. Rehagen:

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit these comments on the NAIC’s proposed “ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdictions” (hereafter the “Review Process”). The Review Process and accompanying guidance to states and reinsurers is a critical component of the 2019 amendments to the NAIC’s Credit for Reinsurance Model Law (#785) and Model Regulation (#786). Although the 2019 amendments have been passed into law by 40 states and promulgated in approximately 15 states and the Uniform Checklist has been available on the NAIC’s website for over a year, we hope that those states that have completed the updates will begin accepting applications from reinsurers to be recognized as reciprocal jurisdictions. We hope that the publication of the Review Process will lead to even more states to begin accepting applications for reciprocal reinsurer status.

ACLI generally supports the proposed Review Process, although we encourage the drafters to clarify section 10(c). We think states and reinsurers would benefit from additional guidance on this point. Section 10(c) notes that

“…previously filed information used in the review of the reinsurer as a Certified Reinsurer may also be utilized in its review as a Reciprocal Jurisdiction Reinsurer… ReFAWG will take full advantage of the passporting process, with the intent of reducing the amount of documentation filed with the states and reduce duplicate filings.” (p. 12).

This provision is mentioned in passing in the document, but it is an important point. There is significant overlap in the documents required for Certified Reinsurers and Reciprocal Jurisdictions. Given the overlap between the materials, if a reinsurer applies for reciprocal jurisdiction status in a state where the applicant is already recognized as a certified reinsurer, does the applicant need to...
provide the full package of materials (financial statements, actuarial opinions, etc.), or can the applicant cross reference the previous Certified Reinsurer application filed with the state? While we expect that the decision to allow cross-referencing previous applications may vary by state, it would be helpful if the NAIC could provide more definitive guidance on the point that information provided by a certified reinsurer can be used in a reciprocal jurisdiction application. We believe that allowing the reinsurer to cross-reference it’s certified reinsurer application, without having to re-file voluminous, duplicative filings, is in line with the section 10(c)’s objectives of reducing the amount of documentation filed with states and reducing duplicate filings.

Conclusion

Thank you, as always, for the opportunity to provide these comments and your consideration of our suggestion to provide more detailed guidance in section 10(c). As always, we would be happy to discuss our comments in greater detail if you or your staff have any additional questions.

Sincerely,

Steve Clayburn

Mariana Gomez
NAIC Consultation on Review Process for Passporting Certified and Reciprocal Jurisdiction
Reinsurers

The Association of Bermuda Insurers and Reinsurers ("ABIR") kindly thanks the National Association of
Insurance Commissioners ("NAIC") for the opportunity to comment on its consultation on the review process
for passporting certified and reciprocal insurers. ABIR represents the public policy interests of Bermuda’s
leading insurers and reinsurers and make up over 35% of the global reinsurance market based on property &
casualty net premiums earned. ABIR members employ over 43,000 Americans in the U.S. and protect
consumers around the world by providing affordable and accessible insurance protection and peace of mind.

ABIR also would like to thank the NAIC for effecting revisions to the Credit for Reinsurance Model Law (#785)
and Credit for Reinsurance Model Regulation (#786), which implemented the reinsurance collateral
provisions of the Covered Agreements with the European Union (EU) and the United Kingdom (UK), thus
providing a mechanism for Qualified Jurisdictions, if they meet certain requirements in the credit for
reinsurance models, to be afforded the same elimination of collateral requirements as insurers domiciled in
the EU and UK.

We acknowledge the areas that the Reinsurance Financial Analysis Working Group (ReFAWG) anticipates
providing advisory support and assistance relating to the passporting process, such as:

- Support, encourage, promote and coordinate multi-state efforts in addressing issues related to
certified reinsurers, including but not limited to multi-state recognition of certified reinsurers.
- Provide analytical expertise and support to the states with respect to certified reinsurers and
applicants for certification.
- Ensure the public passporting website remains current.

ABIR supports a process to facilitate multi-state recognition of assuming insurers and to encourage
uniformity among the states. For insurance groups that have multiple entities with Certified Reinsurer
status across several states and that plan to apply for Reciprocal Reinsurer status for all entities, then such
reinsurer should have the ability to file one set of supporting documents to renew both (as there is a lot of
proposed duplication). As per above, having the ability to streamline this submission of the same
documentation for both processes would be beneficial not only to the Reciprocal Reinsurers, but to those
individuals reviewing applications in the state insurance regulators’ offices.

In addition, we would recommend that states are strongly encouraged to collaborate to facilitate uniformity,
reduce friction and increase efficiency. More specifically, we encourage the consideration of consistent
filing dates (e.g., June 30th) across states for applications & renewals for each of Certified and Reciprocal
Reinsurer status. We also encourage the use of a streamlined process as the ReFAWG coordinates with
individual states in support of the review process.

We would ask the NAIC to continue efforts to encourage states to adopt passporting, as it is not currently
mandatory. We believe that consistency is key, while acknowledging states’ ‘sovereignty’ to manage the
application process as they deem appropriate. Utilization of the passporting process does not remove
states’ ability to make enquiries if there are specific details they wish to obtain about an applicant.
Finally, we would ask that the NAIC consider permitting Reciprocal Reinsurers to submit evidence of their minimum capital and surplus and minimum solvency or capital ratio requirements status (as required by Section 9C(7)) directly to the state insurance regulator on behalf of their supervisory regulators instead of requiring the submission to be made directly by their respective supervisory regulators. This could prove to be a heavy burden on the supervisory regulator to track and collect information, create new forms of ‘confirmation’ letters, and then actually file with various state insurance regulators. Reciprocal Reinsurers are more likely to have the relevant financial information and systems in place to facilitate this kind of filing.

I am willing to make myself available, if you wish to discuss any of these matters further.

Kind regards
Suzanne Williams-Charles

Suzanne Williams-Charles | Director of Policy and Regulation, Corporate Secretary & Data Privacy Officer | Association of Bermuda Insurers and Reinsurers (ABIR) | Office: 441-294-7221 | Cell: 441-705-4422 | suzanne.williams-charles@abir.bm | O’Hara House, #1 Bermudiana Road, Hamilton, HM 08, Bermuda
July 15, 2021

VIA EMAIL to jstultz@naic.org and dschelp@naic.org

John Rehagen (MO), Chair Representative of the Reinsurance (E) Task Force
National Association of Insurance Commissioners
1100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

RE: Feedback on the NAIC's ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers

The Reinsurance Task Force has requested comments on the ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers (“ReFAWG Review Process”). Thank you for the opportunity to comment on the exposure.

We support the development of the ReFAWG Review Process pursuant to the NAIC’s Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786). This process is an important step forward in the implementation of collateral reform that will allow for more equitable application of credit for reinsurance and compliance with the Covered Agreements. We offer a few particular comments on the exposure.

I. Role of NAIC Staff in Reciprocal Jurisdiction Review:

We would request clarification on a key point in the process – the role of NAIC staff in Reciprocal Jurisdiction review, addressed in Section 7 of the proposal. If the Lead State has already made its determination at the time it submits information to the NAIC, then we are not sure what further role there is for staff. Alternatively, if staff will be assisting the Lead State in making its determination, that role is straightforward and may help maintain consistency. In order for the passporting process to work effectively and have credibility with the non-Lead States, it will help for Lead States to follow the same process when reviewing applications.

II. Application of Review Process:

We also note in Section 7 that it is unclear whether this section applies to both Certified Reinsurers and Reciprocal Jurisdictions. We recommend adding language to clarify its applicability.

III. Confidentiality:

Section 8 of the exposure addresses confidentiality, but only in the context of “ongoing monitoring” information. We recommend making the second sentence, related to information submitted by reinsurers, a separate section of the document. The confidentiality provisions indicated should be the approach for all information submitted during the process, not specific just to “ongoing monitoring” information.
IV. Other Comments and Suggestions:

We have a number of additional comments that we suggest will contribute to clarity and consistency in the document for your consideration:

Section 1 – ReFAWG Review Process

- On page 2, section 1.b, we recommend the following clarifying changes:

On June 25, 2019, the NAIC adopted further revisions to the models, which implement the reinsurance collateral provisions of the Covered Agreements with the European Union (EU) and the United Kingdom (UK). These revisions create a new type of jurisdiction, which is called a Reciprocal Jurisdiction and eliminates reinsurance collateral requirements and local presence requirements for EU and UK reinsurers that maintain a minimum amount of own-funds equivalent to $250 million USD and a solvency capital requirement (SCR) of 100% under Solvency II. The revisions also incorporate the “Reciprocal Jurisdiction” concept. Reciprocal Jurisdiction status is afforded to: 1) jurisdictions subject to an in-force Covered Agreement within the U.S.; 2) accredited U.S. jurisdictions; and 3) Qualified Jurisdictions if they meet certain requirements in the credit for reinsurance models. ReFAWG has also been given additional responsibilities with respect to these “Reciprocal Jurisdiction Reinsurers.” ReFAWG will coordinate its efforts with the Mutual Recognition of Jurisdictions (E) Working Group (formerly known as the Qualified Jurisdictions (E) Working Group).

Section 3 – ReFAWG Review Process for Certified Reinsurers

- It is unclear whether the timeline on page 4 applies also to Reciprocal Jurisdictions. We recommend clarifying.

Section 5 – Reciprocal Jurisdiction Process – Initial Application to Lead State

- In section 5.a on page 9, we recommend the following corrections and clarifying language:

The assuming insurer must be licensed to write reinsurance by, and has its head office or is domiciled in, a Reciprocal Jurisdiction that is listed on the NAIC List of Reciprocal Jurisdictions: A “Reciprocal Jurisdiction” is a jurisdiction, as designated by the commissioner, that meets one of the following: (1) a non-U.S. jurisdiction that is subject to an in-force Covered Agreement with the United States; (2) a U.S. jurisdiction that meets the requirements for accreditation under the NAIC Financial Standards and Accreditation Program; or (3) a Qualified Jurisdiction that has been determined by the commissioner to meet all applicable requirements to be a Reciprocal Jurisdiction.

- In sections 5.b (page 9) and 5.c (page 10), we recommend replacing “complies with” with “satisfies”.

- In section 5.c, we recommend ending the first sentence with a colon instead of a period.

- We recommend the following change to section 5.d on page 10 to eliminate both ambiguity and redundancy about what is required in submitting a Form RJ-1:
Page 3. BILTIR response to Feedback on the NAIC’s ReFAWG Review Process for Passorting Certified and Reciprocal Jurisdiction Reinsurers

The assuming insurer must agree to and provide a signed Form RJ-1, which must be properly executed by an officer of the assuming insurer.

Section 6 – Reciprocal Jurisdiction Process – Passorting States

- We recommend the following change to section 6.a on page 11, again regarding the submission of Form RJ-1:

  The assuming insurer must agree to and provide a signed Form RJ-1, which must be properly executed by an officer of the assuming insurer.

- In section 6.b on page 11, we suggest the following clarifying edits:

  The applicant must provide a copy of the approval letter or other documentation provided to the applicant by the NAIC accredited jurisdiction. The letter should include the approving state, effective date, and approved lines of business.

Section 8 – Process for Ongoing Monitoring and Certified Reinsurers

- For consistency, we recommend the following changes to the first sentence:

  Certified and Reciprocal Jurisdiction Reinsurers are required to file specific information to a certifying state on an ongoing basis.

Section 10 – Interaction Between Certified Reinsurers and Reciprocal Jurisdiction Reinsurers

- If the NAIC Blanks have already been amended, we recommend the following change to the last sentence of section 10.b on page 12:

  The NAIC Blanks will be have been amended to reflect the status of these reinsurers with respect to each type of insurance assumed.

Thank you again for the opportunity to comment on the ReFAWG Review Process.

Sincerely,

BILTIR

CC BILTIR Board of Directors
July 19, 2021

VIA ELECTRONIC MAIL

Mr. Jake Stultz  
Senior Accounting and Reinsurance Policy Advisor  
National Association of Insurance Commissioners  
1100 Walnut Street Suite 1500  
Kansas City, MO 64106-2197

Mr. Daniel Schelp  
Chief Counsel, Regulatory Affairs  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197


Dear Mr. Stultz and Mr. Schelp:

Thank you for the opportunity to submit comments on the ReFAWG Review Process. The IUA represents more than 70 re/insurers active in the London Insurance Market and has been fully engaged in NAIC debates and discussions regarding changes in U.S. reinsurance regulation for the past two decades. Many IUA members or their affiliates accept U.S. risks both as insurers and as reinsurers. Accordingly, a number of IUA members or their affiliates are well known to the NAIC, being listed by International Insurers Department and are therefore eligible as surplus lines insurers in every U.S. jurisdiction. Similarly, some of those same insurers, functioning as reinsurers, have either established multi-beneficiary reinsurance trusts in the U.S. pursuant to Section 2.D. of the Credit for Reinsurance Model Act (#785) or have qualified as Certified Reinsurers, or both. The IUA understands that some members are applying now for Reciprocal Reinsurer status to various lead states and expects that a number of its members and their affiliates will be applying for reciprocal reinsurer status in the future— and will be seeking Reciprocal Reinsurer approvals in multiple states via the passport process that ReFAWG is fine-tuning now.

The IUA’s comments with respect to June 17th draft of the ReFAWG Review Process center on the following goals, all designed to build upon the NAIC’s excellent June 17th draft:

- Maximize and leverage ReFAWG’s knowledge and expertise with respect to both Certified and Reciprocal Reinsurers in order to assist in the collection, maintenance and sharing of reinsurers’ financial information with both Lead and Passport States
• Promote uniformity and consistency with respect to the passport processes for both Certified and Reciprocal Reinsurers—with the goal that, to the maximum extent possible, these processes should be virtually the same, pursuant to a single Uniform Checklist—particularly since for some period of time the same reinsurer may hold both certified and reciprocal statuses.

• Centralize and streamline the communication between insurance regulators in Qualified and Reciprocal Jurisdictions and state insurance regulators (and ReFAWG) with respect to the required annual (i) confirmation of minimum capital and surplus levels and (ii) confirmation of solvency/capital ratios for Reciprocal Reinsurers.

We note preliminarily that due to the likelihood that certain Certified Reinsurers that desire to obtain Reciprocal Reinsurer status will have two lead states—one for certified status and the other for reciprocal status—the ReFAWG’s support for both Certified and Reciprocal Reinsurer status will prove to be indispensable. Similarly, with the addition of Section 2. f. Change of Lead State, ReFAWG’s experience and leadership should assist with such changes in the future.

Our specific comments on the ReFAWG Review Process are as follows:

1. As just noted, since we believe that many of today’s Certified Reinsurers will also seek to be recognized as Reciprocal Reinsurers and since reciprocal reinsurance “zero collateral” can only be prospective, “old” reinsurance liabilities secured on a reduced collateral basis will remain, perhaps for some years. Reinsurers will need to maintain both statuses. Indeed, we understand that today there are U.S. reinsurance buyers that do not accept certified status or that accept it only for certain classes of business or for reinsurers that meet financial metrics (e.g. minimum policyholders’ surplus of $5 billion) acceptable to the buyers. We assume, therefore, that there will continue to be reinsurance buyers that will not accept zero collateral. So, for years to come, some reinsurers will continue to be making annual filings to maintain both statuses.

And again it is conceivable that a single non-U.S. reinsurer will have two lead states—one for Certified Reinsurer status and the other for Reciprocal status.

The importance of having the same compliance filing deadlines for both statuses cannot be overstated but we believe that is the intent of all parties. And this should be coupled with an instruction that both Certified and Reciprocal Reinsurers file—ideally either via a single lead state or with ReFAWG directly—only a single set of the same renewal documents each year.

Required minimum capital and surplus ($250 million) levels are the same, of course, for both statuses. Many elements of initial and annual requalification filings are also the same for both statuses, eg. multiple letters confirming compliance, audited financials, actuarial certifications, etc. The same disclosures as to assumed and ceded reinsurance—CR-F, Parts 1 and 2—are required for both statuses.
It would be extremely helpful if the states would agree that ReFAWG could be the repository for Certified and Reciprocal Reinsurer filing information, data and documents—at least for annual requalification and for passporting purposes. We again note that the emerging phenomenon of two lead states, one for Certified Reinsurer purposes, one for Reciprocal Reinsurer purposes, highlights the benefit of having ReFAWG be the repository of documents, data and information for both certified and reciprocal reinsurers.

2. Many IUA members and clients that are not IUA members have commented to us about required disclosures/confirmations with respect to disputed or overdue balances owed to cedents. One overarching concern is to confirm that these disclosures are confined to obligations owed to U.S. cedents only and can be made by reinsurers without having to obtain data from U.S. cedents.

Both the US-EU and US-UK Covered Agreements (in Article 3. Paragraph 4. (h)(iii)) have the identical straightforward claims disclosure filing requirement for Reciprocal Reinsurers:

“….prior to entry into the reinsurance agreement and not more than semi-annually thereafter, an updated list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers of the jurisdiction of the ceding insurer…”

Beyond this, for reinsurers with both Certified and Reciprocal Reinsurer status, the process is unclear. Will such reinsurers supply only a Certified Reinsurer disclosure? Only a Reciprocal Reinsurer disclosure with respect to overdue and/or disputed claims? Or both Certified and Reciprocal Reinsurer disclosures?

Currently and for a number of years, Certified Reinsurers have become familiar with the following elaboration in the NAIC’s Checklist for Certified Reinsurers on disputed or overdue reinsurance recoverables:

<table>
<thead>
<tr>
<th>Disputed and/or Overdue Reinsurance Claims / Business Practices:</th>
</tr>
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<tbody>
<tr>
<td>The Commissioner may consider the applicant’s business practices in dealing with its ceding insurers, including compliance with contractual terms and obligations. The applicant must provide the following if 1) applicant’s reinsurance obligations to U.S. cedents that are in dispute and/or more than 90 days past due exceed 5% of its total reinsurance obligations to U.S. cedents as of the end of its prior financial reporting year; or 2) the applicant’s reinsurance obligations to any of the top 10 U.S. cedents (based on the amount of outstanding reinsurance obligations as of the end of its prior financial reporting year) that are in dispute and/or more than 90 days past due exceed 10% of its reinsurance obligations to that U.S. cedent,</td>
</tr>
</tbody>
</table>
Then, in either case, the applicant will provide:

a. Notice of that fact to the Commissioner and a detailed explanation regarding the reason(s) for the amount of disputed or overdue claims exceeding the levels noted above; and.

b. A description of the applicant’s business practices in dealing with U.S. ceding insurers and a statement that the applicant commits to comply with all contractual requirements applicable to reinsurance contracts with U.S. ceding insurers.

Upon receipt of such notice and explanation, the Commissioner may request additional information concerning the applicant’s claims practices with regard to any or all U.S. ceding insurers.

But in the ReFAWG Review Process, Section 5. i. (for Reciprocal Reinsurers) the disputed and overdue claim metrics change:

“i. **Prompt Payment of Claims** - The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment will be evidenced if any of the following criteria is met: (1) more than fifteen percent (15%) of the reinsurance recoverables from the assuming insurer are overdue and in dispute as reported to the commissioner; (2) more than fifteen percent (15%) of the assuming insurer’s ceding insurers or reinsurers have overdue reinsurance recoverable on paid losses of 90 days or more which are not in dispute and which exceed for each ceding insurer $100,000, or as otherwise specified in a Covered Agreement; or (3) the aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by 90 days or more, exceeds $50,000,000, or as otherwise specified in a Covered Agreement. “

While we understand that the Reciprocal Reinsurer disclosure formulation track the criteria evidencing “lack of prompt payment” in Article 3, Paragraph 4. (i) of both the US-EU and US-UK Covered Agreements, for reinsurers that are both Certified and Reciprocal, a single set of “disputed or overdue” metrics that evidence “lack of prompt payment” would be greatly appreciated. IUA members that plan to have both Certified and Reciprocal Reinsurer status have a strong preference that the current set of metrics in use for Certified Reinsurers be carried through for Reciprocal Reinsurers as well—at least for the reinsurer’s annual requalification filings for both Certified and Reciprocal Reinsurer status.

Then, assuming that the Certified/Reciprocal Reinsurer making a filing triggers either of the Certified Reinsurer disputed and overdue metrics—one for individual cedents (more than 10% of obligations owed to any Top 10 cedent) and the other for the reinsurer’s portfolio of assumed reinsurance from U.S. cedents (5% of all U.S. reinsurance obligations), the Lead State or ReFAWG could then require preparation of a Reciprocal Reinsurer-specific disputed or overdue claims report using the metrics in the two Covered Agreements and in Section 5.i. of the ReFAWG Review Process. Specifically, for the reinsurer’s book of U.S. reinsurance business overall are the disputed or overdue obligations in excess of
15% of the reinsurer’s total book? And for individual reinsureds, if more than 15% of them have overdue (undisputed) recoverables, does the reinsurer owe more than $100,000 to each of them?

We believe that this two stage approach would be workable ---at least for a transition period when it can be expected that many, if not all, of today’s Certified Reinsurers will be seeking Reciprocal Reinsurer status as well.

3. As we commented with respect to the Process for Evaluating Qualified and Reciprocal Jurisdictions in our April 23, 2021 letter it would be incredibly helpful to avert a situation in which non-U.S. regulators are asked to prepare and send multiple certifications as to minimum capital and surplus and minimum solvency ratios (i.e. when the reinsurer is approved in multiple jurisdictions). Could ReFAWG be the repository for such certifications, able to confirm to states that request a copy that the “original” confirmation from the overseas regulator is on file with the NAIC? At the absolute minimum, we would urge the states to permit Reciprocal Reinsurers to obtain a single certification from their domiciliary regulator and then supply certified copies to the individual states that require copies—just as non-U.S. insurers do now with customary “good standing” certificates. As the IUA commented earlier this year:

“Section 9C(7) of the Credit for Reinsurance Model Regulation (#786) requires the supervisory authority of an assuming insurer domiciled in a Reciprocal Jurisdiction (a “Reciprocal Reinsurer”) to confirm on an annual basis to the relevant state insurance regulator that such Reciprocal Reinsurer complies with the minimum capital and surplus and minimum solvency or capital ratio requirements set forth in the Credit for Reinsurance Model Regulation (#786). To that end, the new Section III, Paragraph 15 of the Process for Evaluating Qualified and Reciprocal Jurisdictions creates a process for Reciprocal Jurisdictions to make annual filings of the relevant financial information.

To make such a filing, the supervisory authority in a Reciprocal Jurisdiction would need to: (1) track on an annual basis which Reciprocal Reinsurers domiciled in their jurisdiction had obtained such status and file the required information on behalf of multiple reinsurers in potentially multiple states; (2) collect the relevant financial information from the Reciprocal Reinsurers domiciled in their jurisdiction; and (3) develop a system for filing such information with U.S. insurance regulators. This filing process would clearly impose considerable burdens on Reciprocal Jurisdictions. The process, however, could be streamlined by adding as an option allowing individual Reciprocal Reinsurers to file the required financial information directly with U.S. insurance regulators [or with ReFAWG].

A Reciprocal Jurisdiction should be permitted to either make an annual filing as reflected in the proposed draft or, alternatively, issue a document to the Reciprocal Reinsurers confirming the information required by Section 9C(7) of the Credit for Reinsurance Model Regulation (#786), similar to a certificate of good standing, which the Reciprocal Reinsurers would then annually file directly with state insurance regulators (e.g., as part of a Reciprocal Reinsurer’s application for or renewal of status as a Reciprocal Reinsurer). [or with ReFAWG]
Given that the Reciprocal Reinsurers are more likely to already have developed systems of making filings with supervisory authorities in general, allowing those Reciprocal Reinsurers to make the required filings with U.S. insurance regulators [or a single filing with ReFAWG]* directly would likely be more efficient than asking supervisory authorities in Reciprocal Jurisdictions to establish whole new systems and procedures for making [multiple] financial filings on behalf of the Reciprocal Reinsurers domiciled in those Reciprocal Jurisdictions. “

* Pursuant to Section 2. d. of the ReFAWG Review Process:
“The commissioner may accept financial documentation filed with the Lead State or with the NAIC. ReFAWG and the Mutual Recognition of Jurisdictions (E) Working Group will coordinate efforts to obtain and disseminate to the states financial information regarding both Certified Reinsurers and Reciprocal Jurisdiction Reinsurers.” [emphasis added]

We applaud Section 10 of the ReFAWG Review Process, particularly this passage that underscores the desirability of having a single renewal process for both Certified and Reciprocal Reinsurers pursuant to a single Uniform Checklist:

“….states may share this information with other states through the NAIC and the ReFAWG Review Process, and previously filed information used in the review of the reinsurer as a Certified Reinsurer may also be utilized in its review as a Reciprocal Jurisdiction Reinsurer. ReFAWG will take full advantage of the passporting process, with the intent of reducing the amount of documentation filed with the states and reduce duplicate filings.”

On behalf of the IUA many thanks again for the opportunity to submit comments on the proposed ReFAWG Review Process. Please let us know if you or ReFAWG members have any questions or need additional information.

Sincerely,

Thomas M. Dawson

cc: J. Finston
A. Best
July 14, 2021

Rolf Kaumann
Chair, Reinsurance Financial Analysis Working Group
Colorado Division of Insurance

Re: ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers

Dear Mr. Kaumann,

This comment letter is submitted on behalf of Underwriters at Lloyd’s, London (“Lloyd’s”). Lloyd’s is one of the largest non-US domiciled providers of reinsurance capacity to the US insurance industry. In 2020, the Lloyd’s market assumed over $6.4 billion in reinsurance premiums from US ceding insurers.

Lloyd’s very much appreciates the effort that was put into the ReFAWG Review Process document. Having a clear and documented process will help regulators and reinsurers and result in more efficient evaluations of reinsurer applications. We look forward to working with ReFAWG as the Reciprocal Reinsurer regime comes into effect.

Regards,

[Signature]
July 19, 2021

Director Chlora Lindley-Myers, Chair
Reinsurance (E) Task Force
National Association of Insurance Commissioners
c/o Mr. Dan Schelp and Mr. Jake Stultz
Via e-mail dschelp@naic.org, jstultz@naic.org

Re: NAIC Request for Comments on ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers

Dear Director Lindley-Myers:

The Reinsurance Association of America (RAA) appreciates the opportunity to submit comments on the NAIC’s exposure draft of the ReFAWG Review process for Passporting Certified and Reciprocal Jurisdiction Reinsurers. The Reinsurance Association of America (RAA) is a national trade association representing reinsurance companies doing business in the United States. RAA membership is diverse, including reinsurance underwriters and intermediaries licensed in the U.S. and those that conduct business on a cross-border basis. The RAA also has life reinsurance affiliates and insurance-linked securities (ILS) fund managers and market participants that are engaged in the assumption of property/casualty risks. The RAA represents its members before state, federal and international bodies.

We appreciate the Reinsurance Task Force’s continued thoughtful engagement with respect to implementation of its 2019 revisions to the NAIC Credit for Reinsurance Model Law and Model Regulation, including its continued work on the passporting process for Certified and Reciprocal jurisdiction reinsurers. This is another important step in the implementation process for the U.S./EU and U.S./UK covered agreements and in the NAIC’s expressed goal to revise the credit for reinsurance framework in the U.S. to create an equal playing field for all reinsurers that meet the legal requirements and commitments from the new category of “Reciprocal Jurisdictions.”

General Comments

As detailed more specifically below, in general the current draft does not always clearly specify where it applies to Certified Reinsurers and where it applies to Reciprocal Reinsurers, or both. More clarity is needed with respect to whether the guidance is applicable to both categories or is limited to one. In addition, there are differences in the requirements imposed by a lead state Commissioner and a non-lead state commissioner and more clarity as to the requirements of each of those two categories would be helpful.

Also, before the document moves from the initial overview into the specifics relating to individual company applications, it would be useful for this document to provide a summary of or cross-reference to the process for becoming a Qualified or Reciprocal Jurisdiction, as that process is a necessary precursor for the Certified or Reciprocal Reinsurer application and/or passporting process.
The NAIC ReFAWG passporting process – along with other NAIC resources relating to Certified and Reciprocal Reinsurers and Qualified and Reciprocal Jurisdictions should be noted on state websites. In addition, each state should specify on its website its process for entertaining applications for Reciprocal Reinsurers, including whether they are open to passporting so that a company seeking to do business through this process knows and understands the process it must complete in that jurisdiction. Further, we believe ReFAWG and the NAIC should draft sample document(s) that states could evaluate, use or adapt in developing their own websites and related processes for Certified and Reciprocal reinsurers. This would help ensure clarity, consistency and expediency in the process for both state regulators and applicants.

Specific comments relevant to the exposure draft are set forth below.

Section 1: ReFAWG Review Process

Section 1. provides a list of issues upon which the Working Group may provide advisory support and assistance. A number of the subcategories make specific reference to Certified Reinsurers, but only one expressly relates to reinsurers domiciled in Reciprocal Jurisdictions. In our view, each of the categories relevant to Certified Reinsurers would also apply to reinsurers from Reciprocal Jurisdictions. We suggest revising this list to reflect application to both Certified and Reciprocal reinsurers.

Section 2: Lead States and Passporting Process

As noted above, to help make the passporting process smoother and more transparent for applicants, it would be extremely helpful if each state would include information on their process on their website. For example, in Section 2.a., it states that a reinsurer seeking recognition as either a Certified or Reciprocal Jurisdiction reinsurer must submit certain information to the state in which it seeks such recognition. Clear guidance on the state’s website about the process for an initial application (i.e., seeking to have that state designated as its Lead State) or through passporting is needed, including to whom information should be submitted. If the Commissioner is willing to accept financial documentation filed with the Lead State or with the NAIC (as referenced in Section 2.d.), or to waive requirements for submission of information that is available through the NAIC, it would be very helpful to have that set forth on the state’s website.

Section 2.a. should include a reference that makes clear there is a distinction between submitting information to a state as a Lead State for purposes of passporting and submitting a complete application to a state. We recommend the following amendment:

A reinsurer seeking recognition as either a Certified Reinsurer or a Reciprocal Jurisdiction Reinsurer must submit certain information to each the state in which it seeks such recognition. A reinsurer may decide to make a filing with a Lead State and use the NAIC Passporting process to facilitate multi-state recognition or a reinsurer may decide to submit the information to each state as a separate application. Under the ReFAWG Review Process, ReFAWG will assist states with the initial review of this information and provide
guidance to the states in making their review of the reinsurer to determine whether it has met the regulatory requirements to be recognized as a Certified Reinsurer and/or a Reciprocal Jurisdiction Reinsurer.

Sections 2.b. and 2.c. apply to Certified and Reciprocal Reinsurers, respectively. For clarity’s sake, we suggest that you include a subheading at the beginning of both paragraphs indicating that the first applies to Certified Reinsurers and the second applies to Reciprocal Reinsurers.

Section 2.d. should be revised to clarify which state may decide whether to rely on the determination of another state. We suggest the following amendment:

If an NAIC accredited jurisdiction has determined that the conditions set forth for recognition as a Reciprocal Jurisdiction Reinsurer have been met, the commissioner of any other state has the discretion to defer to that jurisdiction’s determination and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit. The commissioner may accept financial documentation filed with the Lead State or with the NAIC and is encouraged to support a uniform submission and approval process among the states the NAIC, ReFAWG and the Mutual Recognition of Jurisdictions (E) Working Group will coordinate efforts to obtain and disseminate to the states financial information regarding both Certified Reinsurers and Reciprocal Jurisdiction Reinsurers.

Section 3: ReFAWG Review Process for Certified Reinsurers

To provide clarity between the roles of ReFAWG and NAIC staff as set forth in the timeline, it may be useful to cross-reference Section 7 in this section.

In Section 3.f., the draft states that a Certified Reinsurer is required to notify the Commissioner of a “certifying state” of any regulatory actions, changes in its license or ratings. We suggest modifying this paragraph to make clear that the required notice would be made to the Lead State and then that information distributed through the NAIC or ReFAWG to other relevant states.

Section 4: Certified Reinsurers – Certified by Another NAIC Accredited Jurisdiction

Section 4.b. references the process for verification of certification issued by an NAIC accredited jurisdiction. If this information is also available through the NAIC and ReFAWG processes, then verification through accessing that information also should be referenced.

Section 5: Reciprocal Jurisdiction Process – Initial Application to Lead State

The lead-in paragraph to Section 5 states that reinsurers may provide documentation so that other states may rely on the Lead State’s determination. Section 5.a., however, does not specifically refer to any documentation. As a result, the type of documentation that must be provided to the Lead State or to the NAIC is not clear. Cross-reference to the checklist and/or enumeration of what documentation is required would be helpful.
In Section 5.h., ReFAWG should clarify that information should be provided regarding claims to U.S. cedents only. The administrative burden to the applicant of compiling information regarding worldwide claims payments outweighs the regulatory relevance for U.S. regulators regarding these claims payments.

Section 8: Process for Ongoing Monitoring of Certified Reinsurers

Section 8 (as with Sections 9-11) appears to apply substantively to both Certified and Reciprocal reinsurers. If that is correct, then we suggest that the title of that section be modified to reflect that it applies to both categories.

We agree with the substantive intent of the reference to non-public information in this Section. However, we suggest making it clear that the Commissioner is required to maintain the confidentiality of any information submitted by reinsurers that is not otherwise public and not just to withhold that information from public disclosure.

Section 10: Interaction Between Certified Reinsurers and Reciprocal Jurisdiction Reinsurers

Section 10.b. states that it is expected that certain assuming insurers may be considered to be Certified Reinsurers for purposes of “in-force business”. This section should be modified to reflect that such status is not limited just to in-force business but may also apply to the run-off of existing business written under its Certified Reinsurer status.

Section 10.c. states that information previously submitted by a reinsurer can be shared with other states through the NAIC and the ReFAWG review process and previously filed information used in the review of a reinsurer may also be utilized in its review as a Reciprocal Reinsurer. We suggest that the draft should go farther to reflect that states should be encouraged to waive the requirements for documents to be separately filed if they can be accessed through the NAIC.

Section 10.d. should address the likely situation where a lead state has adopted the new model law and regulations and a passporting state has not fully adopted them (or vice versa). The guidance should permit a reinsurer that has been approved as a Reciprocal Reinsurer to be approved for passporting by ReFAWG and accepted by a state even if that state has not yet completed the process to implement Reciprocal Jurisdiction/Reinsurer status.
Conclusion

Thank you for your continued work and engagement with us in this important process. We would be happy to answer any questions or discuss any concerns.

Sincerely,

[Signature]

Karalee C. Morell
SVP and General Counsel
Reinsurance Association of America
Final Evaluation Report

REPUBLIC OF KOREA: FINANCIAL SERVICES COMMISSION (FSC) & FINANCIAL SUPERVISORY SERVICE (FSS)

Approved By:

Mutual Recognition of Jurisdictions (E) Working Group

May 27, 2021
I. Evaluation of Financial Services Commission (FSC) and the Financial Supervisory Service of the Republic of Korea

The Mutual Recognition of Jurisdictions (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Preliminary Evaluation Report with respect to the Financial Services Commission (FSC) and the Financial Supervisory Service (FSS), the lead insurance supervisors for the Republic of Korea. It is the recommendation of the Working Group that the NAIC recognize the Republic of Korea as a Qualified Jurisdiction and place it on the NAIC List of Qualified Jurisdictions, to be effective upon approval by the NAIC Executive (EX) Committee and Plenary. Further, the Working Group recommends that California be designated the Lead State for purposes of regulatory cooperation and information sharing with the FSC and FSS. These recommendations are based on the following analysis:

II. Procedural History

The NAIC adopted the Process for Evaluating Qualified and Reciprocal Jurisdictions (Qualified Jurisdiction Process) on August 27, 2013, with the current revisions effective December 10, 2019. The 2011 revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (collectively, the “Credit for Reinsurance Models”) require an assuming insurer to be licensed and domiciled in a “Qualified Jurisdiction” in order to be eligible for certification by a state as a certified reinsurer for reinsurance collateral reduction purposes.

The purpose of the Qualified Jurisdiction Process is to provide a documented evaluation process for creating and maintaining an NAIC list of jurisdictions recommended for recognition by the states as Qualified Jurisdictions. Toward this end, the Qualified Jurisdiction Process designates key elements believed to be basic building blocks for sound (re)insurance regulation. Each jurisdiction under consideration to be included on the NAIC List of Qualified Jurisdictions is requested to submit detailed information in support of these criteria. In addition, the NAIC review will also rely on publicly available reports evaluating the reinsurance regulatory practices of each jurisdiction.

The Korean FSC/FSS submitted an application to the NAIC to be considered a Qualified Jurisdiction on September 28, 2020, along with a voluminous amount of supporting documentation. The Working Group met in regulator-to-regulator session on March 17, 2021, to review initial findings prepared by NAIC staff to determine whether the FSC/FSS should be approved as a Qualified Jurisdiction. The Working Group requested additional supplementary information from the FSC/FSS with respect to specific questions raised during this meeting, which the FSC/FSS provided to the Working Group on April 2, 2021.
Notice of the Republic of Korea’s application was sent to the Federal Insurance Office (FIO) and the United States Trade Representative (USTR) on May 5, 2021. The Working Group met in regulator-to-regulator session on May 27, 2021, and voted to recommend the Republic of Korea FSC/FSS for approval as a Qualified Jurisdiction.

### III. Review of Evaluation Materials

Under the requirements of the Qualified Jurisdiction Process, the Working Group performed an initial evaluation of the FSC/FSS’s regulatory system by using the information identified in Section A through Section G of the Evaluation Methodology (Evaluation Materials). The Working Group began by undertaking a review of the most recent Detailed Assessment of Observance on Insurance Core Principles under the International Monetary Fund (IMF)/World Bank Financial Sector Assessment Program (FSAP Report), Report on Observance for Standards and Codes (ROSC), and any other publicly available information regarding the laws, regulations, practices and procedures applicable to the reinsurance supervisory system.

The Working Group also reviewed information the FSC/FSS provided relative to Section A through Section G of the Evaluation Methodology. The Working Group’s review was focused on how the Republic of Korea’s laws, regulations, administrative practices and procedures, and regulatory authorities regulate the financial solvency of its domestic reinsurers in comparison to key principles underlying the U.S. financial solvency framework and other factors set forth in the Evaluation Methodology.

The Working Group considered the following information with respect to the evaluation of the FSC/FSS:

1. **Republic of Korea FSC/FSS 2020 Qualified Jurisdiction Application Submission (Confidential)**
IV. Standard of Review

The evaluation is intended as an outcomes-based comparison to financial solvency regulation under the NAIC Accreditation Program, adherence to international supervisory standards and relevant international guidance for recognition of reinsurance supervision. The standard for qualification of a jurisdiction is that the NAIC must reasonably conclude that the jurisdiction’s reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction, that the jurisdiction’s demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system, and that the jurisdiction’s laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

V. Evaluation Recommendation

The Working Group finds that it has performed the required review of the Evaluation Materials, including review of the publicly available information, and that the FSC/FSS provided the Working Group with information relative to Section A through Section G of the Evaluation Methodology to update and supplement the identified public information. The Working Group further finds that interested parties will be given an opportunity to provide public comments on the FSC/FSS application. Further, appropriate notice was provided to the FIO and the USTR. Based on the information provided by the FSC/FSS and the review of the Evaluation Materials, the Working Group has determined that there is no indication that the Republic of Korea fails to adequately and promptly enforce final U.S. judgments and arbitration awards.

Finally, the Working Group notes that the FSC/FSS and the California Department of Insurance are signatories to the IAIS Multilateral Memorandum of Understanding (MMoU), and that California has consented to act as the Lead State for purposes of regulatory cooperation and information sharing under the Qualified Jurisdiction Process, and further that the FSC/FSS has consented to the designation of California as the Lead State. This Lead State designation for purposes of regulatory cooperation and information sharing should not be confused with the Lead State designation by the Reinsurance Financial Analysis (E) Working Group for individual certified reinsurers for passporting purposes.

The Working Group has reached the conclusion that the FSC/FSS’s reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is acceptable for purposes of reinsurance collateral reduction, that the FSC/FSS’s demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system, and that its laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.
Models. Therefore, it is the recommendation of the Working Group that the NAIC recognize the Republic of Korea as a Qualified Jurisdiction with respect to reinsurance companies regulated by the FSC/FSS and place it on the *NAIC List of Qualified Jurisdictions*, to be effective upon approval by the NAIC Executive (EX) Committee and Plenary. This designation as a Qualified Jurisdiction shall be valid on an ongoing basis, absent a material change in circumstances.
John Rehagen (MO)  
Chair of the Reinsurance (E) Task Force  
National Association of Insurance Commissioners  
NAIC Staff: Jake Stultz and Dan Schelp

On behalf of the American Property Casualty Insurance Association and American Council of Life Insurers, we appreciate the opportunity to comment on the Republic of Korea Final Evaluation Report as to whether to designate Korea as a Qualified Jurisdiction.

Local Korean branches of U.S. reinsurers are hindered in conducting business because they are required to localize all personal data onshore and are not permitted to transfer such data outside of Korea, even to their headquarters and affiliates. These rules impede foreign reinsurers’ ability to underwrite, manage risk, comply with regulatory requirements like OFAC rules, and transfer risk to other reinsurers, all of which are activities that are in the ordinary course of reinsurance business.

Korea has been interpreting its laws to prohibit offshore transfer of personal information unless the reinsurer obtains specific, prior consent from the policyholder, rather than allowing the reinsurer to rely on the consent obtained by the insurance (ceding) company. Reinsurers have no relationship with policyholders and are generally unable to obtain such consent.

We believe Korea’s actions are in contravention of their commitments under the Korea-U.S. Free Trade Agreement (KORUS), which went into effect in 2012. The KORUS stipulates in Annex 13B, Section B that each party shall allow a financial institution of the other party to transfer information in electronic or other form, into and out of its territory, for data processing where such processing is required in the institution’s ordinary course of business. The U.S. government (in particular, USTR and Treasury) has been working for years to persuade Korea to change these restrictions and allow financial services companies, including reinsurers, to transfer personal data offshore, as provided in the KORUS.

Under Korea’s current interpretation of its law and pursuant the standard consent form provided to insurers by the Korean government, insurance companies are permitted to transfer data to reinsurers located onshore in Korea, but those reinsurers are not permitted to transfer that data offshore, even to an affiliate. Thus, it is unduly difficult and inefficient for U.S. reinsurers to provide reinsurance to Korean insurers.

Korea has recently advised the U.S. government that it plans to change this policy to comply with KORUS, but as of now, reinsurers are still required to localize all personal and sensitive data in Korea. We understand that Korea has indicated that it will revise the standard policyholder consent forms for new business and to change its interpretation of existing consent forms to allow reinsurers to transfer personal data offshore to their headquarters, affiliates, and third-party service providers, as envisioned in the KORUS. We also understand that Korea will...
not extend this new interpretation to transfers to retrocessionaires, even though retrocessions are just reinsurance for reinsurers.

Until these issues are resolved and U.S. companies with reinsurers in Korea are permitted to conduct business freely and as intended by the KORUS, we request that Korea not be granted preferential treatment by being designated as a Qualified Jurisdiction.

We understand that this is a complicated issue and not explicitly encompassed in any “reinsurance” specific regulation, but the effect of Korea’s policies is to deny U.S. reinsurers reciprocal treatment. The Credit for Reinsurance Model Regulation requires U.S. regulators to consider the extent of reciprocal recognition afforded by the non-U.S. jurisdiction to reinsurers licensed and domiciled in the U.S. We are happy to provide additional information and discuss this issue further.

Sincerely,

Robert Woody  
Vice President, 
Reinsurance & Counsel 
APCIA

David Snyder  
Vice President, 
International & Counsel 
APCIA

Brad Smith  
Chief International Officer 
ACLI

The American Property Casualty Insurance Association (APCIA) is the primary national trade association for home, auto, and business insurers. APCIA promotes and protects the viability of private competition for the benefit of consumers and insurers, with a legacy dating back 150 years. APCIA members represent all sizes, structures, and regions—protecting families, communities, and businesses in the U.S. and across the globe.

The American Council of Life Insurers (ACLI) advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers' products for peace of mind. ACLI members represent 94 percent of industry assets in the United States.
Disclaimer: This map represents state action or pending state action regarding NAIC amendments to the model(s). This map does not reflect a determination as to whether the pending or enacted legislation contains all elements of NAIC amendments to the model(s) or whether a state meets any applicable accreditation standards.
Implementation of the 2019 Revisions to the Credit for Reinsurance Model Regulation #786
[status as of July 16, 2021]

Disclaimer: This map represents state action or pending state action regarding NAIC amendments to the model(s). This map does not reflect a determination as to whether the pending or enacted legislation contains all elements of NAIC amendments to the model(s) or whether a state meets any applicable accreditation standards.
Implementation of Model #787 (XXX/AXXX)
Term and Universal Life Insurance Reserve Financing Model Regulation
[status as of June 22, 2021]

Disclaimer: This map represents state action or pending state action regarding NAIC amendments to the model(s). This map does not reflect a determination as to whether the pending or enacted legislation contains all elements of NAIC amendments to the model(s) or whether a state meets any applicable accreditation standards.
Risk Retention Group (E) Task Force
Virtual Meeting (in lieu of meeting at the 2021 Summer National Meeting)
July 26, 2021

The Risk Retention Group (E) Task Force met July 26, 2021. The following Task Force members participated: Michael S. Pieciak, Chair, represented by Sandra Bigglestone (VT); Karima M. Woods, Vice Chair, represented by Sean O’Donnell (DC); Andrew N. Mais represented by Fenhua Liu (CT); Sharon P. Clark represented by Russell Coy (KY); Troy Downing represented by Steve Matthews (MT); Barbara D. Richardson (NV); Marlene Caride represented by David Wolf (NJ); and Raymond G. Farmer represented by Eva Conley (SC).

1. **Adopted its May 25 Minutes**

The Task Force met May 25 to discuss the results of the 2021 risk retention group (RRG) survey and discuss applicability to RRGs of the 2020 revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450).

Mr. O’Donnell made a motion, seconded by Mr. Matthews, to adopt the Task Force’s May 25 minutes (Attachment One). The motion passed unanimously.

2. **Adopted its 2022 Proposed Charges**

Ms. Bigglestone discussed a memorandum that includes the Risk Retention Group (E) Task Force’s 2022 proposed charges, noting the proposed charges are unchanged from the Task Force’s 2021 charges.

Commissioner Richardson made a motion, seconded by Mr. O’Donnell, to adopt the Task Force’s 2022 proposed charges (Attachment Two). The motion passed unanimously.

3. **Discussed the RRG Task List**

Ms. Bigglestone summarize the updated RRG task list. She stated there is a section for items that are 2019 and prior, as well as a section for 2021 results of the RRG survey. While a lot of work has been completed on the items gathered in 2019 and prior, some items may still warrant consideration and, therefore, remain on the list. However, the focus will likely be on the new information learned from the survey to direct where the next impact should be.

Ms. Bigglestone stated that the first issue that came out of the survey is the issue of incomplete and/or inaccurate registration forms. To address this concern, some simple instructions or additional guidance to supplement the registration form may be developed and is one area that could be addressed sooner rather than later. The second concern is limited information available for new RRGs registering in other states. Concerns were raised about how little information is available to a non-domiciliary regulator when it initially starts and may begin registering in other states prior to its first financial statement filings. While it is the domestic regulator’s responsibility to oversee this type of information for an RRG, transparency and communication among state insurance regulators is encouraged. To address this issue, a template with some basic information that could be provided by the domestic regulator in this situation could be drafted and included in the best practices document previously adopted by the Task Force. This is another item the Task Force could address sooner rather than later.

Ms. Bigglestone said the next two items related to training and communication are both ongoing items that will continue to be addressed as opportunities present. One recent opportunity for training was the RRG session at the NAIC Insurance Summit, and an upcoming opportunity for communication is to participate in the regulator licensing forum on Aug. 25.

Ms. Bigglestone said the final item added as a result of the survey relates to licensing best practices for domestic regulators. The survey indicated most states already have processes in place that are similar. However, more research is likely needed and, therefore, may be a good project for a future time.

Mr. O’Donnell and Ms. Richardson agreed that the first two items related to registration forms and better information for new RRGs need more immediate attention, and the Task Force should concentrate on them first. The Task Force agreed to move forward with drafts for these items, and volunteers to help with the drafting process were asked to notify NAIC staff of their interest.
4. Received Updates on Related NAIC and/or Federal Act

Ms. Bigglestone reminded everyone that at the Summer National Meeting, the Financial Regulation Standards and Accreditation (F) Committee will discuss inclusion of the group capital calculation (GCC) as part of the accreditation standards under the Insurance Holding Company Systems standard. The exposure recommends that a GCC be required for every group with an insurer and affiliate. The model allows an exemption for certain multistate insurers, but only if the group files the GCC at least once initially. Comment letters were received related to extending the commissioner’s ability to allow exemptions and, therefore, will be a topic of discussion at the meeting. The next step for the Committee is to expose the recommendation, along with any revisions to the recommendation, for a one-year exposure period beginning Jan. 1, 2022. The Task Force expects to consider the proposal and provide a comment letter regarding application to RRGs during that one-year period.

Chrys Lemon (Vermont Captive Insurance Association—VCIA) stated that there is a lot of interest in this issue as far as the exemptions possible under the GCC and that the VCIA will be submitting some information in anticipation of the comment period.

Joseph Deems (National Risk Retention Association—NRRA) stated the NRRA will be providing some anecdotal examples of items that should be considered as part of the Task Force’s due diligence.

Having no further business, the Risk Retention Group (E) Task Force adjourned.
The Risk Retention Group (E) Task Force met May 25, 2021. The following Task Force members participated: Michael S. Pieciak, Chair, represented by Sandra Bigglestone (VT); Karima M. Woods, Vice Chair, represented by Sean O’Donnell (DC); Andrew N. Mais represented by Fenhua Liu (CT); Troy Downing represented by Steve Matthews (MT); Russell Toal represented by Leatrice Geckler (NM); and Raymond G. Farmer represented by Daniel Morris (SC).

1. **Adopted its Feb. 24 Minutes**

The Task Force met Feb. 24 to discuss the applicability to risk retention groups (RRGs) of the 2020 revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450).

Mr. O’Donnell made a motion, seconded by Mr. Matthews, to adopt the Task Force’s Feb. 24 minutes *(see NAIC Proceedings – Spring 2021, Risk Retention Group (E) Task Force).* The motion passed unanimously.

2. **Discussed the 2021 RRG Survey Results**

Ms. Bigglestone said that 32 states completed the survey, which was conducted to identify what is working well and what areas the Task Force can improve related to non-domiciliary and domiciliary regulation of RRGs.

Becky Meyer (NAIC) summarized the survey results (Attachment One-B). She noted that the new tools the Task Force developed—including the frequently asked questions (FAQ), best practices, and revisions to the NAIC Uniform Registration Form (registration form)—were well received. However, nine states reported they were not aware of the revised registration form, indicating a potential opportunity for the Task Force to increase communication. There were also several recommendations related to additional training, which could include the registration process, but also general information about RRGs, their structure, and the related risks.

Ms. Bigglestone highlighted a few items in the survey, noting it brought to light some ideas to consider as the Task moves forward. Comments on completion of the registration form were encouraging but also indicated that some additional improvements may be needed. Ms. Bigglestone said she was pleased to know that communication between domiciliary and non-domiciliary states is occurring, and it is important to continue to encourage and improve that communication. She noted there were comments regarding electronic signatures, which is a hot topic for many filings and a topic the Task Force can follow through the work of other groups including work surrounding the Uniform Certificate of Authority Application (UCAA). Ms. Bigglestone noted one concern is the lack of information available to a non-domiciliary state on a newly formed RRG that is registering in that state and does not yet have an Insurer Profile Summary (IPS). She noted there may be room for development of alternative documents to supplement when no IPS is available, such as a summary prepared by the domiciliary state of their recommendation for approval of the license. She also noted that best practices surrounding domestic licensing could be developed to encourage transparency of practices and procedures. Overall, more communication and education of RRGs will be helpful to continue to support the work being done.

Mr. O’Donnell agreed that the survey results were useful and that additional education and awareness are areas the Task Force can consider. There are also ideas the Task Force can explore to add to the FAQ or best practices.

Ms. Bigglestone encouraged Task Force members, interested state insurance regulators and interested parties to review the survey and provide additional comments to NAIC staff. She asked that NAIC staff use the results of the survey to update the task list for discussion during the Task Force’s next meeting.
3. Discussed the Applicability of Revisions to Model #440 and Model #450 Related to the GCC as an Accreditation Standard for RRGs

Ms. Bigglestone provided an update on the revisions to Model #440 and Model #450. The relevant changes relate to applying a group capital calculation (GCC) to groups with at least one insurer and one affiliate and are currently under consideration as an update to the accreditation standards. The Financial Regulation Standards and Accreditation (F) Committee exposed a referral on the revised standard at the Spring National Meeting. The exposure recommends that the GCC applies to all groups with an effective date for accreditation of Jan. 1, 2026. To fulfill the Task Force’s charge to assess whether and how accreditation changes should apply to RRGs, the Task Force will continue to follow the work of the Committee and consider providing a comment letter during the upcoming one-year exposure period. Ms. Bigglestone encouraged states to begin considering the potential implications on their domestic RRGs, including any concerns in applying the GCC, as well as potential benefits of obtaining the GCC for ongoing analysis.

3. Referred an Update to the Quarterly Non-Troubled Company Procedures to the Financial Analysis Solvency Tools (E) Working Group

Ms. Bigglestone stated that the quarterly non-troubled procedures contained within the NAIC Financial Analysis Handbook (Handbook) generate a set of indicators for any company not considered troubled by the domestic regulator. The results of the indicators help the analyst determine the depth of procedures necessary to perform in the first, second and third quarters. Two indicators—prior year risk-based capital (RBC) and prior year trend test—have an exclusion for RRGs. However, as the indicators are applicable to RRGs, the exclusions are no longer necessary. While RRG regulators have added flexibility in applying actions related to RBC, RBC is still calculated and can be a useful indicator when looking at the overall financial position of an RRG. The referral (Attachment One-B) recommends removing the exclusion for RRGs in items B.2 and B.3 of the quarterly non-troubled procedures.

Mr. O’Donnell made a motion, seconded by Mr. Matthews, to send the referral to the Financial Analysis Solvency Tools (E) Working Group. The motion passed unanimously.

5. Discussed Training Initiatives

Ms. Bigglestone stated that one element of the Task Force’s charges is to consider educational opportunities that relate to RRG resources for both domiciliary and non-domiciliary states. One educational opportunity offered to help satisfy this element of the charges is the development of an RRG session at the 2021 Insurance Summit. The session is designed for both domiciliary and non-domiciliary state insurance regulators.

Having no further business, the Risk Retention Group (E) Task Force adjourned.
MEMORANDUM

TO:    Risk Retention Group (E) Task Force
FROM:  NAIC Staff
DATE:  May 17, 2021
RE:    2021 Risk Retention Group Survey Results

In February 2021, the Risk Retention Group (E) Task Force conducted a survey to identify what is working well and what areas the Task Force can improve related to both non-domiciliary and domiciliary regulation of risk retention groups. 32 states responded to the survey.

1) Does your state license domestic risk retention groups?

![Licensed Domestic RRGs](image)

Many states commented that while they have the structure to license an RRG as a traditional insurer, they do not currently have any RRGs licensed in their state.

2) Has your state implemented and provided access to the Best Practices and FAQs for Risk Retention Groups to: 1) - employees in your state responsible for registering or licensing RRGs; 2) - RRGs licensed or registered in your state; 3) - the general public? (referenced documents can be found on the RRGTF webpage under Related Documents [https://content.naic.org/cmte_e_risk_retention_group_tf.htm](https://content.naic.org/cmte_e_risk_retention_group_tf.htm))
Further revisions were in reference to the DOI website, without specific mention of revisions to the Best Practices or FAQ.

3) (Non-Domiciliary Regulators) Has your state implemented the NAIC’s revised Uniform Risk Retention Group Registration Form adopted in 2020 by the C Committee?

Generally, those that don’t intend to implement the updated form indicated they will incorporate the revisions into their state-specific registration forms.
4) (Non-Domiciliary Regulators) Describe your state’s requirements and procedures/processes for the registration of a non-domiciliary RRG in your state.

Most responses referenced the state’s registration form (see question #3 regarding how many states implemented the revised NAIC registration form). Another common theme in the states’ processes was to reach out to the domestic state if needed.

5) (Non-Domiciliary Regulators) As a result of the NAIC’s revised Uniform Risk Retention Group Registration Form, and the Best Practices and FAQ documents, has your state implemented new or additional means of communicating/making inquiries with RRG domiciliary regulators as part of the registration process or annual review process?

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Many no answers commented that they already had procedures to reach out to the domiciliary regulator as needed. One noted they will consider incorporating this communication in the future.

6) (Non-Domiciliary Regulators) Do you believe RRGs applying for registration in your state are properly completing the registration form and providing all required information?

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States answering “no” generally indicated the forms were complete, but lacked supporting documentation, particularly the plan of operations or feasibility study.
7) (Non-Domiciliary Regulators) When communicating with a domiciliary regulator, did you receive timely responses and were the responses satisfactory?

[Diagram showing Timely / Satisfactory Responses]

8) (Domiciliary Regulators) Have you seen an increase in communication received from non-domiciliary states regarding RRGs?

[Diagram showing Increase in Communication Received from Non-domiciliary States]

*Respondents who reported communication was unchanged generally noted they already received communication and that communication continues.*
9) (Domiciliary Regulators) If an RRG becomes troubled or potentially troubled do you notify the states it is registered in?

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RRGs are subject to the same accreditation requirements as traditional insurers regarding troubled companies. This includes a requirement to notify other states of a troubled or potentially troubled company.

10) (Domiciliary Regulators) If an RRG is no longer eligible to write in other states (voluntary or involuntary liquidation, regulatory action, etc.) do you notify the states it is registered in?

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All domiciliary RRG states noted that they do provide communication for an involuntary action, although communications are often informal. The unsure response specified a voluntary withdrawal may not prompt communication, but involuntary action will always prompt communication.

11) What areas of the updated tools (NAIC’s revised Uniform Risk Retention Group Registration Form, and the Best Practices and FAQ documents) do you find most beneficial in your regulatory role (what is working well)?

There was an overall positive response to the new tools including improved communication (better understanding of non-domiciliary vs domiciliary role), comments that the new registration form is more useful, and comments about improved accessibility of the information that the new tools provide.

12) What parts of the registration process for non-domestic RRGs do you feel need further clarification, improvement, expanded guidance (what is not working well)?

Following is a summary of the suggestions regarding the registration of non-domiciliary RRGs.

- Consider a format for electronic signatures.
- Consider asking what other states the RRG is registered in and if there are any issues.
- Improve awareness as it seems some non-domestic states still require approval prior to conducting business similar to the UCAA application and contrary to the Liability Risk Retention Act (LRRA).
- Continue improving communication, including resolving Issues receiving initial capitalization information from domestic regulator.
- **RRGs controlled by MGAs are known to be especially risky; consider additional safeguards for these types of RRGs.**
- **One challenge is that newly formed RRGs often don’t have financial information available when registering (including not having an Insurer Profile Summary—IPS) and the projections or business plan often do not address all regulatory concerns in the depth an IPS would.**
- **Response times from domiciliary states should be timely.**
- **Registration forms, even if complete, can lack clarity in certain areas such as commonality of risk among members, who owns the RRG, identity of members of corporate subsidiaries or corporate entities (as members of the RRG).**

13) **Do you have suggestions for the NAIC RRG Task Force to consider focusing on to keep moving forward with improvements or additional tools and resources (for example – communication considerations, common problem areas, information gaps with other states or the industry, etc.)?**

Following is a summary of suggested next steps:
- **Increased communication via webinars, education sessions, panel discussions, etc.**
- **Increased education on LRRA – especially to non-domiciliary states.**
- **Communicate licensure stipulations and requirements of the RRG to registered states – include licensure stipulations, capital requirements, etc. on the registration form to reduce need to reach out to domiciliary state.**
- **Consider best practices to reduce differences in regulatory response when an RRG is having financial difficulty.**

14) **What other topics should the NAIC RRG Task Force focus on to further improve and bring more uniformity to the licensing and registration processes, improve the ongoing regulation of RRGs, and/or further improve the understanding of RRGs?**

Responses often focused on more education, including in the area of licensing and a need to reach not only domiciliary states, but also non-domiciliary states. In addition to education, there were comments about how to provide better financial information to non-domiciliary states when registering as a new company or a company with very little history, reviewing the Model Risk Retention Act (#705) to ensure consistency with LRRA, and the ability to electronically file a registration statement with multiple states.
15) Would individuals from your state participate if a webinar or other training is offered covering RRG registration, licensing or other RRG hot topics?

![Training Opportunity chart]

The comments indicated some awareness of the current NAIC online RRG course, but noted they would take advantage of other training as well. One area of training that is currently lacking is training on risks specific to RRGs for both examiners and analysts responsible for domiciliary state oversight.

16) What suggestions do you have to best disseminate information on RRG regulation to state regulators (both domiciliary and non-domiciliary)?

The most common recommendations were:
- Email notifications
- Webinars

Other suggestions include:
- Maintain state contact list (note this is already included in the RRPG Handbook, but this recommendation demonstrates it may not be widely known)
- NAIC newsletter updates to regulators
- Ensure inclusion of product regulation staff
- Encourage at least one rep from each state to follow the RRGT (or at least be on the distribution list)
- Education efforts should include outreach and topics specific to non-domiciliary regulators
- In addition to notification by the domestic state when an RRG is troubled or potentially troubled, encourage conference calls with the states where the RRG is registered
- Create something similar to the UCAA specific to RRG primary licensing
17) Do you utilize the NAIC Risk Retention and Purchasing Group Handbook?

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18) Do you have suggestions for updating and improving the NAIC Risk Retention and Purchasing Group Handbook?

Improvement suggestions include:
- more guidance on RRG’s ownership structures, corporate structures and the different ways an RRG can define members or structure their membership
- include the FAQ and Best Practices documents (or reference to these documents)
- discuss the impact of cyber risk on the utilization of service providers
- more guidance on entrepreneurial RRGs including case studies/steps to evaluate holding companies and/or influence of non-owner parties in these types of RRGs

19) (Domiciliary Regulators) Do you utilize the UCAA for licensing new Risk Retention Groups?

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20) (Domiciliary Regulators) If you use a process other than UCAA for licensing new Risk Retention Groups, please check all the following elements that are part of the process to charter/license a new RRG.

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<th>Element</th>
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<tr>
<td>Background checks and use of biographical affidavit forms</td>
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<tr>
<td>Use of a consulting actuary to review the plan of operation, feasibility analysis and financial projections</td>
<td>5</td>
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<td>Review and evaluation of management personnel</td>
<td>6</td>
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<tr>
<td>Review of related parties, MGUs and service providers</td>
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<td>Review of corporate documents</td>
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<td>Review of corporate governance procedures and guidelines</td>
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<td>Review of plan of operation, including risks to be insured, limits and maximum retained risk</td>
<td>6</td>
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<td>Review of feasibility study, including financial projections</td>
<td>6</td>
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<tr>
<td>Require the RRG to list the states the RRG proposes to register in</td>
<td>6</td>
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<td>Require the RRG to include a description of any permitted practice requests</td>
<td>5</td>
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<td>Review of the reinsurance program and creditworthiness of proposed reinsurers</td>
<td>6</td>
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<tr>
<td>Review of the investment policy and custodial arrangement/agreement</td>
<td>6</td>
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<tr>
<td>Review of the capital structure, and if applicable, form of surplus note or letter of credit</td>
<td>6</td>
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<tr>
<td>Review of ownership (including financial information of owners/members) and form of shareholder/subscriber agreements</td>
<td>6</td>
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<tr>
<td>Review of rates, policy forms and underwriting guidelines, and if applicable, comparison of rates in states proposed to operate in</td>
<td>6</td>
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<tr>
<td>Review of risk mitigation and loss prevention measures</td>
<td>5</td>
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<tr>
<td>Review of prospective risks</td>
<td>5</td>
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<tr>
<td>Review for compliance with the Federal Liability Risk Retention Act</td>
<td>6</td>
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<tr>
<td>Review for compliance with holding company regulations</td>
<td>6</td>
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<tr>
<td>Review of marketing materials</td>
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Practices appear generally consistent across all states that do not utilize the UCAA. Of the few deviations, one state indicated formal background checks are not currently required (but they would consider doing them if needed), but they do require and review biographical affidavits for all proposed directors and officers. Another deviation noted that they require a feasibility study by a credentialed actuary, but not a review.
MEMORANDUM

TO: Financial Analysis Solvency Tools (E) Working Group

FROM: Risk Retention Group (E) Task Force

DATE: May 25, 2021

RE: Quarterly Quantitative Assessment of Non-Troubled Insurers

Revisions to the NAIC Financial Analysis Handbook (the Handbook) were adopted in 2020 to better incorporate RRG-specific procedures within the risk assessment worksheet and to remove outdated guidance that risk-based capital (RBC) is not applicable for risk retention groups (RRGs). Following these changes, further review of the Handbook identified the Quarterly Quantitative Assessment of Non-Troubled Insurers as another area to consider updates related to RRGs. This section of the Handbook, which contains indicators to assist regulators in determining the need and extent of quarterly procedures, excludes RRGs from two indicators within the overall assessment. The two indicators are (a) prior year risk-based capital (RBC) less than 250% and (b) prior year triggered the RBC Trend Test.

Because RBC is calculated for RRGs and can be a useful indicator when looking at the financial position of an RRG, the Task Force recommends that this exclusion is no longer necessary and should be removed for both indicators. The Task Force further observed that removing the exclusion aligns with current regulatory practices for RRGs, which take RBC into consideration in the ongoing analysis process.

The Task Force requests that the Working Group consider the proposed revisions shown tracked on the attached excerpt from the Analysis Handbook to remove the exclusion for RRGs from the applicable indicators.

If there are any questions regarding the recommendation, please feel free to contact Sandy Bigglestone, Chair of the Risk Retention Group (E) Task Force, or NAIC staff support (Becky Meyer) for clarification. Thank you for your consideration.

G:\ACCREDITATION\Data\RRGTF Emails\Conference Calls\Troubled Company Worksheet and RRGs Referral.docx
III.A.3. Risk Assessment (All Statement Types) – Quarterly Quantitative Assessment of Non-Troubled Insurers

Quantitative Risk Assessment

A. Non-troubled insurers will receive the following automated review each quarter. Troubled insurers will receive a full risk assessment analysis each quarter.

Each quarter, non-troubled insurers should be assessed based on the results of the following automated system. Based on the results of the automated system, you may need to proceed with a full risk assessment analysis. Also consider any other information that may not be reflected in the quarterly statement but may be known or noted in the analysis file or Insurer Profile Summary (IPS), which could impact the company on a prospective basis prior to relying solely on an automated review.

B. If any of the following criteria is met, the insurer may be assigned a full quarterly risk assessment analysis:
   1. The insurer is a troubled insurer
   2. Prior year risk-based capital (RBC) is less than 250% \((\text{excluding title insurers and risk-retention-groups RRGs})\) (ST)
   3. Prior year triggered the RBC Trend Test \((\text{excluding title insurers and RRGs})\) (ST)
   4. Scoring System result greater than or equal to (excluding title insurers):
      - 450 for property/casualty (P/C) insurers
      - 350 for life or fraternal insurers
      - 300 for accidental and health (A&H) insurers
      - 325 for health entities

C. Based on the results of the automated system calculations, a full quarterly risk assessment analysis may be completed if the insurer has the following number of “yes” responses from the automated calculations:
   1. Four or more for P/C insurers, title insurers and health entities or
   2. Three or more for life/A&H/fraternal insurers

Special Notes: Any automated results in D where the denominator is 0 return a “yes” response.

A default “no” response will be returned for insurers with no net retention for automated results #8 and #9.

For companies that have not filed a prior year-end or quarterly statement (e.g., either a new start-up insurer or exempt from filing), all responses in section D will default to a “yes.” In this scenario, it is recommended the analyst perform a full quarterly risk assessment analysis.

D. Automated system calculations:
   1. Are unassigned funds negative? (ST)
   2. Has surplus/capital and surplus (based on business type) increased ≥ 12.5% (for first quarter), 25% (for second quarter), or 37.5% (for third quarter)? (ST)
   3. Has surplus/capital and surplus (based on business type) decreased ≥ 5% (for first quarter), 10% (for second quarter), or 15% (for third quarter)? (ST)
III.A.3. Risk Assessment (All Statement Types) – Quarterly Quantitative Assessment of Non-Troubled Insurers

4. Has any individual asset category that is greater than 5% of surplus/capital and surplus (based on business type) changed by more than +/- 10% from the prior year-end? (CR, MK, LQ)

5. Has any individual liability category that is greater than 5% of surplus/capital and surplus (based on business type) changed by more than +/- 10% from the prior year-end? (RV, OP, ST)

6. Are affiliated investments greater than or equal to 75% of surplus/capital and surplus (based on business type), OR unrealized capital loss more than -15% of prior year-end surplus/capital and surplus (based on business type)? (CR, LQ)

7. Does the net loss exceed 20% of surplus/capital and surplus (based on business type)? (OP)

8. For property/casualty insurers, title insurers and health entities, is the combined ratio greater than or equal to 100%? (PR/UW, OP)

9. Has net premiums written changed by more than +/- 5% (for first quarter), +/- 10% (for second quarter), or +/- 15% (for third quarter) from the prior year-to-date? (PR/UW)

Follow-up Analysis

If any of the following supplemental filings, information or analyses are received during the quarter, review and assess any risks, and document material risks in the IPS.

- Management Discussion & Analysis (MD&A)
- Audited Financial Statement Report
- Impact of the group on the domestic insurer from the analysis of the Holding Company Analysis (as completed by or received from the lead state)
- Risks related to the insurer from the analysis of the ORSA Summary Report Analysis (as completed by or received from the lead state)
- Business Plan and Projections
- Communications from the insurer, other departments or other regulators

Recommendation for Further Analysis

Does the automated system indicate a full quarterly risk assessment analysis should be performed?

- If “yes,” complete a full risk assessment analysis, or if a full risk assessment analysis was not completed, justify and document the reason(s) on the Quarterly Procedures for Non-Troubled Insurers.
- If “no,” no further actions are required.
2022 Proposed Charges

RISK RETENTION GROUP (E) TASK FORCE

The mission of the Risk Retention Group (E) Task Force is to stay apprised of the work of other NAIC groups as it relates to financial solvency regulation and the NAIC Financial Regulation Standards and Accreditation Program. The Task Force may make referrals to the Financial Regulation Standards and Accreditation (F) Committee and/or other NAIC groups, as deemed appropriate.

Ongoing Support of NAIC Programs, Products or Services

1. The Risk Retention Group (E) Task Force will:
   A. Monitor and evaluate the work of other NAIC committees, task forces and working groups related to risk retention groups (RRGs). Specifically, if any of these actions affect the NAIC Financial Regulation and Accreditation Standards Program, assess whether and/or how the changes should apply to RRGs and their affiliates.
   B. Monitor and analyze federal actions, including any U.S. Government Accountability Office (GAO) reports. Consider any action necessary as a result of federal activity.
   C. Monitor the impacts of recent tools and resources made available to domiciliary and non-domiciliary state insurance regulators pertaining to RRGs. Consider whether additional action is necessary, including educational opportunities, updating resources and further clarifications.

NAIC Support Staff: Becky Meyer
VALUATION OF SECURITIES (E) TASK FORCE

Valuation of Securities (E) Task Force July 15, 2021, Minutes ....................................................................................... 10-1267
   Valuation of Securities (E) Task Force May 24, 2021, Minutes (Attachment One) .................................................. 10-1273
   Comment Letter from the American Council of Life Insurers (ACLI), the North American Securities
   Valuation Association (NASVA), and the Private Placement Investors Association (PPiA) Regarding
   Proposed Amendment to the *Purposes and Procedures Manual to the NAIC Investment Analysis Office
   (P&P Manual) to Require the Filing of Private Letter Rating Rationale Reports, Dated May 6, 2021
   (Attachment One-A) .................................................................................................................................... 10-1277
2022 Proposed Charges (Attachment Two) ............................................................................................................... 10-1279
   Comment Letters Regarding Proposed Amendment to the P&P Manual to Add Additional Instructions to the
   Review of Funds (Attachment Three) ................................................................................................................ 10-1280
   Memorandum from the Securities Valuation Office (SVO) Regarding Proposed Amendment to the P&P Manual
   to Add Additional Instructions to the Review of Funds, Dated May 27, 2021 (Attachment Four) ................. 10-1290
   Comment Letters Regarding Proposed Amendment to the P&P Manual on Filing Exemption (FE) for Real
   Estate Lease-Backed Securities (Attachment Five) ............................................................................................ 10-1301
   Memorandum from the SVO Regarding FE for Real Estate Lease-Backed Securities, Dated May 27, 2021
   (Attachment Six) ................................................................................................................................................ 10-1306
   Memorandum from the SVO Regarding Proposed Amendment to the P&P Manual to Incorporate Updates Made
   to *Statement of Statutory Accounting Principles (SSAP) No. 105R—Working Capital Finance Investments,
   Dated Sept. 10, 2020 (Attachment Seven) .......................................................................................................... 10-1315
The Valuation of Securities (E) Task Force met July 15, 2021. The following Task Force members participated: Dana Popish Severinghaus, Chair, represented by Kevin Fry (IL); Doug Ommen, Vice Chair, represented by Carrie Mears (IA); Lori K. Wing-Heier represented by Wally Thomas (AK); Ricardo Lara represented by Laura Clements (CA); Andrew N. Mais represented by Kathy Belfi (CT); Trinidad Navarro represented by Rylynn Brown (DE); David Altmaier represented by Carolyn Morgan (FL); Dean L. Cameron represented by Eric Fletcher (ID); Vicki Schmidt represented by Chut Tee (KS); James J. Donelon represented by Stewart Guerin (LA); Gary D. Anderson represented by John Turchi (MA); Kathleen A. Birrane represented by Matt Kozak (MD); Chlora Lindley-Myers represented by Debbie Doggett (MO); Marlene Caride represented by John Sirovetz (NJ); Linda A. Lacewell represented by Jim Everett (NY); Doug Slape represented by Amy Garcia (TX); Jonathan T. Pike represented by Jake Garn (UT); Scott A. White represented by Doug Stolte (VA); Mike Kreidler represented by Jim Everett (WA); and Mark Afable represented by Randy Milquet (WI).

1. **Adopted its May 24 and Spring National Meeting Minutes**

Mr. Fry said the Task Force met May 24 and took the following action: 1) discussed comments received and adopted proposed amendments to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual)* for the following: a) require the filing of private rating letter rationale reports; and b) permit filing exemption (FE) for credit tenant loan (CTL) and ground lease financing transactions; and 2) received and discussed the Securities Valuation Office (SVO) referral response to the Statutory Accounting Principles (E) Working Group on CTLs.

Mr. Thomas made a motion, seconded by Ms. Clements, to adopt the Task Force’s May 24 (Attachment One) and March 22 (see NAIC Proceedings – Spring 2021, Valuation of Securities (E) Task Force) minutes. The motion passed unanimously.

2. **Adopted its 2022 Proposed Charges**

Mr. Fry said the Task Force’s 2022 proposed charges remain unchanged from 2021.

Ms. Doggett made a motion, seconded by Mr. Kozak, to adopt the Task Force’s 2022 proposed charges (Attachment Two). The motion passed unanimously.

3. **Adopted a P&P Manual Amendment to Add Additional Instructions to the Review of Funds**

Mr. Fry said the next agenda item is to discuss and consider for adoption an amendment to the P&P Manual to add additional instructions to review of funds. The original amendment was received by the Task Force during the Spring National Meeting and exposed for a 45-day public comment period ending May 6. This updated amendment reflects technical comments and recommendations that were received from interested parties (Attachment Three). The revised amendment was received and approved for exposure through a Task Force e-vote on June 1 and exposed for a 30-day public comment period ending July 1. There was one supportive joint comment letter received on the updated amendment from the American Council of Life Insurers (ACLI), the North American Securities Valuation Association (NASVA), and the Private Placement Investors Association (PPIA).

Marc Perlman (NAIC) said the new proposal would adhere much more closely than the previous one to Rule 18f-4 under the U.S. Securities and Exchange Commission’s (SEC) Investment Company Act of 1940 related to the use of derivatives by registered investment companies, including funds, which the SEC adopted in October 2020. Unlike the previous amendment, which had two separate tests for derivatives depending on the NAIC Fund List on which a fund is listed, this amendment would create a single test. Pursuant to the new proposal, a fund’s exposure to: 1) derivatives under which a fund is or may be required to make any payment or delivery of cash or other assets during the life of the instrument or at maturity or early termination, whether as margin or settlement payments or otherwise; 2) short sale borrowings; and 3) reverse repurchase agreements or similar financing would be limited to 10% of the fund’s net assets in normal market conditions. Exposure would be calculated based on the gross notional amounts of derivatives, the value of assets sold short for short sale borrowings, and the proceeds received by the fund but not repaid for reverse repurchase agreements. Consistent with the SEC Rule, interest rate derivatives and option contracts exposure could be calculated with other defined methods consistent with market practice.
with the rule, certain currency and interest rate derivatives that hedge currency or interest rate risk associated with one or more specific equity or fixed-income investments of the fund would be excluded from the 10% exposure calculation.

One difference between this proposal and the SEC Rule is that the P&P Manual’s methodology requires a look-through assessment of all funds which, in turn, includes a requirement that a fund “predominantly hold” bonds or preferred stock, as applicable. As defined in the P&P Manual, “predominantly hold” means that a fund holds at least 80% of its assets in bonds or preferred stock, depending on the type of fund, in normal market conditions. This existing requirement, therefore, limits total derivatives, short sale borrowing, and reverse repurchase agreement exposure in any fund to 20%, exclusive of the excluded currency and interest rate derivatives. The amendment proposes calculating that exposure as previously explained, using gross notional amount for the derivatives. However, for derivatives under which a fund is not or a fund shall not be required to make any future payment or delivery of cash or other assets, exposure would be calculated based on the derivative’s market value, a less conservative measure than gross notional, due to diminished risk of loss to the fund. These derivatives would include, for example, certain options pursuant to which the fund would have no possible future payment obligation following the initial premium payment. The Credit Risk Assessment portion of the existing methodology would also be updated to include a calculation of derivative exposure and, if analytically appropriate, the inclusion of derivatives in the weighted average rating factor (WARF) analysis. Derivative documentation can be complex and its review time-consuming. To expedite reviews of funds with derivatives while ensuring that the fund does not breach the proposed exposure thresholds, the proposal includes a new filing requirement to include certain derivatives information in the schedule of portfolio securities and assets, which is provided to the SVO for its review. Such additional information would include: 1) derivative type; 2) whether the derivative will require the fund to make a future payment or delivery of cash or other assets; 3) whether the derivative is an “excluded derivative transaction;” 4) the counterparty credit rating; and 5) the derivative exposure and how it is calculated. The expectation is that a complete and accurate summary of derivatives in the schedule will prevent the need for the SVO to review derivative legal documentation, but the SVO will reserve the right to request it if it deems it necessary.

Based on comments received from interested parties, the SVO removed the initially proposed management assessment from this amendment. Interested parties expressed concern that the management assessment could further weaken market clarity and predictability.

Mr. Fry said this will add a lot of transparency and understanding of the use of derivatives, and it will be a welcome addition to the P&P Manual.

Mike Reis, representing the ACLI, the NASVA, and the PPiA, said this provides clarity. He said industry appreciates the thought that went into the proposal and fully supports the exposure. It serves multiple purposes that are beneficial to everyone. One thing that was highlighted in the comment letter was that for some of the funds that get a designation, the risk-based capital (RBC) does not flow through from that designation, specifically, those funds in Statement of Statutory Accounting Principles (SSAP) No. 30R—Unaffiliated Common Stock. There has been talk in the past of potentially getting the RBC to be reflective of the NAIC designation on those funds. That change may have to go to the Capital Adequacy (E) Task Force and industry is certainly supportive of that change. There are certain things happening in the bond project at the Statutory Accounting Principles (E) Working Group, and there may be a population of other securities that would also benefit from some type of look through for RBC treatment as well.

Eric Hovey (Payden & Rygel) said Payden & Rygel had commented on the earlier version and appreciates that the input was taken, supports the new version, and appreciates the continued movement forward in looking at ways to treat bond mutual funds with look through for capital treatment more aligned to the holdings of securities. Also, the SEC rule that is being mentioned here is not in force until August 2022 for the investment industry. There is a little bit of timing mismatch as far as the industry coming to terms exactly with what will be done for that rule versus this proposal being put forth today.

Ms. Mears made a motion, seconded by Mr. Milquet, to adopt the updated proposed amendment to the P&P Manual to add additional instructions to the review of funds (Attachment Four). The motion passed unanimously.

4. Adopted an Amendment to the P&P Manual to Permit FE for CTLs and Ground Lease Financing Transactions.

Mr. Fry said the next item on the agenda is to discuss and consider for adoption an amendment to the P&P Manual to permit FE for CTLs and ground lease financing transactions. This is a change from the existing policy where these transactions had to be filed with the SVO for a legal, structure and credit assessment and only allow the residual asset exposure up to 5% of the original loan amount. This amendment was exposed on May 28 for a 30-day public comment period ending June 28. The Task Force has received three comment letters (Attachment Five).
Charles A. Therriault (NAIC) said the Statutory Accounting Principles (E) Working Group chairs proposed updating the definition of CTL and ground lease financing (GLF) transactions in the P&P Manual to limit them to only those investments that would meet the definition of a mortgage loan under SSAP No. 37—Mortgage Loans. Investments that are securities (which are expressly excluded from SSAP No. 37) that fall under the definition of SSAP No. 26R—Bonds or SSAP No. 43R—Loan-Backed and Structured Securities would no longer meet the definition of a CTL and ground lease financing transactions in the P&P Manual and would, therefore, become eligible for FE, which includes private rating letters. The SVO can still review these transactions and refer to the CTL and GLF methodologies for any unrated security that is CTL-like or ground lease financing-like that requires filing with the SVO, as would any other unrated security. If this amendment is adopted by the Task Force, the SVO will look to see if there are any rated CTL or GLF transactions in the VISION application, remove the SVO assigned NAIC designation from them, and permit them to flow through FE.

Mr. Fry said that originally this was created for transactions that were mortgage loans that wanted to be on Schedule D, and over time, these types of structures made their way into being securities. The policy in the past has been that even if it was a security, it still had to be filed with the SVO and looked at for those characteristics. The Task Force recognizes that there are other securities that do not have to go through this type of criteria. There is also the SSAP No. 43R—Loan-Backed and Structured Securities project at the Statutory Accounting Principles (E) Working Group that will complement this in the future if it gets adopted.

John Garrison (Lease-Backed Securities Working Group) said the Lease-Backed Securities Working Group appreciates the consideration and thought that went into this proposal.

Mike Reese (Northwestern Mutual), representing the ACLI, NASVA and PPIA, said this has had a lot of discussion over the past year. Industry is happy that these securities will receive similar treatment to other securities, and this change dovetails with the SSAP No. 43R—Loan-Backed and Structured Securities project at the Statutory Accounting Principles (E) Working Group.

Mr. Thomas made a motion, seconded by Mr. Fletcher, to adopt the proposed amendment to the P&P Manual permitting securities similar to CTL and GLF transactions to use NAIC credit rating provider (CRP) ratings through the FE policy (Attachment Six). The motion passed unanimously.

5. Adopted Guidance for WCFIs Consistent with the Statutory Accounting Principles (E) Working Group’s Adopted of Changes to SSAP No. 105R and Exposed an Amendment Permitting the SVO to Rely Upon the Unrated Subsidiaries of a CRP-Rated Parent Entity for Only WCFIs

Mr. Fry said the next item on the agenda deals with working capital finance investments (WCFIs). This was last exposed on Nov. 18, 2020, during the Fall National Meeting. There are two separate amendments. One amendment deals with the changes that the Statutory Accounting Principles (E) Working Group made to SSAP No. 105R—Working Capital Finance Investments and brings the P&P Manual into alignment with those changes. No comments were received on those changes. The second amendment deals with unrated subsidiaries, and it was exposed in November too but there were comments and updates made to that amendment. It is likely that the second amendment will be re-exposed and also referred to the Statutory Accounting Principles (E) Working Group.

Marc Perlman (NAIC) said the first WCFI amendment the SVO is proposing is unchanged since it was exposed in November 2020. It is intended to remove from the P&P Manual inconsistencies that arose when SSAP No. 105R was revised.

Under the second proposed WCFI amendment, when a WCFI obligor is unrated, cannot be designated by the SVO and is not guaranteed by its parent, the Task Force would direct the SVO to rely on the rating or NAIC designation of an obligor’s parent based on its implied support. With this second iteration of the policy amendment, the SVO is recommending certain changes.

First, the initial test for whether the SVO should be able to rely on the parent’s rating required that the obligor constitute a “substantial portion of its parent’s operations representing at least 25% or greater of the parent entity’s assets, revenue and net income.” The SVO proposes removing this requirement since it was deemed too restrictive and could prevent, for example, a 5% subsidiary, which manufactures a crucial component for its parent’s product, from benefiting from the policy. Additionally, interested parties explained that they did not think it would always be possible to determine the percentage of the parent’s operations because it is not always clear from the parent’s financial statements, and the subsidiary often lacks financial statements.

Second, the initial proposal allowed the SVO to notch the designation down from that of the parent based on several subjective factors related to the parent/obligor relationship. The notching provisions were removed so that, according to the policy, the
SVO will only imply the parent’s rating on the obligor without notching. However, under the policy, the SVO expressly retains its right, in its sole analytic discretion, to notch the designation or choose not to assign a designation to a WCFI program for reasons unrelated to the relationship between the obligor and its parent.

Lastly, there is one clerical correction to the amendment. Where it currently references “eligible NAIC CRP rating” throughout, the word “eligible” was removed because an eligible NAIC CRP credit rating specifically refers in the P&P Manual to ratings assigned to securities eligible for Schedule D reporting. Since the rating on a parent could be an issuer rather than an issue rating, it might not meet the definition of “eligible NAIC CRP credit rating.”

Mr. Fry said it would be easiest to consider the two amendments separately. The first amendment brings the P&P Manual into alignment with SSAP No. 105R. It has been previously exposed, and Mr. Fry asked if the ACLI, whose comment letter discussed both amendments, would like to specifically address this first amendment,

Mike Monahan (ACLI) said that the ACLI supports amending the language to agree with SSAP No. 105R and moving forward with the first amendment.

Mr. Fry ask Mr. Therriault for the SVO’s recommendation. He recommended adoption of the first amendment to align the P&P Manual to the adopted changes with SSAP No. 105R. Mr. Monahan said the ACLI supports that recommendation.

Mr. Fry said that the second amendment deals with the unrated subsidiary piece and asked if there were any comments on it. Mr. Monahan said the ACLI is supportive of what the Task Force has done and will comment on the exposure. He said it is a safe asset class for large insurers.

Mr. Everett asked if industry might be able to address in their comments some questions he had, and that is that SSAP No. 105R now requires an obligor rating, and the parent will not be the obligor. The SVO indicated that a methodology for these kinds of things is lacking and, in light of the Greensill supply chain financing situation, it has become clear that not even generally accepted accounting principles (GAAP) has any standards for supplier finance programs. Standard & Poor’s (S&P) just had a seminar and released a research paper on supply chain finance disruptions. Mr. Everett said if possible, if industry could distinguish the situation from Greensill and address the standards issue in their comment letter, it would be appreciated.

Mr. Monahan said they are on top of what happened with Greensill and have been working with the Financial Standards Accounting Board (FASB) on disclosures so that it is more transparent to users of financial statements.

Mr. Thomas made a motion, seconded by Ms. Doggett, to adopt proposed amendments to the P&P Manual to conform the WCFI guidance to reflect the changes adopted by the Statutory Accounting Principles (E) Working Group to SSAP No. 105R (Attachment Seven). The motion passed unanimously.

The Task Force also directed the SVO to expose the amendment to direct the SVO to rely upon the unrated subsidiaries of a CRP rated parent entity for only WCFI for a 30-day public comment period and refer it to the Statutory Accounting Principles (E) Working Group for comment.

6. Received a Report on Projects Before the Statutory Accounting Principles (E) Working Group

Julie Gann (NAIC) said the Statutory Accounting Principles (E) Working Group has three meetings scheduled for the near future. The Working Group plans to meet July 29 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings, to hear state insurance regulator reports regarding financial statement information from the 2020 financial filings. The Statutory Accounting Principles (E) Working Group usually does that in conjunction with the national meetings, but since those have been hybrid sessions, there has not been the opportunity to do so. Any state insurance regulator who would like to have information on any disclosure can contact NAIC staff. There are a handful of items planned for presentation with regard to information that the Working Group has gathered from the financial statements. Some examples are the Federal Home Loan Bank (FHLB) disclosure, the SVO-identified exchange-traded funds (ETFs), the new cash pooling, and permitted practices. Ms. Gann said if anyone wants anything specific, let NAIC staff know.

Additionally, the Working Group plans to meet Aug. 10 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings, to discuss comments received on the Schedule -D project and on the SSAP No. 97—Investments in Subsidiaries, Controlled and Affiliated Entities exposure. It also plans to meet Aug. 26 to hear comments on proposed items.
Ms. Gann said with the action taken today on CTLs, Interpretation (INT) 2010 will be reviewed. It formally expires Oct. 1, but with the action that occurred today, that interpretation may no longer be needed. She said the Statutory Accounting Principles (E) Working Group will look at that and hopes to have an update for its Aug. 26 meeting.

7. Discussed Other Matters

Mr. Fry said there is an update from Eric Kolchinsky (NAIC) on updating the structured securities reporting for the legacy and non-legacy changes adopted this spring along with planning for the recently adopted updated RBC factors.

Mr. Kolchinsky said there are two broad categories of updates. The first is the announcement of the selection for the financial modelling request for proposal (RFP). It was a long and tough RFP, and the Structured Securities Group (SSG) selected BlackRock Solutions. There were some excellent bidders, and it was an interesting RFP. Mr. Kolchinsky said the SSG looks forward to working with BlackRock Solutions on many of the issues that are going to be discussed next.

Mr. Kolchinsky said the second issue is that the SSG has a number of overlapping changes that are happening with modeled securities: 1) there is BlackRock Solutions, a vendor that has worked with the SSG before; 2) there is the change from breakpoints to designations for non-legacy securities that requires a technical change; 3) there is through-the-cycle modeling; and 4) there are the changes to the RBC factors from Capital Adequacy (E) Task Force. The SSG and the SVO received a letter from the ACLI discussing many of these issues on financially modeled securities that the SSG will look at with the SVO. The SSG staff are in general agreement with the ACLI letter as to how to prioritize the rollout of all these changes and appreciates the letter in general. The letter has not been exposed yet. There are some issues that are short on details that the SSG needs to work out such as implementation of the zero-loss framework. Mr. Kolchinsky said the SSG may come back to the Task Force to discuss these issues, and there may be a need for some minor changes to the P&P Manual. The biggest issues is moving the implementation of both the breakpoints and on the new 20 designation categories using the new RBC factors into 2022. The rationale for moving this into 2022 is that it will give the SSG the opportunity to think through these changes and bring it to Valuation of Securities (E) Task Force for approval instead of rushing it in for year-end 2021, given all these other changes.

Francisco Paez (MetLife) said, there are a number of changes that are happening on the RBC front, not only on the bond side, but also in other parts of the business, and structured securities is part of that equation. It was important to keep that in consideration. There are changes that industry hoped would get done on the modelled security side to address the issues encountered last year. There is also an operational component, and one thing that industry wanted to make sure of is that things are managed in a way that do not lend themselves to any kind of last-minute operational complexities or risks that are not necessary. The letter recommends prioritizing the orderly adoption of these changes and makes suggestions in terms of which changes are most meaningful to industry to achieve some balance.

Mr. Fry asked if when mentioning year-end 2021 and the 20 designations, is this considering only the six designations for this year-end and then going with 20 designations for next year, 2022.

Eric Kolchinsky said that is correct. He said what would occur is that the reporting would still be as currently defined in the P&P Manual. There is already a provision for reporting the NAIC designation categories. In terms of calculating the breakpoints between the layers, as well as for the designations, that is a process the SSG would like to do on a more interactive basis with the Valuation of Securities (E) Task Force and not do it hastily, considering everything else that needs to be done for this year-end. He said the SSG would also like to run a few more scenarios, given the extra granularity that will be seen now in the 20 versus the six designations. SSG staff are concerned that having just four scenarios will force the results to bunch up in just a few categories, which understates or overstates the risk to the securities. SSG staff would like to take the year of 2022 to discuss these issues with Task Force and report for the current year with the existing designation categories.

Mr. Paez said what was done last year in terms of mapping of securities is a little bit of a road map that could be used again this year. That way, there can be six categories but still mapping on to the new designation categories where they map to the middle of the designation category. The only point that is going to be important for industry is that those bonds that meet the highest quality definition can make it to the 1.A category. There may be a need for enhancements to the scenarios in order to capture all the granularity. Thinking specifically about this year-end and the path that was used last year could be replicable this year. Mr. Paez said all that would be needed to do is figure out a way to address that 1A category, which, in the absence of more detail, the methodology for the zero loss could be that indicator that allows the mapping to the 1.A category. It should capture really what it is supposed to capture because most of those securities are going to be AAA securities.

Eric Kolchinsky said, in general, SSG staff agreed, but they need to work through it and the operational concerns. The new breakpoint file will need 19 columns instead of five. Vendors on the industry side will need to figure out how to take in the
new files, and not having to rush is a huge benefit. Mr. Therriault said the SVO will expose the ACLI comment letter on the Task Force web page.

Having no further business, the Valuation of Securities (E) Task Force adjourned.

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The Valuation of Securities (E) Task Force met May 24, 2021. The following Task Force members participated: Dana Popish Severinghaus, Chair, represented by Kevin Fry (IL); Doug Ommen, Vice Chair, represented by Carrie Mears (IA); Lori K. Wing-Heier represented by Wally Thomas (AK); Ricardo Lara represented by Laura Clements (CA); Andrew N. Mais represented by Kathy Belfi (CT); Trinidad Navarro represented by Rylynn Brown (DE); David Altmaier represented by Carolyn Morgan and Ray Spudeck (FL); Dean L. Cameron represented by Eric Fletcher (ID); Vicki Schmidt represented by Tish Becker (KS); James J. Donelon represented by Stewart Guerin (LA); Gary D. Anderson represented by John Turchi (MA); Kathleen A. Birrane represented by Matt Kozak (MD); Clara Lindley-Myers represented by Debbie Doggett (MO); Eric Dunning represented by Lindsay Crawford (NE); Marlene Caride represented by Nakia Reid and John Sirovetz (NJ); Linda A. Lacewell represented by Jim Everett (NY); Doug Slape represented by Amy Garcia (TX); Jonathan T. Pike represented by Jake Garn (UT); Scott A. White represented by David Smith (VA); Mike Kreidler represented by John Jacobson (WA); and Mark Afable represented by Randy Milquet (WI). Also participating was: Dale Bruggeman (OH).

1. **Adopted an Amendment to the P&P Manual to Require the Filing of a Private Rating Letter Rationale Report**

Mr. Fry said the first item on the agenda is to discuss comments and updates to a proposed amendment to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) to require the filing of a private rating analysis report. The Task Force has discussed this amendment several times, most recently at the Spring National Meeting. The Securities Valuation Office (SVO) staff has been working closely with the American Council of Life Insurers (ACLI), the North American Securities Valuation Association (NASVA), and the Private Placement Investors Association (PPIA) to address concerns regarding confidentiality restrictions and potential operational issues since this amendment was first exposed at the 2020 Fall National Meeting on Nov. 18, 2020. As reflected in their supportive joint comment letter (Attachment One-A), this collaboration has resulted in the amendment before the Task Force today that addresses those outstanding issues. The amendment requires the filing of private rating letter rationale reports beginning Jan. 1, 2022. There is a provision for deferring the submission for private letter rating securities in certain situations. The Task Force was informed of a typo in the last section of paragraph 22; the word “Filing Exception” should be changed to “Filing Exemption.” Mr. Fry thanked industry and staff on their close collaboration on developing this amendment.

Sasha Kamper, representing the ACLI, the PPIA and the NASVA, said industry's concerns with the Bespoke Securities proposal was always twofold. Industry wanted to provide the transparency that state insurance regulators are asking for so they can understand what insurers are investing in and minimize the amount of disruption that any sort of change could potentially cause in capital markets. The private placement market not only is an opportunity to provide incremental yield to insurers at a time when interest rates are quite low, but it also provides incremental downside protection through financial covenants and collateral packages in many of these deals. The U.S. private placement market is a very important market for several insurers and something to preserve. Industry believes that this exposure really strikes that right balance. There was extensive work over the last several months to get through some of the operational details and get the timing right in this proposal. The proposal is somewhat retroactive, and the first stage takes place for securities issued beginning Jan. 1, 2018. It was important not to expect rating agencies to go back and reopen commercial contracts with borrowers and need to amend the terms of those contracts. The SVO staff were very understanding of that and worked to accommodate these concerns; if there was a ratings rationale and it was allowed to be shared, if required to do so, they would not expect insurers and borrowers to renegotiate deals that were done a few years ago. Industry also worked with the SVO staff to explain that certain rating agencies, even some of the larger more established rating agencies, do less surveillance work on certain types of structured securities. There will be an initial study and publication put forth that describes the transactions and the ratings rationale in great detail. If nothing changes with the structure and things are performing about as expected, the annual surveillance reports are light. This is true, both on the public and private side. The SVO staff understood that and were only looking for similar work product to what is produced in the public sector. Industry believes this is something that all the rating agencies should be able to comply with, and they are being given enough time to put things in place. There are still some operational details to work out with the SVO, and the rating agencies specifically, about the delivery mechanism, but these ratings rationales will be provided to the SVO.

Ms. Doggett made a motion, seconded by Mr. Thomas, to adopt the amendment to the P&P Manual to require the filing of private rating letter rationale reports. The motion passed unanimously.
2. Discuss and Receive an Amendment to the P&P Manual to Permit FE for CTLs and GLF Transactions

Mr. Fry said the next item on the agenda is to discuss and receive an amendment to the P&P Manual to permit filing exemption (FE) for credit tenant loans (CTLs) and ground lease financing (GLF) transactions that exceed a 5% residual exposure. This amendment would give insurers the option to submit either CTLs or GLF transactions to the SVO for their review, or they could use the NAIC FE process. After exposing this amendment, the Task Force received a referral from the Statutory Accounting Principles (E) Working Group chairs with an alternative P&P Manual amendment recommendation to achieve the same outcome, but without what the chairs saw as a possible overstep of the Task Force and possible conflict in guidance.

Mr. Bruggeman said that part of this challenge has always been the term “CTL.” It has been used in a lot of different ways than what was originally introduced back in the ‘90s. A CTL, by statutory accounting definition, is a direct mortgage to someone that is backed by whoever is leasing the property and backed by those lease payments. It is a mortgage that is following Statement of Statutory Accounting Principles (SSAP) No. 37—Mortgage Loans, and if those credit tenant financings are being provided at least 95% (one minus the 5% the Task Force has been talking about), that can move from Schedule B (the mortgage schedule) to Schedule D-1 (the bond schedule). All of those had to be reviewed by the SVO. Over the years, these CTLs have been put inside securities. Those securities are also called CTLs. Therein lies part of this confusion; i.e., when that CTL ends up inside of a security and that security issues debt, now that debt is a security, and it is now covered under SSAP No. 26R—Bonds or SSAP No. 43R—Loan-Backed and Structured Securities. If there are multiples of these inside a structure, that goes to SSAP No. 43R; otherwise, it will stay in SSAP No. 26R. Those are the statutory accounting definitions. The challenge is that when statutory accounting staff see CTLs, they immediately assume the mortgage SSAP No. 37 definition, but it has been utilized more than that. The memo that was sent out to the Task Force from the Working Group chairs tries to go through that process. The memo tried to highlight the terms “security” and “mortgage.” The memo proposes changes in the P&P Manual in Part Three, paragraph 4, in the “FE Securities” section, changing the sentence from, "[a] CTL is a mortgage loan …" to, “[a] CTL is a mortgage loan, in scope of SSAP No. 37….” because by definition, SSAP No. 37 excludes securities that would be covered under SSAP No. 26R or SSAP No. 43R. There is a similar change in Part One, paragraph 100; any change to the residual percentage on the securities side does not affect the SSAP No. 37 CTLs. CTLs really fit into three different buckets—a mortgage bucket under SSAP No. 37, a bond bucket under SSAP No. 26R, and a structured bucket SSAP No. 43R.

Julie Gann (NAIC) said the Working Group chairs are recommending exposing the very limited proposed changes to the P&P Manual to clarify that the references of the CTL are mortgage loans in scope of SSAP No. 37. That separates the conversation between what is a direct mortgage loan and what is a security. This guidance would then refer to the Accounting Practices and Procedures Manual (AP&P Manual) to SSAP No. 26R and SSAP No. 43R on defining what should be in scope and reported on Schedule D. It was anticipated that this would eliminate the inconsistency and the confusion that currently exists regarding the different named structures that could perhaps have underlying real estate risk. From information that the SVO has provided, some companies have called those CTLs, some have called them lease-backed securities, and some companies call them other names. Anything that meets the current definition of a bond would continue to be in scope of SSAP No. 26R or SSAP No. 43R, as applicable. As the bond proposal continues, if there is concern about some of these investments and the ultimate residual risk, they would also be captured within that bond proposal and perhaps need be relocated to a different schedule once that project is done; but it would eliminate the inconsistency that currently exists and clarify that the current reference to mortgage loans is specific to those non-security structures that are in scope of SSAP No. 37. This came about Thursday evening after the Working Group call. The Working Group took action to expose modifications to Interpretation (INT) 20-10: Reporting Nonconforming Credit Tenant Loans. Contingently, in response to the original proposal that was suggested to the Task Force, if the Task Force moves forward with the limited edits that are reflected in the chair memo that was submitted, that exposure would be pulled back, and the Working Group would be informed of this change and work on the next way forward with regards to INT 20-10. If these proposed revisions to clarify the scope of the CTLs go through, INT 20-10 may no longer be applicable.

Mr. Fry said operationally, if there is a security that has a lot of CTL characteristics and under 5%, as defined in the P&P Manual, the SVO can still designate those; even though they are a security, they would not lose their standing in that regard. Mr. Everett questioned how the proposal interacts with the proposal that was sent out for the P&P Manual on Friday. Mr. Fry said the exposure in the materials has an amendment that would have created a similar effect. The Task Force will expose a new version, the simplified version that Mr. Bruggeman and Ms. Gann explained, and take comments on it. If the Task Force adopts that exposure, it would be the smoother, or at least disruptive path, and complement the SSAP No. 43R project. It would put a natural guard rail around those investments as everyone begins understanding those principles. If there are a lot of residual risks and securities start looking and acting like something else, there is a risk of possibly not falling into the new principles-based SSAP No. 43R. The Task Force has got some work to do regarding looking at how it is using ratings and private letter rating. The Task Force can always look at ways to accomplish accounting for these risks through its processes.
John Garrison (Leased-Backed Securities Working Group) said this is an elegant and simple solution to the confusion that has been existing in the market. CTLs would stay in the P&P Manual, as they always have with all their guidelines and so forth. They would be preserved as an asset class with just a clarification that they would be deals that would normally be in the scope of SSAP No. 37. The clarification would be that any deal that is done in the form of a security would be FE, just like any bond. Investors would have the option, depending on the characteristics of the deal, to either do them under FE or submit them to the SVO for a NAIC Designation. This also applies to GLF transactions that are a security, and they would be FE. Mr. Fry confirmed that interpretation.

Ms. Mears said insurers should be thoughtful about those types of security characteristics that currently have large residual values in relation to the bond project and the bond proposal. As the residual values get higher and higher, more of an analysis needs to occur to show that those still produce bond like cash flows under the proposal. Should that proposal move forward the detail, securities with CTL like characteristics, along with any other investments that have those high residual values, would fall under that definition and its requirements.

Ms. Mears made a motion, seconded by Mr. Everett, directing the SVO staff to expose a new amendment to the P&P Manual following the suggestions proposed by the Working Group chairs permitting CTLs and GLF transactions that are securities to be FE for a 30-day public comment period. The motion passed unanimously.

3. Discussed the SVO Referral Response to the Statutory Accounting Principles (E) Working Group on CTLs

Mr. Fry said the next item on the agenda is to hear a summary from the SVO on the referral it received from the Statutory Accounting Principles (E) Working Group on CTLs. The referral asked the SVO some basic questions about CTLs.

Mr. Therriault said a lot has changed, given the new direction just discussed, but the Working Group asked the SVO a number of questions related to CTLs centered around the appropriateness of the 5% residual exposure and whether it is appropriate to revisit the 5% risk threshold restrictions for conforming CTLs. The SVO agreed that it makes sense to revisit that threshold. It sounds like the bond definition project will be covering that issue, so it is not necessary to do that here. Also, with the change in definition just discussed, it seems like it will no longer be necessary for the P&P Manual instructions.

Another question was for a recommendation of an appropriate residual risk threshold. That is where the SVO response went into some detail on the various risks that it has observed. The SVO staff did not think it was appropriate for the SVO to weigh in on the residual risk threshold, as that was more of a regulatory policy decision. The SVO staff assumed that the Task Force would come back and make a recommendation to the Working Group in that regard as to what it believes is the appropriate residual risk for the bond project.

Mr. Therriault said there was a question regarding other mechanisms for compensating controls beyond a residual risk insurance policy that could be incorporated to mitigate those factors for CTLs. The residual risk insurance is the most common mitigant that the SVO is seeing, but other mitigants that would be acceptable include non-cancelable guarantees, cash escrows and reserves, excess rent set asides, and recourse to the lessee. The SVO did not have an all-encompassing list, because it was anticipated that there could be other mitigants, and it did not want to exclude them.

The other question from the Working Group was for a listing of the nonconforming CTLs that had been filed with the SVO and some characteristics about them. The SVO received 61 CTLs since the time INT 20-10 was issued through April 21. There were 16 conforming CTLs, 27 nonconforming CTLs, and 18 transactions where documentation was still pending. Typical outstanding documentation include the primary legal agreement, the CTL evaluation form, the mortgage, residual value insurance, lease agreement, condemnation insurance, appraisal, and assignment of lease and rents. For the nonconforming CTLs, 20 had balloon payments in excess of 5%, six involved a lack of casualty or condemnation gap insurance, and one involved a keep-well agreement that would not be adequate for credit substitution purposes. The Working Group was sent a regulator-only list of those nonconforming CTLs, as it had requested.

Mr. Fry said the Task Force would likely preserve the 5% residual risk for the things that otherwise would be on the mortgage loan schedule that want to go over to Schedule D. It may no longer be relevant how much over the 5% limitation the Task Force would suggest to the Working Group because there is no limit now for any other asset class. The new SSAP No. 43R principles will probably end up setting that benchmark.

Mr. Bruggeman asked Mr. Therriault if all the CTLs listed were structured as securities. Mr. Therriault said that is correct; CTLs structured as securities is what the SVO has traditionally received. The SVO has not received a mortgage type CTL in a
long time. Mr. Therriault said the comments in the SVO’s response to the Working Group highlighted risks that were generic to any lease-backed securities. The SVO wanted to make the Working Group and Task Force aware of those risks without making any policy recommendations. Mr. Bruggeman said he appreciated the SVO memo sent to the Working Group, as it broke out CTLs from the old definition and how they are being used now in securities.

Ms. Belfi asked for clarification regarding whether the Task Force should take up the policy questions from the Working Group, such as whether the residual exposure percentage should increase from 5% to something else now that it would not apply anymore, because the Working Group is going to be looking at the risk factors within SSAP No. 43R. Mr. Fry said a lot of these CTLs were not mortgage loans. They were a security, and like any other security, such as collateralized fund obligations (CFOs), they have different characteristics; and the Task Force does not really highlight those and create a special process for them, but they are just part of the FE universe. Everything is being put into that basket, then someday the new SSAP No. 43R principles will serve a useful purpose to keep that in check.

Mr. Bruggeman said for the bond definition project, most of these are already there, but there might be a few that fall outside of that principle in the bond definition. Those that are outside of the principles would have to move off Schedule D as securities, not as mortgages that are on Schedule D, but the second two buckets described earlier.

Having no further business, the Valuation of Securities (E) Task Force adjourned.
May 6, 2021

Mr. Kevin Fry, Chair
NAIC Valuation of Securities (E) Task Force
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Ms. Carrie Mears, Vice Chair
NAIC Valuation of Securities (E) Task Force
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197


Dear Mr. Fry and Ms. Mears,

The American Council of Life Insurers (“ACLI”)¹, Private Placement Investors Association (“PPiA”)², and North American Securities Valuation Association (“NASVA”)³ (collectively, the “undersigned”) appreciate the opportunity to comment on the above-referenced proposed amendment to the P&P Manual. We continue to appreciate the SVO’s willingness to meet with industry and have open, meaningful, and collaborative dialogue on complex and important changes, while also being responsive to practical constraints that, if left unaddressed, would potentially needlessly disrupt important markets.

The undersigned support the proposed amendment to the P&P Manual and remain committed to full transparency surrounding securities currently benefiting from private letter ratings. We believe this...
transparency is important and will give regulators greater insight, via the SVO, regarding securities (and the related rating methodologies) with private letter ratings.

The approach taken, as laid out in the exposure, is also accommodating to practical constraints on immediately obtaining all rating rationale reports, and therefore will minimize disruption to the private placement market. The private placement market is extremely important to insurance companies, and therefore, both policyowners and regulators, as private placement bonds consistently outperform the public market.

We continue to look forward to working with the SVO and regulators on this very important topic and continue to be fully committed to transparency, as it pertains to both industry and the SVO, regarding the securities deemed appropriate for Schedule D bond treatment as well as the ratings and designations applied.

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We thank the SVO, and regulators, for their continued dialogue on these and other important issues. We continue to stand ready and offer our assistance and input as needed.

Sincerely,

Mike Monahan
American Council of Life Insurer

Tracey Lindsey
NASVA

John Petchler

on behalf of PPIA Board of Directors

cc: Charles Therriault, Director, Securities Valuation Office

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VALUATION OF SECURITIES (E) TASK FORCE
PROPOSED 2022 CHARGES

The mission of the Valuation of Securities (E) Task Force is to provide regulatory leadership and expertise to establish and maintain all aspects of the NAIC’s credit assessment process for insurer-owned securities, as well as produce insightful and actionable research and analysis regarding insurer investments.

Ongoing Support of NAIC Programs, Products or Services

1. The Valuation of Securities (E) Task Force will:

   A. Review and monitor the operations of the NAIC Securities Valuation Office (SVO) and the NAIC Structured Securities Group (SSG) to ensure they continue to reflect regulatory objectives.

   B. Maintain and revise the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to provide solutions to investment-related regulatory issues for existing or anticipated investments.

   C. Monitor changes in accounting and reporting requirements resulting from the continuing maintenance of the Accounting Practices and Procedures Manual, as well as financial statement blanks and instructions, to ensure that the P&P Manual continues to reflect regulatory needs and objectives.

   D. Consider whether improvements should be suggested to the measurement, reporting and evaluation of invested assets by the NAIC as the result of: 1) newly identified types of invested assets; 2) newly identified investment risks within existing invested asset types; or 3) elevated concerns regarding previously identified investment risks.

   E. Identify potential improvements to the credit filing process, including formats and electronic system enhancements.

   F. Provide effective direction to the NAIC’s mortgage-backed securities modeling firms and consultants.

   G. Coordinate with other NAIC working groups and task forces—including, but not limited to, the Capital Adequacy (E) Task Force, the Investment Risk-Based Capital (E) Working Group, the Statutory Accounting Principles (E) Working Group and the Blanks (E) Working Group—to formulate recommendations and to make referrals to such other NAIC regulator groups to ensure expertise relative to investments, or the purpose and objective of guidance in the P&P Manual, is reflective in the guidance of such other groups and that the expertise of such other NAIC regulatory groups and the objectives of their guidance is reflected in the P&P Manual.

   H. Identify potential improvements to the filing exempt process (the use of credit rating provider ratings to determine an NAIC designation) to ensure greater consistency, uniformity and appropriateness to achieve the NAIC’s financial solvency objectives.

NAIC Support Staff: Charles Therriault, Marc Perlman

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June 28, 2021

Mr. Kevin Fry, Chair
NAIC Valuation of Securities (E) Task Force
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Ms. Carrie Mears, Vice Chair
NAIC Valuation of Securities (E) Task Force
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: Proposed Amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to Add Additional Instructions to the Review of Funds

Dear Mr. Fry and Ms. Mears,

The American Council of Life Insurers ("ACLI")\(^1\), Private Placement Investors Association ("PPiA")\(^2\), and North American Securities Valuation Association ("NASVA")\(^3\) (collectively, the "undersigned") appreciate the opportunity to comment on the above-referenced proposed amendment to the P&P Manual.

The undersigned are supportive of the Valuation of Securities Task Force’s ("VOSTF") goal to provide greater clarity and predictability to fund sponsors and investors regarding the acceptable use of derivatives in funds and permit some funds to have greater flexibility in their use of derivatives. We are also supportive of the Securities Valuation Office’s ("SVO") well thought out and appropriately targeted changes to the P&P Manual that achieve that end.

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\(^1\) The American Council of Life Insurers ("ACLI") is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 94 percent of industry assets in the United States.

\(^2\) The Private Placement Investors Association ("PPiA") is a business association of insurance companies, other institutional investors, and affiliates thereof, that are active investors in the primary market for privately placed debt instruments. The association exists to provide a discussion forum for private debt investors; to facilitate the development of industry best practices; to promote interest in the primary market for privately placed debt instruments; and to increase accessibility to capital for issuers of privately placed debt instruments. The PPiA serves 63 member companies and works with regulators, NASVA, the American College of Investors Counsel, and the investment banking community to efficiently implement changes within the private placement marketplace. Learn more at www.usppia.com.

\(^3\) The North American Securities Valuation Association ("NASVA") is an association of insurance company representatives who interact with the National Association of Insurance Commissioners Securities Valuation Office to provide important input, and to exchange information, in order to improve the interaction between the SVO and its users. In the past, NASVA committees have worked on issues such as improving filing procedures, suggesting enhancements to the NAIC’s ISIS electronic security filing system, and commenting on year-end processes. Find more information here.
We greatly appreciate both the VOSTF’s and SVO’s continued efforts to expand the universe of funds where the SVO can appropriately assess a fund’s portfolio to determine if it will generate predictable and periodic cash flows so similar to a bond (or a preferred stock) that it can be assigned an NAIC Designation and obtain an applicable risk-based capital charge.

We, therefore, continue to support any further efforts to obtain bond-like risk-based capital charges for an SEC registered fund on the NAIC Fixed Income-Like SEC Registered Funds List in the scope of SSAP No. 30R—Unaffiliated Common Stock and reported on Schedule D, Part 2, Section 2 with an NAIC Designation. Similar treatment may also be warranted for certain funds that issue debt securities, that may not meet the definition of a bond because the debt security is “stapled” together with the equity tranche, per Example 1 of Appendix 1, of SAPWG’s recently exposed bond definition for purposes of Schedule D reporting.

We again sincerely thank the VOSTF, SVO, and regulators for their efforts on this important matter and we continue to stand ready to offer our assistance and input as needed.

Sincerely,

Mike Monahan
American Council of Life Insurer

Tracey Lindsey
NASVA

John Petchler
on behalf of PPIA Board of Directors

cc: Charles Therriault, Director, Securities Valuation Office
Mike Monahan  
Senior Director, Accounting Policy  
(202) 624-2324  
mikemonahan@acli.com  

May 6, 2021  

Mr. Kevin Fry, Chair  
Ms. Carrie Mears, Vice Chair  
NAIC Valuation of Securities (E) Task Force  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197  

Re: Proposed Amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to Add Additional Instructions to the Review of Funds  

Dear Mr. Fry and Ms. Mears,  

The American Council of Life Insurers (“ACLI”)1, Private Placement Investors Association (“PPiA”)2, and North American Securities Valuation Association (“NASVA”)3 (collectively, the “undersigned”) appreciate the opportunity to comment on the proposed amendment to the P&P Manual.  

The undersigned support these proposed amendments to the P&P Manual and believe they pragmatically address risks associated with derivatives, is consistent with the recent SEC guidance, and provides additional transparency.  

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1 The American Council of Life Insurers (“ACLI”) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 94 percent of industry assets in the United States.  

2 The Private Placement Investors Association (“PPiA”) is a business association of insurance companies, other institutional investors, and affiliates thereof, that are active investors in the primary market for privately placed debt instruments. The association exists to provide a discussion forum for private debt investors; to facilitate the development of industry best practices; to promote interest in the primary market for privately placed debt instruments; and to increase accessibility to capital for issuers of privately placed debt instruments. The PPiA serves 63 member companies and works with regulators, NASVA, the American College of Investors Counsel, and the investment banking community to efficiently implement changes within the private placement marketplace. Learn more at www.usppia.com.  

3 The North American Securities Valuation Association (“NASVA”) is an association of insurance company representatives who interact with the National Association of Insurance Commissioners Securities Valuation Office to provide important input, and to exchange information, in order to improve the interaction between the SVO and its users. In the past, NASVA committees have worked on issues such as improving filing procedures, suggesting enhancements to the NAIC’s ISIS electronic security filing system, and commenting on year-end processes. Find more information here.
We continue to support the SVO’s stated (and regulator’s) objective for funds to be assigned an NAIC Designation and obtain applicable risk-based capital charges, if the portfolio generates predictable and periodic cash flows so similar to a bond (or preferred stock).

We also continue to support extending such treatment for funds on the “NAIC Fixed Income-Like SEC Registered Funds List” that are currently in the scope SSAP No. 30R – Unaffiliated Common Stock and believe the SVO’s proposed guidance provides appropriate clarity and reasonableness as a foundation toward achieving this end.

***

We thank the SVO, and regulators, for their continued dialogue on these and other important issues. We continue to stand ready and offer our assistance and input as needed.

Sincerely,

Mike Monahan          Tracey Lindsey          John Petchler
American Council of Life Insurer       NASVA          on behalf of PPIA Board of Directors

cc: Charles Therriault, Director, Securities Valuation Office
5 May, 2021

Kevin Fry
Chair, NAIC Valuation of Securities (E) Task Force
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108
Via email

Re: Comments on Proposed Amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to Add Additional Instructions to the Review of Funds

Dear Mr. Fry and Task Force Members:

In reviewing the captioned Proposal, it is clear that insufficient attention has been paid to the derivative instruments that staff has recently stated are present in many, perhaps most, of the ETFs on the SVO's ETF Bond List. Derivatives held in any form deserve extra scrutiny, particularly when present in portfolios held by insurance companies. This letter discusses that phenomenon and makes recommendations regarding five specific provisions of the proposed language. The Proposal quotes selectively from the Securities and Exchange Commission's guidelines in Rule 18f-4 and contorts and redefines those guidelines. Rather than better controlling or monitoring the use of riskier derivative instruments in ETFs, the Proposal allows for greater freedom to use leverage to boost returns while increasing risk. I believe that a few key changes will make this Proposal far more effective in protecting insurance companies and hence policy holders. Derivatives have a very bad reputation for good reason and the SVO’s Proposal must be improved to take this into account.

281 Derivative Transactions This section of the Proposal defines what exactly constitutes a derivative transaction. The staff is clearly using the SEC’s Rule 18f-4. The wording in this section of the Proposal is a verbatim copy of SEC 18f-4, with two words changed. However, the staff does not disclose that it changed these words from the SEC rule, and this change literally inverts the SEC rule. Please see the difference highlighted below:

SEC Rule 18f-4:

“means any swap, security-based swap, futures contract, forward contract, option, any combination of the foregoing, or any similar instrument (“derivatives instrument”), under which a fund is or may be required to make any payment or delivery of cash or other assets during the life of the instrument or at maturity or early termination, whether as margin or settlement payment or otherwise ... ”
¶281 of the Proposal:

“means any swap, security-based swap, futures contract, forward contract, option, any combination of the foregoing, or any similar instrument (“derivatives instrument”), under which a fund is or **may shall not** be required to make any payment or delivery of cash or other assets during the life of the instrument or at maturity or early termination, whether as margin or settlement payment or otherwise ...”

By changing these words, staff completely inverts the SEC definition in such a way as to cause it to include certain instruments that the SEC was purposefully trying to exclude. The goal of the definition in ¶281, according to the Proposal itself, is to limit funds from "...magnify(-ing) its gains and losses compared to the fund’s investment, while also obligating the fund to make a payment or deliver assets to counterparty under specified future conditions." This is a reasonable and understandable goal. But by changing the SEC’s language, this modified definition does exactly the opposite.

As an example, let us imagine two different derivative instruments:

In the chart above, the red line shows the payout from a derivative that "may" (the actual SEC18f-4 definition) cause its owner to make a future payment. As we can see, such derivatives are inherently riskier as their possible future losses are unknown and limitless. In fact, this is exactly the type of derivative owned by Archegos. It **did** cause its owner to make a future payment, in an amount greater than the company could pay. The same type of derivative brought down Barings Bank. This is precisely why derivatives that “may” force ETFs to make future payments are given greater scrutiny by the SEC under Rule 18f-4.

On the other hand, the blue derivative has defined and controlled downside risk that limits the risk to the market value of position. There is no obligation by the ETF to make a future payment.
Additionally, it is noted that staff used the unaltered language from SEC 18f-4 (reverting to the use of “may” in place of “shall not”) in ¶289, thereby making the change here in ¶281 seem even more out of place. In essence, the Proposal literally contradicts itself by defining a derivative in diametrically different ways in two places. Yet, there is no acknowledgement of or justification for this very material modification which literally flips the meaning of 18f-4 on its head, even while retaining the actual SEC rule later in the document.

**Recommendation:** Adopt the SEC language without alteration in ¶281 just as staff has done in ¶289, because instruments that can cause magnification of gains/losses should continue to be defined as derivatives and those that are out of scope should be excluded as the SEC has determined.

### ¶282. Exempt Derivative

This section seeks to define which derivatives would be exempt from the Proposal. It is somewhat confusing as “derivative transactions” were just defined in the immediately preceding ¶281 and derivatives that do not contain obligations in the future are already exempted by virtue of that definition.

**Recommendation #1:** Adopting the SEC language as written (as recommended for ¶281) would eliminate the need for this provision.

**Recommendation #2:** Staff should ensure that “exempt derivatives” are truly exempt. The SVO is uniquely positioned to make sure that ETF portfolios with exempt derivatives are able to document how their hedges are applied to other positions. For now, there appears to be little or no scrutiny at the position level to determine if “exempt derivatives” truly are complying with this language.

### ¶287 Management Assessment

This is a completely new provision, and it should be eliminated for several reasons.

First, given the priorities of the VOSTF it is difficult to imagine how directing the SVO to conduct management analyses of funds is a reasonable use of scarce resources. Management assessments are commonplace for rating agencies and examiners and they can assist significantly in the credit evaluation process. To the best of my knowledge, however, that the SVO does not perform such assessments currently and has not done so in the past at least not on any significant scale. If the SVO had the capacity, expertise and guidelines to begin these assessments, it would be far more logical to do so for "issuer obligations" where the role of management is much more significant and impactful than for funds.

Second, the SVO proposes for itself a new role evaluating the experience, management, compliance, and operations of ETF managers. All listed ETF Bond Funds are '40 Act Funds under the regulatory purview of the SEC, which has a vast staff with the resources, expertise and enforcement powers to evaluate management companies in a much more rigorous way. The SEC already monitors and evaluates all listed ETF managers for experience, management, compliance, and operations. It is unlikely that a review by the SVO would be anywhere near as thorough as an SEC examination. It would, however, divert staff and resources to a new mission which is already being performed by a regulatory agency with much greater investigative authority and capacity for this work.

Third, allowing the SVO “in its sole discretion” to override its own rules and procedures opens the NAIC and the entire process of rating funds up to legal risks. If the NAIC has gone through the trouble to write the P&P Manual, it should insist that its rules be followed. Either the rules are applied fairly and evenly to all, or they are...
not rules. Allowing the SVO to make a determination “in its sole discretion” without standards or review provisions is clearly bad policy and governance.

**Recommendation #1:** Remove ¶287. Developing an entirely new set of standards, mechanisms, review processes and controls to evaluate the managements of funds is unnecessary when such work is already done by the SEC. If the SVO believes its role is to evaluate management, it should first develop its methodology in other asset classes in which management plays a far more consequential role and submit them to the VOSTF for review and approval.

**Recommendation #2:** Additionally, remove the sentence “Conduct a management assessment” from ¶290 Methodology for conformity.

¶291 Documentation

Staff proposes that it be permitted to consider funds with derivatives to be considered as "Highly Customized Transactions". The SVO has been evaluating funds on the ETF Bond list for many years and recently acknowledged that "...most, if not all, ETFs have provisions in their prospectus allowing them (derivatives)." The effect of classifying an asset as a HCT is to exempt it from the SVO's published and approved fee schedule. In other words, under this Proposal the SVO may, on its own authority and with no review process, subject a filing to whatever fee it determines.

**Recommendation:** This new SVO authority should be reviewed very carefully by the VOSTF to determine whether, after many years of reviewing these transactions on a standard fee schedule, they should be subjected to new unpredictable fees solely because they contain derivative instruments. The SVO should consider specifying under which conditions it treats funds with derivatives as HCTs. It would be bad and risky policy simply to apply different fees to issuers without reasonable bases for doing so.

¶289 Speculative Characteristics Analysis

In the last paragraph of this Analysis section, it is observed that staff proposes a prohibition on the use of "...derivative instruments, under which a fund is or may be required to make any payment or delivery of cash or other assets during the life of the instrument or at maturity or early termination, whether as margin or settlement payment or otherwise and (b) any short sale borrowing or other borrowings, except for exempt derivatives..." It is noted that that is an exact recitation of SEC 18f-4 as written.

This is a very reasonable proposal that will likely reduce the risk of ETFs on the bond list and reduce the use of risky, highly speculative instruments.

**Recommendation:** This provision is supported. Staff should be specifically charged to review the prospectus of each ETF fund on the bond list with regard to the specific derivative instruments that are authorized so that this provision will be effectively enforced. Is very likely that there are dozens of ETFs currently on the NAIC bond list which are in violation of this proposed rule and which may own Archegos-type derivatives in their portfolios. The SVO is uniquely positioned and qualified to monitor and enforce this provision.
In summary, I hope these suggestions will be received as the constructive comments they are intended to be and look forward to discussing them in any venue.

Sincerely,

[Signature]

copy:
Mr. Charles Therriault, CFA
Ms. Denise Genao-Rosado
May 6, 2021

Kevin Fry, Chair, Valuation of Securities (E) Task Force (VOSTF)
Charles Therriault, Director, NAIC Securities Valuation Office (SVO)

Re: Proposed Amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to Add Additional Instructions to the Review of Funds

Dear Messrs. Fry and Therriault,

We appreciate the opportunity to comment on the proposal exposed by the VOSTF with a deadline of May 6, 2021. On behalf of Payden & Rygel and our insurance clients, we appreciate the general thesis of the proposal, but we do have some general concerns and comments.

The SVO references SEC Rule 18f-4 and their definition of a limited user of derivatives. This rule was adopted on October 28, 2020 and came into effect February 19, 2021. However, Fund companies do not need to fully comply until August 19, 2022. At this time, investment managers of the sponsored Funds are formulating best practices and have not fully digested the new rule. We recommend the VOSTF delay the final amendments to the P&P Manual until those best practices are determined.

In regards to Management Assessment, more concrete measurements are appreciated. The introduction of subjective measures into an NAIC Designation invites confusion and room for discrepancies. Additional detail related to what the SVO believes are best practices or deficiencies will help set expectations for Fund companies. Similarly, we would recommend the SVO create an outcome report related to their Management Assessment, especially if it leads to notching of the final NAIC Designation. Lastly, what is the resolution process if a filer disagrees with this notching?

If VOSTF and SVO are open to further consideration, we are happy to gather additional Fund management companies to formalize detailed feedback and ideas for your consideration.

Thank you,

Erinn R. King, CFA
Principal, Payden & Rygel

Eric M. Hovey, CFA
Senior Vice President, Payden & Rygel

cc: Denise Genao-Rosado, Marc Perlman, and Eric Kolchinsky
MEMORANDUM

TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force
Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

RE: Proposed Amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to Add Additional Instructions to the Review of Funds

DATE: May 27, 2021

1. Overview – At the request of the Task Force to provide greater clarity and predictability to fund sponsors and investors regarding the acceptable use of derivatives in funds and permit some funds to have greater flexibility in their use of derivatives, the SVO proposed several amendments to the P&P Manual fund guidelines at the Spring National Meeting of the Task Force on March 22, 2021. The Task Force voted to receive the proposal and expose it for 45 days. The Task Force received comments from interested parties during the exposure period, aspects of which the SVO has incorporated into a new proposed amendment to the P&P Manual fund guidelines.

2. Recommendation Summary – The new proposal would adhere much more closely to Rule 18f-4 (the Rule) under the Investment Company Act of 1940 related to the use of derivatives by registered investment companies, including funds, which the Securities Exchange Commission (SEC) adopted in October 2020. Unlike the previous amendment which had two separate tests for derivatives depending on the NAIC Fund List on which a fund is listed, this amendment would create a single test. Pursuant to the new proposal a fund’s exposure to: (i) derivatives under which a fund is or may be required to make any payment or delivery of cash or other assets during the life of the instrument or at maturity or early termination, whether as margin or settlement payments or otherwise, (ii) short sale borrowings and (iii) reverse repurchase agreements or similar financing, would be limited to 10% of the fund’s net assets in normal market conditions. Exposure would be calculated based on the gross notional amounts of derivatives, the value of assets sold short for short sale borrowings, and the proceeds received by the fund but not repaid for reverse repurchase agreements. Consistent with the Rule, interest rate derivatives and option contracts exposure could be calculated with other defined methods consistent with market practice. Also consistent with the Rule, certain currency...
and interest rate derivatives that hedge currency or interest rate risk associated with one or more specific equity or fixed-income investments of the fund would be exempt from the 10% exposure calculation.

One difference between our proposal and the SEC Rule is that the P&P Manual’s methodology requires a look-through assessment of all funds which, in turn, includes a requirement that a fund “predominantly hold” bonds or preferred stock, as applicable. As defined in the P&P Manual, “Predominantly Hold” means, in part, “The fund will hold at least 80% of its assets in bonds if the fund is a bond fund or at least 80% of its assets in preferred stock if the fund is a preferred stock fund, in normal market conditions.” This existing requirement, therefore, limits total derivatives, short sale borrowing and reverse repurchase agreement exposure in any fund to 20%, exclusive of the currency and interest rate derivatives mentioned above. We propose calculating that exposure as explained above. However, for derivatives under which a fund shall not be required to make any payment or delivery of cash or other assets during the life of the instrument or at maturity or early termination, whether as margin or settlement payments or otherwise, exposure would be calculated based on the derivative’s market value. These derivatives would include, for example, certain options pursuant to which the fund would have no possible future payment obligation following the initial premium payment. Due to diminished risk of loss to the fund it is more appropriate to calculate the exposure based on the less conservative market value measure rather than the gross notional amount. The Credit Risk Assessment portion of our existing methodology would also be updated to include a calculation of derivative exposure and, if analytically appropriate, the inclusion of derivatives in the WARF analysis.

Derivative documentation can be complex and its review time consuming. To expedite reviews of funds with derivatives while ensuring that the fund does not breach the proposed exposure thresholds, we propose a new filing requirement to include certain derivatives information in the schedule of portfolio securities and assets which is provided to the SVO for its review. Such additional information would include (i) derivative type, (ii) might the derivative require the fund to make a future payment or delivery of cash or other assets, (iii) is the derivative an “excluded derivative transaction,” (iv) the counterparty credit rating, and (v) the derivative exposure and how it is calculated. Our expectation is that a complete and accurate summary of derivatives in the schedule will obviate the need for the SVO to review derivative legal documentation, but we would reserve the right to request it if we deem it necessary.

Based on comments we received from interested parties, we have decided to remove the initially proposed management assessment from this amendment. Interested parties expressed concern that the management assessment could further weaken market clarity and predictability.

2. Proposed Amendment – The text referencing the Investments in Funds is shown below, edits in red, as it would appear in the 2020 P&P Manual format.
PART THREE

SVO PROCEDURES AND METHODOLOGY FOR PRODUCTION OF NAIC DESIGNATIONS
NAIC FUND LISTS

... 

NAIC FIXED INCOME-LIKE SEC REGISTERED FUNDS LIST

Description

269. This section encompasses SEC registered funds issued by any type of investment-company registered with the SEC under the Investment Company Act of 1940 that sponsors a fund that will predominantly hold bonds or preferred stock. This listing excludes money market mutual funds as those securities are subject to different accounting treatment.) Different type of investment companies can be considered to have business models that operate differently as to redemption of shares, the life of the fund, whether the portfolio is held to maturity or traded over the life of the fund. The four types of investment companies are summarized below:

- **Open End Management Company (OEMC)** – An OEMC sell redeemable shares, directly or through a broker, on a continuous basis at the fund’s approximate net asset value (NAV) per share and invests the proceeds in highly liquid bonds. Investors redeem shares of an OEMC fund by selling them back to the fund or to a broker. OEMC’s may include exchange-traded funds.

- **Closed End Fund (CEFC)** – A CEFC lists its shares on a stock exchange or trades in the over-the-counter market. The assets of a CEFC are professionally managed in accordance with the fund’s investment objectives and policies. The market price of a CEFC share is determined by supply and demand in the marketplace. Because a CEFC does not maintain cash reserves or sell securities to meet redemptions, it can invest in less-liquid portfolio securities. A CEFC has a stated termination date.

- **Unit Investment Trust (UIT)** – A UIT issues a fixed number of securities called “units” in a public offering and uses the proceeds to buy a diversified professionally selected portfolio of securities. UITs have a preset termination date tied to its portfolio investments and investment goals. The portfolio is held for the life of the UIT; but is not actively managed or traded. Although UIT’s are required by law to redeem outstanding units, the UIT sponsor usually maintains a secondary market so investors can sell units back and other investors can buy units. UIT’s may include exchange-traded funds.
- **Exchange-Traded Fund (ETF)** – An ETF is an investment company that is registered under the Investment Company Act of 1940 either as an OEMC or as a UIT. An ETF combines the valuation feature of an OEMC or UIT, which can be bought or sold at the end of each trading day for its net asset value, with the tradability feature of a closed-end fund, which trades throughout the trading day at prices that may be more or less than its net asset value.

### Regulatory Treatment of Eligible Funds

270. An SEC registered fund on the NAIC Fixed Income-Like SEC Registered Funds List is in the scope of SSAP No. 30R—Unaffiliated Common Stock and reported on Schedule D, Part 2, Section 2 with an NAIC Designation. **These investments are reported at fair value although reporting at net asset value is permitted if there is no readily determinable fair value.**

### REQUIRED DOCUMENTATION, ANALYTICAL PROCEDURES AND ELIGIBILITY CRITERIA

#### Objective

277. The objective of the SVO’s review is to assess whether for NAIC regulatory purposes discussed above, the fund's portfolio will generate predictable and periodic cash flows so similar to a bond (or a preferred stock) that it should be assigned an NAIC Designation and obtain applicable risk-based capital charges.

#### Definitions

278. **Bond** – For fund investment purposes, Bond means debt securities defined or encompassed within SSAP No. 26R–Bonds and SSAP No. 43R–Loan-Backed and Structured Securities.

279. **Credit Risk Assessment** – A calculation of the credit risk of a fund’s underlying investment portfolio using a weighted average rating factor methodology (WARF). The WARF factor for each portfolio security (issue/security specific) is determined by first translating its NAIC CRP rating into an NAIC Designation. For securities that are unrated but have an NAIC Designation, the Designation is used. The WARF factor for that NAIC Designation is then market value-weighted. The weighted factor for each investment is summed to determine the fund’s credit rating which is then translated into the equivalent NAIC Designation. **For funds which use any derivatives instrument or derivatives transaction, the WARF analysis may incorporate each derivative counterparty and the credit risk assessment may include a determination of derivatives exposure.**
280. **Derivatives Exposure** – means the sum of the gross notional amounts of the fund’s derivatives transactions, described in clause (1) of the definition, below, of the term “derivatives transaction”; in the case of short sale borrowings, the value of the assets sold short; and, in the case of reverse repurchase agreements or similar financing transactions, the fund’s derivatives exposure also includes, for each transaction, the proceeds received but not yet repaid or returned, or for which the associated liability has not been extinguished, in connection with the transaction. Consistent with Securities Exchange Commission Rule 18f-4 under the Investment Company Act of 1940, in determining derivatives exposure a fund may convert the notional amount of interest rate derivatives to 10-year bond equivalents and delta adjust the notional amounts of options contracts and exclude any closed-out positions, if those positions were closed out with the same counterparty and result in no credit or market exposure to the fund.

281. **Derivatives Transaction** – means: (1) any swap, security-based swap, futures contract, forward contract, option, any combination of the foregoing, or any similar instrument (“derivatives instrument”), under which a fund is or may be required to make any payment or delivery of cash or other assets during the life of the instrument or at maturity or early termination, whether as margin or settlement payment or otherwise; (2) any short sale borrowing; and (3) any reverse repurchase agreement or similar financing transaction.

282. **Financial Commitment Transactions** – Refers to reverse repurchase agreements, short sale borrowing, any firm or standby commitment or similar agreement as these terms are defined and as they may be subsequently amended by the SEC as part of proposed Rule 18f-4.

283. **Fixed Income Like** – An SVO determination that a fund will generate predictable and periodic cash flows in a manner broadly similar to a situation where the holdings of bonds or of preferred stock of a known credit quality were held individually. A fund’s use of derivatives shall be deemed fixed income like if it meets the guidelines in this section.

284. **Fundamental Policy** – A policy adopted by a fund that requires shareholder approval to change or a policy to provide at least 60 days’ notice to fund shareholders of an intended change of a stated policy. The subject of the policy is that under normal circumstances the fund will invest at least 80% of its net assets plus any leverage for investment purposes in the type of bonds indicated by its name in compliance with Section 13 (a) of the Investment Company Act of 1940 and/or Rule 35d-1 of the 1940 Act. If the fund’s prospectus does not state that this investment objective is a fundamental policy for the fund, the SVO will assume it is not.
285. **Look-through Assessment** – A qualitative and quantitative evaluation of the fund, encompassing the following criteria:

- Verify that the fund’s portfolio, in the case of a bond fund or, preferred stock, in the case of a preferred stock fund *predominantly holds* bonds or preferred stock.
- Confirm that the fund has adopted its investment objective as part of its *fundamental policy* and that other policies are consistent with fixed income investment.
- Review the fund’s stated investment objective to ensure it is consistent with a fixed income investment, and evaluate the fund’s investment policies and investment strategies for consistency with the investment objective and the fund’s portfolio.
- Evaluate the extent to which the composition of the fund’s portfolio can vary under normal market conditions given the fund’s policies and investment strategies and the extent to which the composition of the fund’s portfolio may vary under abnormal market conditions and the extent to which changes in composition of the fund’s portfolio in abnormal market conditions may persist given the fund’s leverage profile or other relevant factors.

*Note:* A fund that invests in another fund will need to have that other underlying fund approved by the SVO and maintained on the appropriate fund list, if not already done.

286. **Predominantly Hold** – The fund will hold *at least 80%* of its assets in bonds if the fund is a bond fund or at least 80% of its assets in preferred stock if the fund is a preferred stock fund, *in normal market conditions* and will deviate from this policy only temporarily to respond to abnormal market conditions. In the case of an ETF, predominantly hold also means that the fund will track a specified bond or preferred stock index, if passively managed, or refers to the bond or preferred stock portfolio the fund will actually hold, if actively managed—under normal market conditions. The *derivatives exposure of derivatives transactions* (exclusive of excluded derivatives transactions, as defined in “Speculative Characteristics Analysis”), and the market value of all other assets will be used when determining whether a fund predominantly holds bonds or preferred stock, as applicable, according to this clause.
287. **Speculative Characteristics Analysis** – Means: (a) an assessment of the fund’s use of leverage, including, but not limited to, its use of derivatives, financial commitment derivatives transactions and borrowings, to examine the impact they may have on the fund’s portfolio cash flow as assessed under the credit risk assessment under normal and abnormal market conditions; and (b) a review and evaluation of the fund’s policy and approaches to covering leverage obligations in relation to current and potential future guidance on the issue provided by the SEC. As used herein potential future guidance refers to proposed SEC Rule 18-f-4, “Use of Derivatives by Registered Investment Companies and Business Development Companies, ICA Release No. 31933 (December 11, 2015) [17 CFR Parts 270 and 274] Proposed Rule 18-f-4.”, the resulting derivatives exposure not to exceed 10% of the fund’s net assets in normal market conditions, excluding, for this purpose, currency or interest rate derivatives that hedge currency or interest rate risks associated with one or more specific (i) equity or fixed-income investments held by the fund (which must be foreign-currency-denominated in the case of currency derivatives), or (ii) the fund’s borrowings, provided that the currency or interest rate derivatives are entered into and maintained by the fund for hedging purposes and that the notional amounts of such derivatives do not exceed the value of the hedged investments (or the par value thereof, in the case of fixed-income investments, or the principal amount, in the case of borrowing) by more than 10 percent (each, an “excluded derivatives transaction”).

**NOTE:** For the avoidance of doubt, Funds on the NAIC U.S. Government Money Market Fund List are not permitted to use any derivatives transaction or other derivatives instrument. Examples of speculative characteristics may include the need to sell assets to meet leverage obligations at a loss; instability in the cash flow introduced by the use of leverage; the need to employ alternative portfolio management strategies as a result of the need to meet payment obligations; the extent to which changes in the composition of the fund’s portfolio in response to abnormal market conditions may persist given the fund’s leverage profile or other relevant factors. The purpose of an analysis of speculative characteristics is to determine whether the fund’s cash flow is inconsistent with a fixed income like determination.

**Methodology**

288. The SVO shall:

- Conduct a look-through assessment
- Conduct a credit-risk assessment to determine the credit risk of the fund’s cash flows.
- Conduct a speculative characteristics analysis.
- Determine whether the fund’s cash flow can or cannot be appropriately characterized as fixed income like for regulatory purposes.
If the SVO determines that the fund’s cash flow can be appropriately characterized as fixed income for regulatory purposes, it assigns an NAIC Designation to reflect the credit risk associated with the fund’s cash flow and includes the name of the fund on the appropriate NAIC List.**

If the SVO determines that the fund’s cash flow cannot be appropriately characterized as fixed income for regulatory purposes it shall communicate the determination to the insurance company or fund sponsor in writing.

*NOTE:* *Italicized text* indicates that the term used is a defined term. Please refer to the definition of the term for a description of SVO criteria associated with the methodology component being described.

**NOTE:** The NAIC Designation does not address the fund’s ability to meet payment obligations because the insurer/shareholder does not own the bonds in the portfolio; the NAIC Designation instead conveys the credit risk/quality of the fixed income like cash flow generated by the ETF.

**Documentation**

289. An insurance company or the sponsor of a bond or preferred stock fund that requests that the SVO conduct the look through and credit assessment submits the following required documentation to the SVO:

- A completed RTAS Application (Information about the RTAS process is contained here: [www.naic.org/documents/svo_rtas_app.pdf](http://www.naic.org/documents/svo_rtas_app.pdf)). A fund with derivatives transactions or other derivative instruments may be considered a Highly Customized Transaction if the SVO determines it necessary to review a derivative’s operative legal documentation.

- For all funds subject to look-through and credit risk assessment and to speculative characteristics analysis: the Prospectus and Statement of Additional Information (SAI) for the fund.

- For funds which use derivatives transactions or other derivative instruments, the applicable operative legal documentation, if requested by the SVO.

- In the case of an ETF, copies of the Application, Notice and Order associated with the fund sponsor’s request for Exemptive Relief from the SEC or a link to the SEC’s EDGAR where the SVO can obtain the documents.

- In the case of a private equity fund, the Private Placement Memorandum, Limited Partnership Agreement or Limited Liability Company Agreement, the Subscription Agreement and the Form D, if one has been filed.
Schedules of the fund’s portfolio securities and assets with a description of the security, the CUSIP or other security identifier and NRSRO credit ratings for the last four quarters of the fund’s existence. For funds which use derivative transactions or other derivative instruments, the schedule shall include for each derivative:

- The derivative type (e.g. ISDA swap, purchase call option, written put option, short sale borrowing, reverse repurchase agreement);
- Is or may the fund be required, pursuant to the derivative, to make any payment or delivery of cash or other assets during the life of the instrument or at maturity or early termination, whether as margin or settlement payment or otherwise;
- Is the derivative a derivatives transaction (as defined above), an excluded derivatives transaction (as defined in “Speculative Characteristics Analysis”) or neither;
- The counterparty credit rating;
- (i) The derivative exposure or market value, as applicable, both as a dollar amount and converted to a percentage of the fund’s net assets in normal market conditions, and (ii) a summary of how the amount is calculated (e.g. gross notional amount, convert the notional amount of interest rate derivative to 10-year bond equivalent, delta adjust the notional amount of option contract, market value, value of assets sold short, proceeds received but not yet paid or returned).

**NOTE:** The documentation provided must enable the SVO to conduct the analysis described below. Applicants are free to provide any supplemental material they believe will assist the SVO to:

- Verify that the fund has adopted a fundamental (stated) policy to predominantly hold bonds (or preferred stock).
- Evaluate the fund’s use of leverage in relation to the management of portfolio risk and in relation to other purposes relevant to the speculative characteristics analysis.
- Understand the fund’s policy and approaches to coverage of obligations arising from the use of leverage, in relation to SEC guidance on the subject.
- Schedules of the fund’s portfolio securities and assets with a description of the security, the CUSIP or other security identifier and NRSRO credit ratings for the last four quarters of the fund’s existence.
A description of likely changes in the fund’s composition under normal market conditions given the fund’s investment objective and the strategies to be employed to attain it.
TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force

FROM: Dale Bruggeman, Chair of the Statutory Accounting Principles (E) Working Group
Carrie Mears, Vice-Chair of the Statutory Accounting Principles (E) Working Group

RE: Proposed VOSTF Attachment B – Filing Exemption for CTLs

DATE: May 21, 2021

After a detailed review of the proposed revisions within Attachment B of the Valuation of Securities (E) Task Force meeting materials for Monday, May 24, it appears that the proposed revisions go beyond providing a filing exemption to allow non-SVO assigned designations. Rather, the edits also appear to modify the structural requirements for credit tenant loans (CTLs), and would thus permit direct mortgage loans, in scope of SSAP No. 37 and reported on Schedule B—Mortgage Loans, to be reclassified from Schedule B to Schedule D-1—Long-Term Bonds with up to 50% residual risk and a CRP rating, without any SVO structural assessments.

From prior review of the history of the CTL provisions, the original intent was to permit mortgage loans, captured on Schedule B, to be reclassified to Schedule D-1 based on the credit standing of a major tenant, but only if there was very limited residual risk (5%). Over time, the structure of these investments has shifted, but not the name used, and it is believed that most designs now meet the definition of a security and not a mortgage loan. Further, since the scope of SSAP No. 37—Mortgage Loans specifically excludes securities, these revised investment designs would not be captured in scope of SSAP No. 37 and not reported on Schedule B. Rather, under the existing guidance in the Accounting Practices and Procedures Manual, securities that reflect a creditor relationship, whereby there is a fixed schedule for one or more future payments, are captured in scope of SSAP No. 26R—Bonds or SSAP No. 43R—Loan-Backed and Structured Securities and reported on Schedule D-1.

Although the process to assess whether securities with underlying real estate risk shall be subject to filing exempt provisions or be submitted to the NAIC SVO for a credit assessment is a decision of the Task Force, as noted above, the current proposed revisions do not appear to be limited to that aspect. To prevent inadvertent application of the proposed revisions to direct mortgage loans, and to clarify that securities (SSAP No. 26R/SSAP No. 43R) shall be reported in accordance with existing AP&P Manual guidance, it is suggested that the Task Force reconsider the proposed exposure of Attachment B. Instead, it is recommended that the Task Force expose proposed edits to the Purposes and Procedures Manual to clarify that in all instances in which a CTL is defined, it is noted to be a mortgage loan “in scope of SSAP No. 37.” It is noted that this limited edit would clarify that the application of the structural assessment of CTLs is limited to direct mortgage loans and relates to the potential reclassification from Schedule B to Schedule D for those investments. Furthermore, it would clarify that securities are not subject to the CTL structural assessments and
should continue to be reported in accordance with the scope provisions of the guidance within the AP&P Manual.

Examples of the proposed recommendations are shown below:

P&P Manual, Page 101 – FE Securities:

**Credit Tenant Loan (CTL)** – A CTL is a mortgage loan, in scope of SSAP No. 37, made primarily in reliance on the credit standing of a major tenant, structured with an assignment of the rental payments to the lender with real property pledged as collateral in the form of a first lien. This Manual identifies four categories of CTLs as eligible for reporting on Schedule D conditioned on an SVO determination that the transaction meets the criteria specified by the VOS/TF for Schedule D treatment. A transaction that purports to be a Credit Tenant Loan, including one that is assigned a credit rating by an NAIC CRP, is not eligible for Schedule D reporting unless the SVO confirms that the transaction is eligible for Schedule D reporting and assigns the transaction an NAIC Designation.

P&P Manual, Page 29 – Credit Tenant Loans:

**CTL Categories**

100. Mortgage loans, in scope of SSAP No. 37, that are made primarily in reliance on the credit standing of a major tenant, structured with an assignment of the rental payments to the lender with real property pledged as collateral in the form of a first lien, are referred to as a Credit Tenant Loan. Four categories of CTLs are recognized as eligible for reporting on Schedule D: Bond Lease Based CTLs; Credit Lease Based CTLs; Acceptable CTL Variants (ACVs); and Multiple Property Transactions (MPTs).

If the limited edits, as shown above, are incorporated, than further revisions to the P&P Manual, particularly to the structural assessment for CTLs and the existing 5% residual risk threshold, are not expected to be needed at this time. It is also believed that this will resolve the current uncertainty and inconsistency with regards to the reporting of securities that have underlying elements of mortgage loan or real estate risk. Although these revisions will clarify the current ability to report securities that represent a creditor relationship under the existing bond definition, it is noted that a current project is underway to establish principles to clarify what should be considered a bond for reporting on Schedule D-1. Once that project is finalized, security structures that do not qualify under those bond principles will be reclassified to a more appropriate schedule.

Thank you for considering this revised proposal. Please contact Dale Bruggeman, or Carrie Mears, SAPWG Chair and Vice Chair, with any questions on this memorandum.
June 28, 2021

Mr. Kevin Fry, Chair
NAIC Valuation of Securities (E) Task Force
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Ms. Carrie Mears, Vice Chair
NAIC Valuation of Securities (E) Task Force
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: Proposed Amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) on Filing Exemption for Real Estate Lease-Backed Securities

Dear Mr. Fry and Ms. Mears,

The American Council of Life Insurers (“ACLI”)1, Private Placement Investors Association (“PPiA”)2, and North American Securities Valuation Association (“NASVA”)3 (collectively, the “undersigned”) appreciate the opportunity to comment on the above-referenced proposed amendment to the P&P Manual.

The undersigned appreciate all the effort of the Valuation of Securities Task Force (“VOSTF”) and Securities Valuations Office (“SVO”) on Credit Tenant Loans and other Real Estate Lease-Backed Securities over the last several years.

As these securities are valuable investments for insurers, and ultimately regulators and policyowners, we would like to offer our full support for the proposed changes as outlined in the exposure. We believe the exposure is the culmination of a years’ long joint effort, in both collaboration and information sharing,

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1 The American Council of Life Insurers (“ACLI”) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 94 percent of industry assets in the United States.

2 The Private Placement Investors Association (“PPiA”) is a business association of insurance companies, other institutional investors, and affiliates thereof, that are active investors in the primary market for privately placed debt instruments. The association exists to provide a discussion forum for private debt investors; to facilitate the development of industry best practices; to promote interest in the primary market for privately placed debt instruments; and to increase accessibility to capital for issuers of privately placed debt instruments. The PPiA serves 63 member companies and works with regulators, NASVA, the American College of Investors Counsel, and the investment banking community to efficiently implement changes within the private placement marketplace. Learn more at www.usppia.com.

3 The North American Securities Valuation Association (“NASVA”) is an association of insurance company representatives who interact with the National Association of Insurance Commissioners Securities Valuation Office to provide important input, and to exchange information, in order to improve the interaction between the SVO and its users. In the past, NASVA committees have worked on issues such as improving filing procedures, suggesting enhancements to the NAIC’s ISIS electronic security filing system, and commenting on year-end processes. Find more information here.
that appropriately treats these securities consistent with other similar securities and is also consistent with Statutory Accounting Principles Working Group’s (SAPWG’s) recently exposed definition of a bond for purposes of Schedule D reporting.

We again sincerely thank the VOSTF, SVO, and regulators for their sustained dialogue on this important matter and we continue to stand ready to offer our assistance and input as needed.

Sincerely,

Mike Monahan Tracey Lindsey John Petchler
American Council of Life Insurer NASVA on behalf of PPiA Board of Directors

cc: Charles Therriault, Director, Securities Valuation Office

G:\SECVAL\DATA\Vos-tf\Meetings\2021\National Meetings\2021 Summer National Meeting\04 - CTL and GLF FE\2021-035.04 REleasdbksecs_Final06281_VOSTFdue062821.docx
Lease-Backed Securities Working Group

To: Mr. Kevin Fry, Chair  
Ms. Carrie Mears, CFA®, Vice Chair  
NAIC Valuation of Securities (E) Task Force  
1100 Walnut Street  
Suite 1500  
Kansas City, MO 64106-2197

June 25, 2012


The members of the Lease-Backed Securities Working Group wholly support the changes which have been proposed to the Purposes and Procedures Manual of the NAIC Investment Office (P&P Manual) clarifying that any real-estate lease-backed transactions issued in the form of securities are eligible for Filing Exempt status in a manner similar to any other bonds.

We strongly agree with the comments which have been submitted in a joint letter from ACLI, the PPIA and NASVA regarding this exposure, which appropriately treats these securities consistent with other similar securities, and is also consistent with Statutory Accounting Principles Working Group’s (SAPWG’s) recently exposed definition of a bond for purposes of Schedule D reporting.

This exposure is the culmination of a years’ long joint effort, in both collaboration and information sharing between regulators and the investment community. We applaud the work that has been done by the members of both the Statutory Accounting Principles Working Group and the Valuation of Securities Task Force, as well as the staff at the Securities Valuation Office, to bring about these changes, which we believe will provide much-needed clarity to the investor community and allow markets which are essential to providing capital to mission critical facilities and infrastructure to reopen once again.

We greatly appreciate your continued time, efforts, and consideration of the proposed changes and clarifications to the P&P Manual and look forward to their speedy adoption.

Sincerely,

JMGarrison

John M. Garrison  
On behalf of the Lease-Backed Securities Working Group

Cc: Charles Therriault  
Mike Monahan  
Mike Reis  
Brian Keating  
John Petchler  
Tracey Lindsay
TO:  Kevin Fry, Chair, Valuation of Securities (E) Task Force
Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

RE: Filing Exemption for Real Estate Lease-Backed Securities

DATE: May 27, 2021

Summary – The SVO staff drafted the attached amendment at the request of the Task Force, based on a proposal referred to the Task Force by the Statutory Accounting Principles (E) Working Group (the Working Group) chairs, intended to clarify the difference between Credit Tenant Loans and real estate lease-backed securities for purposes of amending the Filing Exemption eligibility for each. Initially, at the Task Force’s request, the SVO drafted an amendment to the P&P to permit Credit Tenant Loan (CTL) and Ground Lease Financing (GLF) transactions to use NAIC Credit Rating Provider ratings in the Filing Exemption process and update the residual asset exposure from the current 5% limitation to 50%. If these transactions have greater than a 50% residual asset exposure, they would be ineligible for Filing Exemption. The Working Group chairs proposed an alternate amendment intended to achieve a similar outcome but without requiring the Task Force to opine on acceptable residual thresholds, which is under the purview of the Working Group.

The Working Group chairs contend that the original intent of the CTL provisions when adopted in the 1990s was to allow certain mortgage loans, as currently defined in SSAP No. 37, to be reported on Schedule D-1 as opposed to Schedule B due to the reliance on the creditworthiness of a credit tenant. CTLs have evolved from direct “mortgage loan” structures to “securities” which are expressly excluded from the definition of “mortgage loan” in SSAP No. 37. As such, the Working Group chairs proposed modifying the P&P definition of CTL by clarifying that CTLs only refer to “mortgage loans in scope of SSAP No. 37,” and, by default, not “securities,” which would be in scope of SSAP Nos. 26R or 43R. Real estate lease-backed securities would include CTL-like transactions which meet all the CTL guidelines in the P&P but for a feature making it a security, such as a trust issued certificate, CTL-like securities with balloon payments in excess of 5%, and ground lease financings which do not include a direct mortgage loan from the investor.
Pursuant to the proposed amendment the Working Group would not need to opine on a residual threshold at this time and the Task Force could make its own determination about the Filing Exempt status of these transactions. At the request of the Task Force the amendment would only require CTLs with mortgage loans in scope of SSAP No. 37 to be filed with the SVO for review and potential assignment of an NAIC Designation. All other real estate lease-backed transactions which meet the definition of a “security” would be eligible for Filing Exemption, and have the option to file with the SVO.

**Proposed Amendment** - The text impacting Credit Tenant Loan and Ground Lease Financing Transactions is shown below, addition edits in red underline and deletions in red strikethrough, as it would appear in the 2020 P&P Manual format.
PART ONE

POLICIES OF THE NAIC VALUATION OF SECURITIES (E) TASK FORCE
CTL Categories

100. Mortgage loans, in the scope of SSAP No. 37, that are made primarily in reliance on the credit standing of a major tenant, structured with an assignment of the rental payments to the lender with real property pledged as collateral in the form of a first lien, are referred to as a Credit Tenant Loan. Four categories of CTLs are recognized as eligible for reporting on Schedule D: Bond Lease Based CTLs; Credit Lease Based CTLs; Acceptable CTL Variants (ACVs); and Multiple Property Transactions (MPTs).

GROUN D LEASE FINANCING TRANSACTIONS

108. The ground lease itself typically meets the Credit Tenant Loan (CTL) criteria for Bond Lease Based or Credit Lease Based CTLs in this Manual and is in scope of SSAP No. 37 – Mortgage Loans. Additionally, there can be one or several space tenants or business operators (which (a) may or may not be NAIC CRP rated entities or (b) whose credit worthiness can or cannot be evaluated by the SVO) making lease payments under separate space leases (which may or may not meet the CTL criteria) or a business operation. As such, the SVO cannot rely solely on the CTL criteria for its analysis of GLF transactions and instead must rely on a combination, as necessary and available, of the CTL criteria, the CMBS criteria, the documented analysis of NAIC CRPs, and the SVOs own analytic judgement.
PART THREE
SVO PROCEDURES AND METHODOLOGY FOR PRODUCTION OF NAIC DESIGNATIONS
PROCEDURE APPLICABLE TO FILING EXEMPT (FE) SECURITIES AND PRIVATE LETTER (PL) RATING SECURITIES

... FE SECURITIES

Filing Exemption

3. Bonds, within the scope of SSAP No. 26R and SSAP No. 43R (excluding RMBS and CMBS subject to financial modeling) and Preferred Stock within scope of SSAP No. 32, that have been assigned an Eligible NAIC CRP Rating, as described in this Manual, are exempt from filing with the SVO (FE securities) with the exception of Bonds and/or Preferred Stock explicitly excluded below.

Specific Populations of Securities Not Eligible for Filing Exemption

4. The filing exemption procedure does not apply to:

   - **Credit Tenant Loan (CTL)** – A CTL is a mortgage loan, in scope of SSAP No. 37, made primarily in reliance on the credit standing of a major tenant, structured with an assignment of the rental payments to the lender with real property pledged as collateral in the form of a first lien. This Manual identifies four categories of CTLs as eligible for reporting on Schedule D conditioned on an SVO determination that the transaction meets the criteria specified by the VOS/TF for Schedule D treatment. A transaction that purports to be a Credit Tenant Loan, including one that is assigned a credit rating by an NAIC CRP, is not eligible for Schedule D reporting unless the SVO confirms that the transaction is eligible for Schedule D reporting and assigns the transaction an NAIC Designation. A security which resembles a CTL but is not in scope of SSAP No. 37 – Mortgage Loans, can be filed with the SVO for an NAIC Designation and, if appropriate, the SVO can apply the CTL guidelines in this Part to its review.

...
Ground Lease Financing Transactions – A Ground Lease Financing (GLF) transaction typically has two components: (a) a ground lease for a long period (e.g., 99 years) between a ground lessor who owns the land and a ground lessee who attains a leasehold for the purpose of developing the land; and (b) the subleasing of space or operation of a business such as a hotel, warehouse, intermodal facility, etc., in an existing or to-be-constructed building to one or more tenants (space tenants) under shorter (e.g., 5–15 year) leases (space leases) or to the operator of a business such as a hotel, warehouse, intermodal facility, etc., under a franchise agreement or other arrangement. GLF transactions, in scope of SSAP No. 37 – Mortgage Loans, are not eligible for filing exemption. The GLF section in this Part provides further guidance on how the SVO analyzes GLF transactions for purposes of determining Schedule D eligibility and whether the SVO can assign an NAIC Designation. A security which resembles a GLF transaction but is not in scope of SSAP No. 37 – Mortgage Loans, can be filed with the SVO for an NAIC Designation and, if appropriate, the SVO can apply the GLF guidelines in this Part to its review.
CREDIT TENANT LOANS

...
GROUND LEASE FINANCING TRANSACTIONS

... 

DEFINITION AND OVERVIEW

Ground Lease Financing Transaction – Definition and Overview

108. A ground lease financing (GLF) transaction is in scope of SSAP No. 37 – Mortgage Loans and typically has two components: (a) a ground lease for a long period (e.g., 99 years) between a ground lessor who owns the land and a ground lessee who attains a leasehold for the purpose of developing the land; and (b) the subleasing of space or operation of a business such as a hotel, warehouse, intermodal facility, etc., in an existing or to-be-constructed building to one or more tenants (space tenants) under shorter (e.g., 5–15 year) leases (space leases) or to the operator of a business such as a hotel, warehouse, intermodal facility, etc., under a franchise agreement or other arrangement.
MEMORANDUM

TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force
   Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
       Marc Perlman, Investment Counsel, NAIC Securities Valuation Office (SVO)

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau


DATE: September 10, 2020

1. **Summary** – The Statutory Accounting Principles (E) Working Group adopted updates to SSAP No. 105R Working Capital Finance Investments on May 20, 2020. Key revisions are summarized as follows:
   - Functionally Equivalent Foreign Regulators - Removed the requirement that the Securities Valuation Office (SVO) determine if the International Finance Agent is the functional equivalent of the U.S. regulator.
   - Commingling Prohibitions - Removed the finance agent prohibitions on commingling.
   - Investor Rights Edit - Removed duplicative text regarding exercising of investor rights.
   - Requirements for filer to Certify Perfected Interest – Removed requirements, with revisions allowing the SVO to determine if a first priority perfected interest has been obtained.
   - Finance Agent Validation Requirements – Broadened the independent review requirements to allow independent review of the finance agent by either audit or through an internal control report.
   - Default Date - Changed the default provisions from 15 to 30 days so the default date and the cure period are consistent.
   - Possible Domestic Regulator Approval – Removed the statement that the reporting entity may need to seek approval from the domestic regulator.
2. **Revisions** - The SVO submitted a proposed amendment to the Valuation of Securities (E) Task Force (the Task Force), dated June 15, 2020, to amend the Working Capital Finance Investments (WCFI) section of the P&P Manual to remove any inconsistencies with SSAP No. 105R, as revised. The proposed amendment was received and exposed on July 1, 2020 for a 45-day public comment period that ended on August 17, 2020. The American Council of Life Insurers (ACLI) submitted a detailed comment letter, dated August 17, 2020, recommending additional updates to this section. The SVO staff has reviewed the ACLI’s recommendations and has attached an updated proposed amendment that reflects where the SVO agrees with the ACLI and, as explained below, where it does not.

Generally, the ACLI’s recommendations fall into two categories: (1) those which remove inconsistencies between SSAP No. 105R and the WCFI section of the P&P Manual, thereby adhering to the original purpose of this amendment and, (2) those which would amend WCFI provisions in the P&P Manual which are not identified in SSAP No. 105R and which would impede the SVO’s ability to assess investment risk in WCFI transactions. These analytic provisions were intentionally included in the P&P Manual’s WCFI guidelines to enable the SVO to more accurately assess investment risk in WCFI transactions and they reflect the functional differences between the Accounting Practices & Procedures Manual (AP&P), which is intended to define accounting standards, and the P&P Manual, which is intended guide the assessment of investment risk. The AP&P is not intended to be a substitute for the P&P Manual as only the Task Force is charged to, “… establish and maintain all aspects of the NAIC’s credit assessment process for insurer-owned securities.” The SVO staff has identified the analytical issues below that should be retained in the P&P Manual. These changes are outside of the scope of the SSAP 105R revisions and are necessary for the SVO to perform its responsibility to assess investment risk.

a. **A Certification** (paragraph 102, bullet 5) from the insurance company Investment Officer that the insurance company, in its capacity as an Investor, is not affiliated with the Obligor or with any Supplier in the Working Capital Finance Program, and that the Working Capital Finance Program does not include any insurance or insurance related assets. *This certification relates to the requirements of SSAP No. 105R, paragraph 19 and provides a means by which the SVO can verify that a transaction meets those requirements.*

b. **Process and Methodology** (paragraphs 121) - An NAIC Designation shall be assigned to a Working Capital Finance Program on the basis of a thorough assessment of credit, dilution, operational and other risks, an assessment of protections provided by operative documents to the Investor and the quality of transaction participants. *The assessments of credit, dilution and operational risk are core components of the SVO investment risk assessment for WCFI transactions and none of them conflict with SSAP No. 105R.*

c. **Credit Risk** (paragraphs 122) – The NAIC Designation for a Working Capital Finance Program shall be linked to the credit quality of the Obligor, which may be determined by reference to a credit rating assigned by a NAIC CRP or by an NAIC Designation assigned by the SVO. Credit risk is assessed by the SVO analyst in accordance with any permitted methodology set forth in this Manual for corporate obligors. *The assessments of credit is a core component of the SVO investment risk assessment for WCFI transactions and does not conflict with SSAP No. 105R.*

d. **Dilution Risk** (paragraphs 107, 121, and 123) – This element of the SVO’s analysis is crucial for an accurate assessment of investment risk because it is necessary for the SVO to consider the risk that disputes or certain contractual provisions may reduce the amount of the obligation owed by the obligor to the supplier and thereby impact the insurance company investor.
3. **Recommendation** – The SVO staff recommends re-exposure of this amendment with the changes recommended by the ACLI, excluding the analytically necessary items identified above, to align with the adopted updates to SSAP No. 105R – *Working Capital Finance Investments*.

4. **Proposed Amendment** – The following shows the proposed revisions in Part Three with text in red identifying the changes proposed on July 15, 2020 and additional revisions and comment letter responses in yellow highlight.
PART THREE

SVO PROCEDURES AND METHODOLOGY FOR PRODUCTION OF NAIC DESIGNATIONS
WORKING CAPITAL FINANCE INVESTMENTS


Initial Filing Requirements

102. An insurance company requesting an analysis of a proposed Working Capital Finance Program shall provide the SVO with the documentation described in this subparagraph:

- An RTAS Application.
- The Obligor’s Audited Financial Statements, if the Obligor is not rated for credit risk by a NAIC CRP.
- The insurance company’s Investment Committee Memorandum for the proposed Working Capital Finance Program.
- The audited consolidated financial statements of the group of which the Finance Agent for the Working Capital Finance Program is a part, and one of the following:
  - An annual independent report according to Statement on Standards for Attestation Engagements (SSAE) No. 16 (or functional equivalent), reporting on controls at a service organization related to the administration of the investment.
  - An annual audit of the financial statement and internal controls of the consolidated group of which the Finance Agent is part, which does not note any material weakness related to servicing working capital financial investments.
- A Certification from the insurance company’s Chief Investment Officer that the insurance company, in its capacity as an Investor, is not affiliated with the Obligor or with any Supplier in the Working Capital Finance Program, and that the Working Capital Finance Program does not include any insurance or insurance related assets.
- A Certification from the insurance company’s Legal Counsel.
- In the case of a participation, that it has a commercially reasonable belief that its participation interest meets the Uniform Commercial Code’s standards for creating and preserving first priority security interests in the payments due and in the Confirmed Supplier Receivables.
• In the case of a certificate, note or other manifestation, representing a right to payment from a trust, other special purpose entity, or special purpose pool holding confirmed supplier receivables, that it has a commercially reasonable belief that the documents establishing and governing the Working Capital Finance Program create and preserve interests in the Confirmed Supplier Receivables capable of being enforced by the trustee or other entity holding Confirmed Supplier Receivables as first priority perfected security interests under the Uniform Commercial Code.

NOTE: Please refer to SSAP No. 105—Working Capital Finance Investments for the definition of a “commercially reasonable belief.”

A copy of:

- The document(s) that create the Working Capital Finance Investments (i.e., the short-term receivables) that is the subject of the RTAS – Emerging Investment Vehicle Service Application, and establishes the obligations of the Obligor to, and the protection afforded owners of, Working Capital Finance Investments (including the Investors). This agreement is sometimes referred to as the Invoice Payment Terms Acknowledgement, the Payable Services Agreement or the Paying Services Agreement.

  NOTE: Please refer to “The Regulatory Treatment Analysis Service – Emerging Investment Vehicle” in Part Two for guidance regarding the filing of an RTAS Application with the SVO.

- The agreement(s) between the Obligor and the Finance Agent governing the administration of the Working Capital Finance Program and the Working Capital Finance Investments issued thereunder. These agreements may be included in the documents mentioned above or may be a stand-alone agreement which are sometimes referred to as the Settlement Services Agreement or the Invoice-Related Electronic Services Agreement.

- The agreement governing the sale of the Working Capital Finance Investments from the Supplier to the Finance Agent. This agreement is sometimes referred to as the Receivables Purchase Agreement or the Supplier Agreement. The agreement governing the ongoing purchase of Working Capital Finance Investments or an interest in Working Capital Finance Investments by the Investor from the Finance Agent. This agreement is sometimes referred to as the Agency Agreement, the Participation Agreement or the Program Trust Agreement.
Subsequent Filing Requirements

103. Subsequent filing requirements include:

- Copies of any of the documents originally submitted with the RTAS Application subsequently amended.

- The audited consolidated financial statements of the group of which the Finance Agent for the Working Capital Finance Program is a part, and one of the following:
  - An annual independent report according to Statement on Standards for Attestation Engagements (SSAE) No. 16 (or functional equivalent), reporting on controls at a service organization related to the administration of the investment; or
  - An annual audit of the financial statements and internal controls of the consolidated group of which the Finance Agent is part, which does not note any material weakness related to servicing working capital financial investments.

Definitions in *SSAP No. 105R—Working Capital Finance Investments*

104. Please refer to *SSAP No. 105R—Working Capital Finance Investments*, for the definitions and associated definitional guidance insurance companies must understand and comply with before applying for a NAIC Designation for Working Capital Finance Programs that would permit them to purchase Working Capital Finance Investments.

105. With the exception of the definitions for Dilution Risk and Operational Risk below, the definitions shown below are summaries of those contained in *SSAP No. 105R—Working Capital Finance Investments* intended only to facilitate a discussion and in all cases subordinate to the definitions in SSAP No. 105R.
Summary of Key Definitions

106. **Confirmed Supplier Receivable** – A receivable sold by a Supplier to a Finance Agent or Investor (or by a Finance Agent to an Investor) under a Working Capital Finance Program designated by the SVO that requires the Obligor to confirm to the Finance Agent or Investor, prior to the sale of the receivable from the Supplier to the Finance Agent or Investor, that it has no defenses to payment of the monetary obligation represented by the receivable against the Supplier and, therefore, no defenses to payment of the same monetary obligation to the Finance Agent and/or Investor after such sale. The confirmation by the Obligor that it has no defenses to payment includes confirmation that the Obligor does not have a right to refuse payment that it may have acquired with respect to underlying commercial trade transaction and that, if it has such a right, it will not assert such defenses against the Finance Agent or Investor.

107. **Dilution Risk** – With respect to any Working Capital Finance Program, dilution risk refers to disputes or contractual provisions that may reduce the amount of the obligation owed by the Obligor to the Supplier under the original receivable or the obligation owed by the Obligor to the Finance Agent and/or Investor under the Confirmed Supplier Receivable. Examples of dilution risk are credit for returns of defective goods or an allegation of fraud, such as that the invoice is not legitimate or is a duplicate invoice.

108. **Finance Agent** – A bank, financial institution, financial intermediary or service provider that facilitates the Working Capital Finance Program that arranges the sale, assignment or transfer of the Confirmed Supplier Receivable to the Investor and administers payment.

109. **Investor** – The insurance company that files the RTAS Application with the SVO in order to obtain an NAIC Designation for a proposed Working Capital Finance Program.

110. **Obligor** – An entity that purchases the goods or services from the Supplier and thereby generates the original supplier receivable—and which Obligor has, or can be designated, **NAIC 1** or **NAIC 2** by the SVO or has been assigned an equivalent credit rating by a NAIC CRP.

111. **Operational Risk** – With respect to any Working Capital Finance Program, operational risk refers to the combined effect of the procedures and parties employed to implement the program and their responsibility under the documents and to the determination by the SVO of whether these procedures and parties will ensure full and timely performance by the Obligor of the payment obligation to the Investor. An example of an operational risk is the confirmation process employed to verify that the Obligor has no defenses to payment.
112. **Supplier** – The entity that sells the goods or services to the Obligor, obtains a receivable from the Obligor in exchange and subsequently chooses to sell the right to receive the payment associated with the receivable to the Finance Agent or Investor under the terms of a Working Capital Finance Program designated **NAIC 1** or **NAIC 2** by the SVO.

113. **Working Capital Finance Program** – The program created for the Obligor and its Suppliers by a Finance Agent the terms of which permits Suppliers to the Obligor to negotiate the sale of a right to receive payment from the Obligor (which is associated with and evidenced by a receivable) to the Finance Agent or an Investor.

114. **Working Capital Finance Investment** – The right to receive the payment associated with a Confirmed Supplier Receivable purchased by an Investor under a Working Capital Finance Program designated **NAIC 1** or **NAIC 2** by the SVO and is the subject of SSAP No. 105R—Working Capital Finance Investments.

**NOTE**: SSAP No. 105R—Working Capital Finance Investments imposes reporting and statutory accounting requirements on insurance company investments in Working Capital Finance Investments and specifies analytical procedures to be applied or analytical controls to be verified by the SVO that are not detailed above. Insurance companies are strongly advised to become familiar with SSAP No. 105R before filing an RTAS Application with the SVO.

**Direction and Program Parameters**

115. The SVO may assign an NAIC Designation to a Working Capital Finance Program that would generate Working Capital Finance Investment that meet the criterion and standards identified in this Section.


117. Upon completion of its risk assessment, the SVO will issue an RTAS Letter indicating a preliminary NAIC Designation; i.e., the NAIC Designation that would be assigned if the Investor enters into a Working Capital Finance Program with a Finance Agent and sought to report it to the SVO.

**NOTE**: A preliminary NAIC Designation cannot be used for statutory reporting purposes.

118. The SVO shall issue a final NAIC Designation to the Investor for the Working Capital Finance Program and the Working Capital Finance Investments generated thereunder upon receipt of fully executed final copies of the required documentation.
Variations in Structure

119. Working Capital Finance Programs may differ in structure and in the protection afforded the Investor. Structural strength and weaknesses of various structures in such programs will be reflected in the NAIC Designation assigned by the SVO.

Program Quality

120. The SVO shall only assign an NAIC Designation to Working Capital Finance Programs that can be designated NAIC 1 or NAIC 2. Credit quality is measured by reference to a NAIC CRP credit rating or an NAIC Designation assigned by the SVO. The SVO shall withdraw the NAIC Designation assigned to a Working Capital Finance Program on the date the Obligor’s NAIC CRP credit rating or NAIC Designation is downgraded to NAIC 3 or its NAIC CRP equivalent.

NOTE: SSAP No. 105R—Working Capital Finance Investments provides that Working Capital Finance Investments generated under a Working Capital Finance Program of an Obligor that falls below the equivalent of NAIC 1 or NAIC 2 becomes nonadmitted.

Process and Methodology

121. An NAIC Designation shall be assigned to a Working Capital Finance Program on the basis of a thorough assessment of credit, dilution, operational and other risks, an assessment of protections provided by operative documents to the Investor and the quality of transaction participants.

Risk-Assessment Process

122. Credit Risk – The NAIC Designation for a Working Capital Finance Program shall be linked to the credit quality of the Obligor, which may be determined by reference to a credit rating assigned by a NAIC CRP or by an NAIC Designation assigned by the SVO. Credit risk is assessed by the SVO analyst in accordance with any permitted methodology set forth in this Manual for corporate obligors.

123. Dilution Risk – To achieve an NAIC 1 or NAIC 2 Designation, the Working Capital Finance Program must eliminate dilution risk in the Working Capital Finance Investment proposed to be eligible for purchase by the Investor. The terms governing the Investor’s Working Capital Finance Investment must eliminate Obligor recourse to its Supplier as a condition to payment of the obligation to the Investor so as to result in an unconditional right to receive payment on a full and timely basis.

124. Operational Risk – To achieve an NAIC 1 or NAIC 2 Designation, all operational risks shall be identified and assessed. Key participants shall have a NAIC CRP credit rating or an NAIC Designation assigned by the SVO at a level at least that of the Obligor.
Legal, Structural and Regulatory Considerations

125. Events of default remedies should provide the Investor at least those rights and privileges, unimpaired, of a trade creditor upon default with no Obligor defenses that could cause dilution of principal.

126. The SVO shall verify that either, (i) the Finance Agent is must be an entity regulated or supervised by a financial regulator in one of the countries in the List of Foreign (non-US) Jurisdictions Eligible for Netting for Purposes of Determining Exposures to Counterparties for Schedule DB, Part D, Section 1 and that the regulator is the functional equivalent of the Board of Governors of the Federal Reserve System, the Office of the Comptroller of the Currency (OCC) or the Federal Deposit Insurance Corporation (FDIC). In the alternative, or (ii) the SVO shall verify that payments due the Investor are made directly by the Obligor (a) to the Investor or (b) into an account maintained by a regulated financial institution for the benefit of Investors in the Working Capital Finance Program, and, in either case, the Finance Agent cannot be the beneficiary of such payment with no commingling of funds or assets with those of the Obligor, Supplier, Servicer or Trust Administrator or other Investors.

127. The SVO will verify that the Certification from the insurance company's Chief Investment Officer confirms that the Investor is not affiliated with Obligor and that Working Capital Finance Investment excludes insurance or insurance-related assets.

128. The SVO will verify that the Certification from the insurance company’s Legal Counsel confirms the existence of a commercially reasonable belief that the documents establishing and governing the Working Capital Finance Program establishes the rights and UCC code standard for preserving first priority perfected interest in Confirmed Supplier Receivables.

129. The remedies available to the participants in the Working Capital Finance Program should be expressly identified in the documentation for the Working Capital Finance Investment.

130. Characteristics that shall be present in a proposed Working Capital Finance Investment include, but are not limited to, the following, or a substantial equivalent:

131. The Obligor makes payments directly to the (a) Investor; (b) Finance Agent; or (c) servicer for the Working Capital Finance Program.

132. The Investor must have the option, and not an obligation, to purchase subsequent Working Capital Finance Investment so as to ensure the Investor can exit the Working Capital Finance Investment by permitting existing investments to mature.
133. **SSAP No. 105R—Working Capital Finance Investments** provides that the documentation governing Working Capital Finance Programs must provide that disputes arising under the agreements shall be submitted to a court of competent jurisdiction in the U.S. or be subject to an alternative dispute resolution process sanctioned by state law. Given the nature of Working Capital Finance Programs, the SVO anticipates that documentation governing Working Capital Finance Investments will be subject to the laws and jurisdiction of the courts of California, Delaware or New York, or a similar legal jurisdiction with significant exposure to sophisticated institutional financial transactions.

134. Events of default must be clearly defined, and provide a mechanism that gives the Investor the ability to pursue collection unfettered by actions taken or not taken by participants such as the Servicer or Trustee, or other named persons performing similar functions.
FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE

2022 Proposed Charges (Attachment One) .....................................................................................................................11-4
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Comment Letters Regarding Exposed 2020 Revisions to Model #440 and Model #450 as an Update to the Accreditation Standards (Attachment Four)...........................................................................................................11-18
Modified 2020 Revisions to Model #440 and Model #450 as an Update to the Accreditation Standards Exposure (Attachment Five)...................................................................................................................................................11-27
The Financial Regulation Standards and Accreditation (F) Committee met Aug. 14, 2021. The following Committee members participated: Elizabeth Kelleher Dwyer, Chair (RI); Lori K. Wing-Heier, Vice Chair (AK); Alan McClain (AR); Andrew N. Mais (CT); Colin M. Hayashida (HI); Sharon P. Clark (KY); Gary D. Anderson (MA); Eric A Cioppa (ME); Troy Downing (MT); Mike Causey represented by Jackie Obusek (NC); Eric Dunning (NE); Larry D. Deiter (SD); Doug Slape (TX); Scott A. White (VA); and Jeff Rude (WY). Also participating was: Justin Schrader (NE).

1. **Adopted its Spring National Meeting Minutes**

Director Wing-Heier made a motion, seconded by Commissioner Mais, to adopt the Committee’s April 12 minutes (see NAIC Proceedings – Spring 2021, Financial Regulation Standards and Accreditation (F) Committee). The motion passed unanimously.

Superintendent Dwyer said the Committee met Aug. 13 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings. During this meeting, the Committee voted to award continued accreditation to Arkansas, District of Columbia, Indiana, Michigan, and New Jersey.

2. **Adopted its 2022 Proposed Charges**

Superintendent Dwyer discussed a memorandum that includes the Committee’s 2022 proposed charges, noting the proposed charges are unchanged from the Committee’s 2021 charges.

Commissioner Clark made a motion, seconded by Superintendent Cioppa, to adopt the Committee’s 2022 proposed charges (Attachment One). The motion passed unanimously.

3. **Adopted Revisions to the Part A Preamble to Account for Inclusion of Model #787 as a New Accreditation Standard**

Superintendent Dwyer stated that at the 2019 Fall National Meeting, the Committee adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (#787), more commonly referred to as the XXX/AXXX Model Regulation, as a new accreditation standard, and the decision was confirmed by Plenary at the 2020 Summer National Meeting. Model #787 establishes uniform standards governing reserve financing arrangements pertaining to term life and universal life insurance policies with secondary guarantees. Model development was prompted by concerns regarding the security held under these transactions and an interim solution, outlined by the XXX/AXXX Captive Reinsurance Framework, was included in the accreditation program through the Part A Preamble. With the adoption of Model #787, an update to the Part A Preamble to reference codification of the framework in the form of Model #787 was therefore exposed at the 2021 Spring National Meeting. There were no comment letters received during the exposure period.

In addition, the Preamble includes references to variable annuity and long-term care (LTC) captives, which both have to-be-determined effective dates. Previously, the Committee asked the Financial Condition (E) Committee to conduct some research into the extent these captives are now used. This information will help the Committee determine how to proceed regarding effective dates. That work is ongoing, and an update is expected at the Fall National Meeting.

Commissioner White made a motion, seconded by Commissioner McClain to adopt the revisions to the Part A Preamble to reference Model #787 (Attachment Two). The motion passed unanimously.

4. **Exposed 2020 Revisions to Model #440 and Model #450 as an Update to the Accreditation Standards**

Superintendent Dwyer stated that in December 2020, the NAIC adopted revisions to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation (#450). These revisions implement a group capital calculation (GCC) for the purpose of group solvency supervision and a liquidity stress test (LST) for macroprudential surveillance. A referral was exposed for a 30-day comment period, which ended May 13 (Attachment Three). The exposure recommended that the accreditation standard be applicable to all states with an effective date of Jan. 1, 2026.
Superintendent Dwyer said there were five comment letters received during the exposure period from Louisiana, Mississippi, North Carolina, South Dakota, and Texas (Attachment Four). All five comment letters address the significant elements related to the exemptions to the GCC. Specifically, they recommend that commissioners should be allowed to grant exemptions to companies meeting the standards set forth in the regulation without requiring the GCC filing at least once. In addition, one comment letter recommends the LST requirements should only be applicable to states with a group subject to the LST. The Committee will consider whether to expose the revisions to the accreditation standards consistent with the initial referral or modify the significant elements for exposure to allow exemptions for qualifying groups meeting the standard set forth in Model #450, Section 21A and Section 21B without the requirement to file at least once.

Director Deiter stated he supports modifying the exposure to allow exemptions for qualifying groups meeting the standard set forth in Model #450, Section 21A and Section 21B without the requirement to file at least once. He said that the modifications satisfy the South Dakota Division of Insurance’s concerns noted in its letter and that South Dakota supports the revisions as an accreditation standard.

Chief Deputy Commissioner Slape stated that Texas is supportive of the GCC and LST, but it is not supportive of the modifications to the accreditation requirement because the modifications do not fully address the concerns laid out in the comment letter from Texas. He said a “no” vote from Texas is not a signal of not supporting the models, but is a no to the proposed accreditation standard.

Mr. Schrader stated that Nebraska is supportive of the proposed modification. He noted that the Financial Condition (E) Committee and the Group Capital Calculation (E) Working Group discussed this referral at great length and that this is an unusual situation where the Committee and accreditation is straying from the Financial Condition (E) Committee’s recommendation in its referral. He asked for confirmation that the modification to the accreditation requirement would still give the states the authority to be stricter and does not preclude the commissioner from asking for a GCC in a situation that warrants it on a specific basis, even if that threshold was not met once this becomes an accreditation standard. He also asked that the Committee provide language so that states that do adopt the referral as modified have something to give their legislature to ensure consistency among states.

Dan Schelp (NAIC) stated that accreditation standards are minimum standards for solvency requirements and that states can be more conservative in their requirements. He also stated that the NAIC legislative counsel will provide information to the states regarding these changes and what options are available.

Ms. Obusek stated that North Carolina is in favor of the exposure as modified.

Director Deiter made a motion, seconded by Commissioner Rude, to expose the Financial Condition (E) Committee referral (Attachment Three), as modified (Attachment Five), for the Insurance Holding Company Systems accreditation standard to include the 2020 revisions to Model #440 and Model #450 related to CGC and LST for a one-year public comment period beginning Jan. 1, 2022. The proposed effective date is Jan. 1, 2026. The proposed standards for the GCC are modified from the original referral to allow exemptions to qualifying groups meeting the standards set forth in Model #450 Section 21A and Section 21B without the requirement to file at least once. This will be done by adding a question that states: “Although not required for accreditation, in order to grant an exemption, is the filing required at least once.” The motion passed. Alaska, Arkansas, Connecticut, Hawaii, Kentucky, Maine, Massachusetts, Montana, Nebraska, North Carolina, South Dakota, Virginia, and Wyoming voted in favor. Texas voted against.

Having no further business, the Financial Regulation Standards and Accreditation (F) Committee adjourned.
MEMORANDUM

TO: Members of the Financial Regulation Standards and Accreditation (F) Committee

FROM: Becky Meyer, Senior Accreditation Manager

DATE: July 26, 2021

RE: 2022 Proposed Charges

Below are the Financial Regulation Standards and Accreditation (F) Committee’s 2022 proposed charges. There have been no substantive changes from the Committee’s 2021 charges.

The mission of the Financial Regulation Standards and Accreditation (F) Committee is both administrative and substantive, as it relates to the administration and enforcement of the NAIC Financial Regulation Standards and Accreditation Program. This includes, without limitation: 1) the consideration of standards and revisions of standards for accreditation; 2) the interpretation of standards; 3) the evaluation and interpretation of the states’ laws and regulations, as well as departments’ practices, procedures, and organizations as they relate to compliance with standards; 4) the examination of members for compliance with standards; 5) the development and oversight of procedures for the examination of members for compliance with standards; 6) the selection of qualified individuals to examine members for compliance with standards; and 7) the determination of whether to accredit members.

Ongoing Support of NAIC Programs, Products or Services

1. The Financial Regulation Standards and Accreditation (F) Committee will:
   A. Maintain and strengthen the NAIC Financial Regulation Standards and Accreditation Program.
   B. Assist the states, as requested and as appropriate, in implementing laws, practices, and procedures and obtaining personnel required for compliance with the standards.
   C. Conduct a yearly review of accredited jurisdictions.
   D. Consider new model laws; new practices and procedures; and amendments to existing model laws, practices, and procedures required for accreditation. Determine the timing and appropriateness of the addition of new model laws, practices, procedures, and amendments.
   E. Render advisory opinions and interpretations of model laws required for accreditation and on substantial similarity of state laws.
   F. Review existing standards for effectiveness and relevancy, and make recommendations for change, if appropriate.
   G. Produce, maintain, and update the NAIC Accreditation Program Manual to provide guidance to state insurance regulators regarding the official standards, policies, and procedures of the program.
H. Maintain and update the “Financial Regulation Standards and Accreditation Program” pamphlet.

I. Perform enhanced pre-accreditation review services, including, but not limited to, additional staff support, increased participation, enhanced report recommendations, and informal feedback.
MEMORANDUM

TO: Financial Regulation Standards and Accreditation (F) Committee

FROM: NAIC Staff

DATE: March 15, 2021

RE: Part A Preamble Update for the Term and Universal Life Insurance Reserve Financing Model Regulation (#787)

In 2019, the Financial Regulation Standards and Accreditation (F) Committee adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) as a new Part A accreditation standard, effective Sept. 1, 2022, with enforcement to begin Jan. 1, 2023. Model #787 establishes uniform, national standards governing captive reinsurance agreements pertaining to term and universal life insurance policies with secondary guarantees. Prior to Model #787, Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (Model #830) (AG48) was adopted as an interim step to address concerns regarding such reserve financing transactions. Model #787 completes the XXX/AXXX Reinsurance Framework by codifying the concepts in AG 48.

The NAIC Reinsurance Framework is discussed in the Part A Preamble under the section for captive reinsurers. The current iteration includes reference to the Reinsurance Framework and the impact on compliance with accreditation for captive reinsurers regarding specific lines of business. The lines of business include policies applicable under Section 3 of Model #787, commonly referred to as XXX/AXXX policies. The applicable excerpt of the Preamble is attached and includes recommended tracked changes to reference Model #787. The updates are not considered substantive, but rather are to ensure consistency with the adoption of Model #787 as the new standard for compliance.

Following adoption of AG 48 and prior to the effective date of Model #787, NAIC staff have performed an annual review of all insurers with applicable transactions. The review is designed to ensure all applicable transactions comply with the Reinsurance Framework and, as a result, comply with the Part A accreditation standards. NAIC staff will continue this review until the effective date of Model #787, at which time enactment of the model will be the measure of compliance.
Excerpt from Accreditation Manual – Part A Preamble

Captive Reinsurers
The following Part A standards apply to the regulation of a state’s domestic insurers licensed and/or organized under its captive or special purpose vehicle statutes or any other similar statutory construct (captive insurer) that reinsure business covering risks residing in at least two states, but only with respect to the following lines of business:

1) Term and universal life with secondary guarantee policies that are applicable under Section 3 of the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) required to be valued under Sections 6 or 7 of the Valuation of Life Insurance Policies Model Regulation (Model #830) (commonly referred to as XXX/AXXX policies). The application of this provision is intended to have a prospective-only effect, so that regulation of captive insurers, special purpose vehicles and any other entities that reinsure these types of policies will not be subject to the Part A standards if the policies assumed were both (1) issued prior to Jan. 1, 2015, and (2) ceded so that they were part of a reinsurance arrangement as of Dec. 31, 2014. [Drafting Note: This paragraph of the Preamble became effective Jan. 1, 2016]

2) Variable annuities valued under Actuarial Guideline XLIII—CARVM for Variable Annuities (AG 43). [Drafting Note: This paragraph of the Preamble is not yet effective. Effective date for compliance to be determined.]

3) Long term care insurance valued under the Health Insurance Reserves Model Regulation (Model #10). [Drafting Note: This paragraph of the Preamble is not yet effective. Effective date for compliance to be determined.]

The NAIC Executive (EX) Committee adopted the XXX/AXXX Reinsurance Framework, and the NAIC is currently in the process of adopting actions necessary for its full implementation. With regard to a captive insurer, special purpose vehicle, or any other entity assuming XXX/AXXX business, regulation of the entity is deemed to satisfy the Part A accreditation requirements if the applicable reinsurance transaction complies with Model #787, satisfies the XXX/AXXX Reinsurance Framework requirements adopted by the NAIC.

[Drafting Note: The Part A standards with respect to entities assuming variable annuities and long term care reinsurance business are intended to be effective with respect to both currently in-force and future business. However, the effective dates for variable annuities and long term care insurance are not yet determined, and their application to in-force business need further discussion].
MEMORANDUM

To: Financial Regulation Standards and Accreditation (F) Committee

From: Financial Condition (E) Committee

Date: March 8, 2021

Re: 2020 Revisions to Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)

On Dec. 9, 2020, the NAIC Executive (EX) Committee and Plenary unanimously adopted revisions to the NAIC Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). These revisions implemented a Group Capital Calculation (GCC) for the purpose of group solvency supervision and Liquidity Stress Test (LST) for macroprudential surveillance.

Please find attached, memorandums and proposed changes to the Accreditation (E) Committee as adopted by the Financial Condition (E) Committee related to these most recent changes to #440 and #450. Each of the memorandum’s summarize the basis for recommending that certain provisions of these model changes become part of the Accreditation program as well as suggested timing. With respect to timing, consistent with action taken by the Financial Regulation Standards and Accreditation (F) Committee to use an expedited process in 2019 with respect to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) due to the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement), we recommend a similar expedited process with respect to states who are a Group Wide Supervisor of a group with operations in the EU or UK. The attached provide further details on the specifics of such recommendations.
MEMORANDUM

To: Financial Condition (E) Committee

From: Group Capital Calculation (E) Working Group

Date: February 25, 2021

Re: 2020 Revisions to Insurance Holding Company System Regulatory Model Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)

Executive Summary

On Dec. 9, 2020, the NAIC Executive (EX) Committee and Plenary unanimously adopted revisions to the NAIC Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). These revisions implemented a Group Capital Calculation (GCC) for the purpose of group solvency supervision and Liquidity Stress Test (LST) for macroprudential surveillance. This memorandum makes recommendations with respect to the accreditation standards that this Working Group believes is appropriate with respect to only the GCC and expect the Financial Stability (EX) Task Force to make separate recommendations to the Committee with respect to the LST.

The GCC was developed as a result of discussions which began in 2015. The GCC is a natural extension of work state insurance regulators had begun, in part by lessons learned from the most recent financial crisis, to better understand an insurance group’s financial risk profile for the purpose of enhancing policyholder protections. While state insurance regulators currently have the authority to obtain information regarding the capital positions of non-insurance affiliates, they do not have a consistent analytical framework for evaluating such information. The GCC is designed to address this shortcoming and will serve as an additional financial metric that will assist state insurance regulators in identifying risks that may emanate from a holding company system. The GCC, and related financial reporting, will provide comprehensive transparency to state insurance regulators, making risks more easily identifiable and quantifiable. For these reasons, the Working Group recommends adoption of #440 and #450 as accreditation standards for all states with the normal accreditation timeline, which would result in an effective date of January 1, 2026.

In addition, the GCC is intended to comply with the requirements under the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement), which was signed on Sept. 22, 2017. On Dec. 18, 2018, a similar Covered Agreement was signed with the United Kingdom (UK). The GCC is intended to meet the requirement that the states have a “worldwide group capital calculation” in place by Nov. 7, 2022 in order to avoid the EU from imposing a group capital assessment or requirement at the level of the worldwide parent undertaking. Failure of any state to do so for any U.S. group operating in such jurisdiction raises the potential for any supervisor in the EU or UK to impose its own group capital calculation (e.g., Solvency II capital requirements) on that group and therefore all of the U.S. insurers within that group. Due to this agreement, the Working Group recommends that the accreditation standard become effective Nov. 7, 2022 for those states who are the Group Wide Supervisor of a group with operations in the EU or UK.
A statement and explanation of how the potential standard is directly related to solvency surveillance and why the proposal should be included in the standards:

The current Insurance Holding Company Systems accreditation standard requires that state law shall contain the significant elements from Model #440 and Model #450. These models have provided state insurance departments the framework for insurance group supervision since the early 1970s. Following the 2008 financial crisis, state regulators identified group supervision as an area where improvements could be made to the U.S. system. In December 2010, the NAIC adopted changes to the models enhancing the domestic legal structure under which holding companies are supervised. In December 2014, the NAIC adopted revisions to clarify legal authority and powers to act as a group-wide supervisor for internationally active insurance groups. These changes are newly required elements of the NAIC Accreditation Program and have been satisfactorily adopted by nearly all accredited U.S. jurisdictions. As discussed in the preceding paragraphs, the GCC was designed to enhance these same standards that were previously included as accreditation standards.

A statement as to why ultimate adoption by every jurisdiction may be desirable:

The Group Capital Calculation (E) Working Group believes that all states that are the lead state for a group subject to the GCC should be required to adopt the model revisions. The GCC is a tool intended to help protect the policyholders in all states from the risk that can emanate from outside the domestic insurer and will be an input into the Group Profile Summary (GPS). After an initial filing by all insurance groups, the GCC is required for all U.S. insurance groups with greater than $1 billion in premium. The groups subject to the GCC are expected to have domestic insurers in most U.S. states. Therefore, it is recommended that the new significant elements apply to all states.

A statement as to the number of jurisdictions that have adopted and implemented the proposal or a similar proposal and their experience to date:

We are not currently aware of any states that have adopted the 2020 revisions to Model #440 and Model #450, although we have been advised that many states have begun their legislative processes for adoption of these revisions.

A statement as to the provisions needed to meet the minimum requirements of the standard. That is, whether a state would be required to have “substantially similar” language or rather a regulatory framework. If it is being proposed that “substantially similar” language be required, the referring committee, task force or working group shall recommend those items that should be considered significant elements:

The current accreditation standard for Model #440 and Model #450 requires state adoption on a substantially similar basis. Therefore, the Group Capital Calculation (E) Working Group supports the attached proposed significant elements (Attachment A) be adopted by NAIC-accredited jurisdictions in a “substantially similar” manner, as that term is defined in the Accreditation Interlineations of the NAIC Financial Regulation Standards and Accreditation Program. The Financial Regulation Standards and Accreditation (F) Committee should consider a waiver of procedure as provided for in the Accreditation Program Manual and expeditiously consider adoption of this standard. The Group Capital Calculation (E) Working Group recommends that the accreditation standard become effective Nov. 7, 2022, the end of the 60-month period contemplated under the Covered Agreement, with enforcement of the standard to commence Jan. 1, 2023. However, the Working Group is also supportive of the effective date being bifurcated to allow those states that are not the Group Wide Supervisor of a group with operations in the EU or UK to be subject to a later effective date in line with the normal accreditation timeline, which would result in an effective date of January 1, 2026.
There were also revisions made to Section 8 of Model #440 regarding Confidential Treatment. The Group Capital Calculation (E) Working Group strongly supports the use of language similar to that contained in Section 8G of Model #440. This language was considered very critical to the GCC as its very important that members of the insurance industry (or regulators) not be allowed to make the results of the GCC public in any way as they are designed as regulatory-only tools. Unlike RBC that has regulatory trigger points, the GCC does not, and the regulators of these groups believed it would be detrimental if these tools were used by insurers as a means to advertise their relative solvency strength.

An estimate of the cost for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it, if reasonably quantifiable:

The NAIC has not performed a cost/benefit analysis with respect to the 2020 revisions to Model #440 and Model #450, nor do we believe that the specific costs for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it are reasonably quantifiable. However, the possible exemptions allowed under Model #450 are specifically designed to consider the cost to complete the GCC by the insurance company and the benefits of the GCC to the lead-state commissioner. More specifically, all insurers are required to submit the GCC at least once, after which time the expectation is that the lead state commissioner will evaluate the added insight brought to the state from GCC; then, provided the group has premium less than $1 billion, no international business, no risky non-regulated entities and no banks or similar capital regulated entities in the group, the lead state commissioner can exempt the group from filing in the future.

In addition, the construction of the GCC also considers cost of completion and specifically provides a principle-based approach where the insurance company can exclude non-risky affiliates from the calculation and also provides the insurance company to group the information of multiple non-insurance/non-regulated affiliates as a means to further reduce the burden of completion. In short, the GCC is only as complex as the insurance group has structured itself, and therefore the GCC already inherently considers the cost to comply.
6. Insurance Holding Company Systems

State law should contain the NAIC Insurance Holding Company System Regulatory Act (#440), or an act substantially similar, and the department should have adopted the NAIC Insurance Holding Company System Model Regulation (#450).

Insurance Holding Company Systems – continued

Changes to Existing

k. Filing requirements for the enterprise risk filing similar to those specified in Section 4L(1) of the Model #440?

New

l. Filing requirements for the group capital calculation filing similar to those specified in Section 4L(2) of Model #440?

i. The ultimate controlling person of every insurer subject to registration shall annually file a group capital calculation completed in accordance with the NAIC Group Capital Calculation Instructions as directed by the lead state commissioner similar to section 4L(2)?

ii. Provision for exempting an insurance holding company system that has only one insurer within its holding company structure, that only writes business [and is only licensed] in its domestic state and assumes no business from any other insurer, similar to 4L(2)(a)?

iii. Provision for exempting an insurance holding company system that is required to perform a group capital calculation specified by the U.S. Federal Reserve? If the Federal Reserve Board cannot share the calculation with the lead state commissioner, the insurance holding company system is not exempt from the GCC, similar to 4L(2)(b)?

iv. Provision for exempting an insurance holding company system whose non-U.S. group-wide supervisor is located within a Reciprocal Jurisdiction that recognizes the U.S. state regulatory approach to group supervision and group capital, similar to 4L(2)(c)?

v. Provision for exempting an insurance holding company system that provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program and whose non-U.S. group-wide supervisor that is not in a Reciprocal Jurisdiction recognizes and accepts the GCC as the worldwide group capital assessment for U.S. insurance groups who operate in that jurisdiction, similar to 4L(2)(d)?

vi. Provision that gives the lead state the authority to require the GCC for U.S. operations of any non-U.S. based insurance holding company system where after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes, similar to 4L(2)(e)?

Changes to Existing

c. Provisions for protecting confidential information submitted to the commissioner, including provisions maintaining confidentiality for information shared with state, federal and international regulators similar to Section 8? If sharing confidential information with the NAIC and third-party consultants is permitted, appropriate confidentiality protections should be included.

New

m. Provision prohibiting the making, publishing, disseminating, circulating or placing before the public in any way the group capital calculation and resulting group capital ratio under Section 4L(2) and/or the liquidity stress test along with its results and supporting disclosures required under Section 4L(3), by any insurer, broker, or other person engaged in any manner of the insurance business, except if the sole purpose of the announcement is to rebut a materially false statement, similar to Section 8G of Model #440?

n. Filing requirements for the group capital calculation filing similar to those specified in Section 21 of Model #450?

i. Provision that gives the lead state the authority to exempt the filing of the group capital calculation provided the criteria are similar to those allowed under Section 21A of Model #450?
ii. Provision that gives the lead state the authority to accept a limited group capital filing provided the criteria are similar to those allowed under Section 21B of Model #450?

iii. Provision that gives the lead state the authority to require the group capital calculation of any group that previously met an exemption or submitted a limited filing if any insurer in the holding company system either triggers an RBC action level event, is deemed in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer, similar to those allowed under Section 21C of Model #450?

iv. Provision that sets forth the criteria for a jurisdiction to be included on the NAIC listing that “recognize and accept the group capital calculation” similar to that required under Section 21D and Section 21E of Model #450?
MEMORANDUM

To: Financial Condition (E) Committee

From: Financial Stability (E) Task Force

Date: February 22, 2021

Re: 2020 Revisions to Insurance Holding Company System Regulatory Act (#440)

Executive Summary

On Dec. 9, 2020, the NAIC Executive (EX) Committee and Plenary unanimously adopted revisions to the NAIC Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). These revisions implemented a Group Capital Calculation (GCC) for the purpose of group solvency supervision and Liquidity Stress Test (LST) for macroprudential surveillance. This memorandum makes recommendations with respect to the accreditation standards that this Task Force believes is appropriate with respect to only the LST and expect the Group Capital Calculation (E) Working Group to make separate recommendations to the Committee with respect to the GCC.

Post-financial crisis, regulators from all financial sectors across the globe recognized the need for macroprudential surveillance and tools to address macroprudential risks. While the solvency framework established and managed by the Financial Condition (E) Committee thoroughly addresses legal entity insurers and insurance groups, there was no group with a macroprudential scope. This Task Force was created to fill this gap, and in 2017 was charged to “analyze existing post-financial crisis regulatory reforms for their application in identifying macroprudential trends, including identifying possible areas of improvement or gaps, and propose . . . enhancements and/or additions to further improve the ability of state insurance regulators and industry to address macroprudential impacts.” The Task Force created the NAIC Macroprudential Initiative (MPI) to focus its efforts in four key areas: liquidity risk, recovery and resolution, capital stress testing, and exposure concentrations. Liquidity risk was consistently recognized as a key macroprudential risk by federal and international regulatory agencies, and there were several attempts to assess potential market impacts emanating from a liquidity stress in the insurance sector. Many of these analyses relied heavily on anecdotal assumptions and observations from behaviors of other financial sectors.

In order to provide more evidence-based analyses, the Task Force decided to develop a LST for large life insurers that would aim to capture the impact on the broader financial markets of aggregate asset sales under a liquidity stress event. Unlike capital adequacy, which has risk-based capital as a standardized legal entity capital assessment tool and the newly created Group Capital Calculation to provide a capital analysis tool at the group level, there is no regulatory liquidity assessment or stress tool. The Task Force focused on large life insurers due to the long-term cash buildup involved in many life insurance contracts and the potential for large scale liquidation of assets, not because liquidity risk does not exist in other insurance segments. Thus, the primary goal of the LST is to provide quantitative as well as qualitative insights for macroprudential surveillance, such as identifying the amount of asset sales that could occur during a specific stress scenario; but it will also aid micro prudential regulation as well. Because this stress testing is complex and resource-intensive, a set of scope criteria were developed to identify life insurers with large balances of activities assumed to be highly correlated with liquidity risk; thus, many life insurers will not be subject to the LST.
A statement and explanation of how the potential standard is directly related to solvency surveillance and why the proposal should be included in the standards:

The current Insurance Holding Company Systems accreditation standard requires that state law shall contain the significant elements from Model #440 and Model #450. These models have provided state insurance departments the framework for insurance group supervision since the early 1970s. Following the 2008 financial crisis, state regulators identified group supervision as an area where improvements could be made to the U.S. system. In December 2010, the NAIC adopted changes to the models enhancing the domestic legal structure under which holding companies are supervised. In December 2014, the NAIC adopted revisions to clarify legal authority and powers to act as a group-wide supervisor for internationally active insurance groups. These changes are newly required elements of the NAIC Accreditation Program and have been satisfactorily adopted by nearly all accredited U.S. jurisdictions. As discussed in the preceding paragraphs, the LST was designed to enhance these same standards that were previously included as accreditation standards.

Macroprudential risks can directly impact regulated legal entity insurers and groups, and/or can emanate from or be amplified by these insurers and transmitted externally. The NAIC solvency surveillance framework must address macroprudential risks to ensure that the companies states regulate remain financially strong for the protection of policyholders, while serving as a stabilizing force to contribute to financial stability, including in stressed financial markets. The LST is the first new tool developed for the macroprudential program within the financial solvency framework.

A statement as to why ultimate adoption by every jurisdiction may be desirable:

The Financial Stability Task Force believes that all states that are the lead state for a group subject to the LST should be required to adopt the model revisions. The LST is a tool intended to help assess the impacts the life insurance industry can have on the broader financial markets in a time of stress. Ideally, the tool would have been required of all life insurance groups, but this was not possible due to the complexity and resources required to accomplish such liquidity stress testing. Thus, the LST uses a set of scope criteria to identify those life insurers with significant amounts in activities assumed to have high liquidity risk, thus representing the larger portion of the life insurance industry in terms of liquidity risk rather than representing the entire life insurance industry. If a scoped-in life insurance group was not subject to the LST because a state did not adopt the model revisions, this would significantly reduce the ability of the NAIC to represent the results as truly macroprudential and reflective of the majority of risks of the life insurance sector. Additionally, the LST results will be helpful to the lead states in their group supervision efforts as well.

Though not every state will be the lead state of a scoped-in group, the Task Force still believes the model revisions for the LST should be adopted in every state. It is fairly common for legal entity insurers to move from one group to another, impacting the group dynamics including the lead state determination, and each state should have the LST in their statutes to ensure they will be prepared for any future appointment as lead state. Also, even without legal entities changing groups, business acquisition and operational changes within existing groups might subject a previously excluded group to the LST. Therefore, it is recommended that that the new significant elements apply to all states.

A statement as to the number of jurisdictions that have adopted and implemented the proposal or a similar proposal and their experience to date:

We are not currently aware of any states that have adopted the 2020 revisions to Model #440, although we have been advised that many states have begun their legislative processes for adoption of these revisions.
A statement as to the provisions needed to meet the minimum requirements of the standard. That is, whether a state would be required to have “substantially similar” language or rather a regulatory framework. If it is being proposed that “substantially similar” language be required, the referring committee, task force or working group shall recommend those items that should be considered significant elements:

The current accreditation standard for Model #440 and Model #450 requires state adoption on a substantially similar basis. Therefore, the Financial Stability (E) Task Force supports the attached proposed significant elements (Attached) be adopted by NAIC-accredited jurisdictions in a “substantially similar” manner, as that term is defined in the Accreditation Interlineations of the NAIC Financial Regulation Standards and Accreditation Program. The Financial Regulation Standards and Accreditation (F) Committee should consider a waiver of procedure as provided for in the Accreditation Program Manual and expeditiously consider adoption of this standard. The Financial Stability (E) Task Force recommends that the accreditation standard become effective Nov. 7, 2022, concurrent with the Group Capital Calculation revisions to the model, with enforcement of the standard to commence Jan. 1, 2023.

There were also revisions made to Section 8 of Model #440 regarding Confidential Treatment. The Financial Stability (E) Task Force strongly supports the use of language similar to that contained in Section 8G of Model #440. This language was considered very critical to the LST as its very important that members of the insurance industry (or regulators) not be allowed to make the results of the LST public in any way as they are designed as regulatory-only tools using complex assumptions for potential future stress events and the results could easily be misinterpreted and misrepresented by other users, causing true financial harm to the insurers.

An estimate of the cost for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it, if reasonably quantifiable:

The NAIC has not performed a cost/benefit analysis with respect to the 2020 revisions to Model #440, nor do we believe that the specific costs for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it are reasonably quantifiable. However, the LST scope criteria selects the larger, more complex life insurers, and all of these already perform some form of internal liquidity stress tests. While there are regulatory requirements for inputs and outputs, truly significant costs are avoided by using their existing internal stress testing systems instead of specifying a regulatory model.
6. Insurance Holding Company Systems

State law should contain the NAIC Insurance Holding Company System Regulatory Act (#440), or an act substantially similar.

Insurance Holding Company Systems – continued

Changes to Existing

k. Additions to the filing requirements for the enterprise risk filing specified in Section 4L(1) of the Model #440 (see next item).

New

c. Define “NAIC Liquidity Stress Test Framework” similar to that in Section 1K?

d. Define “Scope Criteria” similar to that in Section 1M?

l. Filing requirements for the liquidity stress test filing similar to those specified in Section 4L(3) of Model #440:

i. The ultimate controlling person of every insurer subject to registration and also scoped into the NAIC Liquidity Stress Test Framework shall file the results of a specific year’s Liquidity Stress Test to the lead state insurance commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook similar to Section 4L(3)?

ii. Insurers meeting at least one threshold of the Scope Criteria for a specific data year are scoped into that year’s NAIC Liquidity Stress Test Framework unless the lead state, after consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should not be scoped into the Framework for that data year similar to Section 4L(3)(a)? Insurers that do not trigger at least one threshold of the Scope Criteria are considered scoped out of the NAIC Liquidity Stress Test Framework for the specified data year, unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should be scoped into the Framework for that data year?

iii. Provision requiring compliance with the NAIC Liquidity Stress Test Framework’s instructions and reporting templates for the specific data year and any lead state insurance commissioner determinations in consultation with the Financial Stability Task Force or its successor, provided within the Framework similar to Section 4L(3)(b)?

Changes to Existing

cc. Provisions for protecting confidential information submitted to the commissioner, including provisions maintaining confidentiality for information shared with state, federal and international regulators similar to Section 8? If sharing confidential information with the NAIC and third-party consultants is permitted, appropriate confidentiality protections should be included.

m. Provision prohibiting the making, publishing, disseminating, circulating or placing before the public in any way the group capital calculation and resulting group capital ratio under Section 4L(2) and/or the liquidity stress test along with its results and supporting disclosures required under Section 4L(3), by any insurer, broker, or other person engaged in any manner of the insurance business, except if the sole purpose of the announcement is to rebut a materially false statement, similar to Section 8G of Model #440?
May 13, 2021

VIA FMAIL

Elizabeth Kelleher Dwyer
Chair, NAIC Financial Regulation Standards and Accreditation (F) Committee
Attention: Becky Meyer (bmeyer@naic.org)

RE: Group Capital Calculation (“GCC”) - (F) Committee Exposure – Louisiana Comments

Dear Superintendent Dwyer,

The Louisiana Department of Insurance is writing in response to the current exposure by the Financial Regulation Standards and Accreditation (F) Committee regarding the group capital calculation (“GCC”) and the liquidity stress test (“LST”), as additions to the accreditation standards for insurance holding company systems. The accreditation standard items are included in the 2020 revisions to the NAIC Insurance Holding Company System Regulatory Act (#440) and the NAIC Insurance Holding Company System Model Regulation (#450).

My comments are regarding Model Regulation #450, Section 21, A and B. Louisiana agrees that GCC should become an accreditation standard and believes that GCC will be a valuable tool for regulators. However, Louisiana does not support the inclusion of Model Regulation #450, Section 21, A and B, as an accreditation standard, which provides that the Commissioner may only grant exemptions “where an insurance holding company system has previously filed the annual GCC at least once”.

I believe that the commissioners should be allowed to grant exemptions to companies meeting the standards set forth in Model Regulation #450, Section 21, A and B, regardless of whether the holding company system has previously filed the GCC. This is based upon the following:

- The cost benefit must be taken into consideration for our small insurance holding company systems and that can only be done on a case-by-case basis by the lead state Commissioner.

- Obtaining the information only once will not provide significant value because it will lack comparability.

- As the ultimate controlling person for their insurance holding company system, many small mutual insurers already provide their own RBC calculation that quantifies the risk for the entire holding company system. As such, the addition of the GCC does not provide significant value but does increase their cost of doing business.
Page 2 of 2
May 13, 2021
Superintendent Dwyer

I appreciate the opportunity to comment on this important topic. Please let me know if you need any additional information or would like to discuss my comments.

Sincerely,

[Signature]
James J. Donelon
Commissioner of Insurance
State of Louisiana
Elizabeth Kelleher Dwyer, superintendent
Chair, NAIC Financial Regulation Standards and Accreditation (F) Committee
Attention: Becky Meyer (bmeyer@naic.org)
RE: Group Capital Calculation ("GCC") - (F) Committee Exposure-MID Comments

Dear Superintendent Dwyer:

The Mississippi Department of insurance is writing in response to the group capital calculation exposure by the Financial Regulation Standards and Accreditation (F) Committee regarding the group capital calculation ("GCC") and the liquidity stress test ("LST"), as additions to the accreditation standards for insurance holding company systems. The accreditation standard items are included in the 2020 revisions to the NAIC Insurance Holding Company System Regulatory Act (#440) and the NAIC Insurance Holding Company System Model Regulation (#450).

Our comments are regarding Model Regulation #450, Section 21, A and B. Mississippi agrees that GCC should become an accreditation standard and believes that GCC will be a valuable tool for regulators. However, Mississippi does not support the inclusion of Model Regulation #450, Section 21, A and B, as an accreditation standard, which provides that the Commissioner may only grant exemptions "where an insurance holding company system has previously filed the annual GCC at least once".

Mississippi believes that the commissioners should have discretion to grant exemptions to small Holding Companies without the first year filing requirement, if the Holding Company does not have a covered agreement and has less than one billion aggregate premium for the group. This follows similar adopted language for ORSA.

Many small insurers provide their own RBC calculation that quantifies the risk for the entire holding company system. Adoption of the Committee Exposure would be an increase cost of doing business.

Thank you for the opportunity to comment on this important topic.

Sincerely,

Mike Chaney, Commissioner
May 13, 2021

VIA EMAIL

Elizabeth Kelleher Dwyer
Chair, NAIC Financial Regulation Standards and Accreditation (F) Committee
Attention: Becky Meyer (bmeyer@naic.org)

RE: Group Capital Calculation ("GCC") - (F) Committee Exposure – NCDOI Comments

Dear Superintendent Dwyer:

The North Carolina Department of Insurance is writing in response to the current exposure by the Financial Regulation Standards and Accreditation (F) Committee regarding the group capital calculation ("GCC") and the liquidity stress test ("LST"), as additions to the accreditation standards for insurance holding company systems. The accreditation standard items are included in the 2020 revisions to the NAIC Insurance Holding Company System Regulatory Act (#440) and the NAIC Insurance Holding Company System Model Regulation (#450).

Our comments are regarding Model Regulation #450, Section 21, A and B. North Carolina agrees that GCC should become an accreditation standard and believes that GCC will be a valuable tool for regulators. However, North Carolina does not support the inclusion of Model Regulation #450, Section 21, A and B, as an accreditation standard, which provides that the Commissioner may only grant exemptions “where an insurance holding company system has previously filed the annual GCC at least once”.

North Carolina believes that the commissioners should be allowed to grant exemptions to companies meeting the standards set forth in Model Regulation #450, Section 21, A and B, regardless of whether the holding company system has previously filed the GCC. This is based upon the following:

- The cost benefit must be taken into consideration for our small insurance holding company systems and that can only be done on a case-by-case basis by the lead state Commissioner.
- Obtaining the information only once will not provide significant value because it will lack comparability.
- As the ultimate controlling person for their insurance holding company system, many small mutual insurers already provide their own RBC calculation that quantifies the risk for the entire holding company system. As such, the addition of the GCC does not provide significant value but does increase their cost of doing business.
We appreciate the opportunity to comment on this important topic. Please let us know if you need any additional information or would like to discuss our comments.

Sincerely,

Mike Causey
Commissioner
May 12, 2021

Superintendent Elizabeth Kelleher Dwyer
Chair, NAIC Financial Regulation Standards and Accreditation (F) Committee
Attention: Becky Meyer (bmeyer@naic.org)

RE: Group Capital Calculation ("GCC") - (F) Committee Exposure – SDDOI Comments

Dear Superintendent Dwyer:

The South Dakota Division of Insurance is writing in response to the current exposure by the Financial Regulation Standards and Accreditation (F) Committee regarding the group capital calculation ("GCC") and the liquidity stress test ("LST"), as additions to the accreditation standards for insurance holding company systems. The accreditation standard items are included in the 2020 revisions to the NAIC Insurance Holding Company System Regulatory Act (#440) and the NAIC Insurance Holding Company System Model Regulation (#450).

Our comments are regarding Model Regulation #450, Section 21, A and B. South Dakota agrees that GCC should become an accreditation standard in general and believes that GCC will be a valuable tool for regulators. South Dakota however does not support the inclusion of the provision in the standard which provides that the Commissioner may only grant exemptions “where an insurance holding company system has previously filed the annual GCC at least once”.

South Dakota believes that the commissioners should be allowed to grant exemptions to companies meeting the standards set forth in Model Regulation #450, Section 21, A and B, regardless of whether the holding company system has previously filed the GCC. A few reasons for this justification are listed below.

- The cost benefit must be taken into consideration for small insurance holding company systems and that can only be done on a case-by-basis by the lead state Commissioner.
- Obtaining the information only once will not provide significant value because it will lack comparability.
- As the ultimate controlling person for their insurance holding company system, many small mutual insurers already provide their own RBC calculation that quantifies the risk for the entire holding company system. As such, the addition of the GCC does not provide significant value but does increase their cost of doing business.
- State legislation that includes an exemption “only where previously filed” will cause this important regulatory standard to fail in multiple states.

We appreciate the opportunity to comment on this topic. Please let us know if you need any additional information or would like to discuss our comments.

Sincerely,

Larry Deiter
Director
South Dakota Division of Insurance

124 South Euclid Avenue, 2nd Floor | Pierre, SD 57501
May 11, 2021

Hon. Elizabeth Kelleher Dwyer, Chair  
Financial Regulation Standards and Accreditation (F) Committee

Dear Superintendent Dwyer:

RE: Exposed accreditation standards for Models 440 and 450

Texas appreciates the opportunity to provide comments on the exposed accreditation standard modifications associated with the group capital calculation (GCC) and the liquidity stress test framework (LST) amendments to Models 440 and 450. Our comments are as follows:

**Group Capital Calculation**

**Exposed Language:**

i. Filing requirements for the group capital calculation filing similar to those specified in Section 4L(2) of Model #440?

   i. The ultimate controlling person of every insurer subject to registration shall annually file a group capital calculation completed in accordance with the NAIC Group Capital Calculation Instructions as directed by the lead state commissioner similar to section 4L(2)?

n. Filing requirements for the group capital calculation filing similar to those specified in Section 21 of Model #450?

   i. Provision that gives the lead state the authority to exempt the filing of the group capital calculation provided the criteria are substantially similar to those allowed under Section 21A of Model #450?

**Comments:**

Texas is opposed to the broad requirement that every group file a GCC as an accreditation requirement. The accreditation standard to file a GCC should be limited to those with international operations and provide the lead state commissioner the discretion to require any group file a GCC.
For years the states debated the merits of group capital. We focused upon our windows and walls approach and enhanced our windows into groups including enhancing Forms B, implementing group supervision and supervisory colleges, enhancing Schedule Y reporting, specifically authorizing holding company examinations, and requiring the filing of enterprise risk reports, ORSA, and Corporate Governance Annual Disclosures. These tools used correctly already give us great insight into most US groups.

Only after it was clear the states' approach would not protect US companies operating internationally from the imposition of international capitals standards did we pivot to developing the GCC. The need for the GCC for groups operating internationally was cemented in the covered agreements.

A state's accreditation status should not be threatened if all groups are not required to file the GCC once. As currently contemplated, if all groups are required to seek an exemption from the lead state commissioner, valuable resources that could be used to monitor solvency will be used in a bureaucratic process that does not enhance solvency oversight of companies. The added filing of the GCC should only be required in situations where the lead state commissioner believes that it would add valuable insight and information to group oversight, not just because it is an accreditation requirement.

Through the supervisory college framework, other regulators would be able to raise concerns about a group's operations and discuss whether a GCC should be required. Because this approach would "achieve the objective of the standard," this approach should be accepted as substantially similar in effect.

Liquidity Stress Test

Exposed Language:

The Financial Stability Task Force believes that all states that are the lead state for a group subject to the LST should be required to adopt the model revisions.

Though not every state will be the lead state of a scoped-in group, the Task Force still believes the model revisions for the LST should be adopted in every state.
Comments:

Less than 15 states are currently the lead state for a scoped-in groups. The requirement that all states adopt the law regardless of whether the state will ever be the lead state for a scoped-in group does not enhance the overall regulation of insurance groups.

The point of adding provisions to Part A of the accreditation standards is to create a floor of solvency regulation that can be relied upon by other states. Threatening a state’s accreditation for not having an unnecessary law on the books puts the state in a position of requesting new laws with the only rationale being the NAIC is telling elected officials what legislation they must pass. This is not a message that will be well received in state capitals.

We anticipate that some states that are not currently lead states for scoped-in groups would adopt the model in order to make their jurisdiction a more attractive domiciliary regulator, but that should be their choice, not a mandate. There is no regulatory reason for all states to be required to adopt these changes.

Conclusion

Texas opposes requiring GCC filings to be prepared by groups when the filing is not needed to understand group operations. A state’s accreditation should not be affected if:

- the state enacts a GCC law that requires filings from all groups with international operations and provides the lead state commissioner discretion to require all other groups file; and,
- aligns with the language included in the covered agreements.

Texas also opposes the application of the LST requirements to all states. There are less than 15 states that are the lead regulators for scoped-in groups. The states that should be subject to those standards should be limited to those that would be required to require LST filings.

Thank you for the opportunity to provide these comments.

Respectfully,

Doug Slape
Chief Deputy Commissioner
Group Capital Calculation (GCC) significant elements as modified and exposed by F Committee on August 14, 2021.

Exposure period is for one year beginning January 1, 2022. Proposed effective date is January 1, 2026.

6. Insurance Holding Company Systems

State law should contain the NAIC Insurance Holding Company System Regulatory Act (#440), or an act substantially similar, and the department should have adopted the NAIC Insurance Holding Company System Model Regulation (#450).

Insurance Holding Company Systems – continued

Changes to Existing

k. Filing requirements for the enterprise risk filing similar to those specified in Section 4L(1) of the Model #440?

New

l. Filing requirements for the group capital calculation filing similar to those specified in Section 4L(2) of Model #440?

i. The ultimate controlling person of every insurer subject to registration shall annually file a group capital calculation completed in accordance with the NAIC Group Capital Calculation Instructions as directed by the lead state commissioner similar to section 4L(2)?

ii. Provision for exempting an insurance holding company system that has only one insurer within its holding company structure, that only writes business [and is only licensed] in its domestic state and assumes no business from any other insurer, similar to 4L(2)(a)?

iii. Provision for exempting an insurance holding company system that is required to perform a group capital calculation specified by the U.S. Federal Reserve? If the Federal Reserve Board cannot share the calculation with the lead state commissioner, the insurance holding company system is not exempt from the GCC, similar to 4L(2)(b)?

iv. Provision for exempting an insurance holding company system whose non-U.S. group-wide supervisor is located within a Reciprocal Jurisdiction that recognizes the U.S. state regulatory approach to group supervision and group capital, similar to 4L(2)(c)?

v. Provision for exempting an insurance holding company system that provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program and whose non-U.S. group-wide supervisor that is not in a Reciprocal Jurisdiction recognizes and accepts the GCC as the worldwide group capital assessment for U.S. insurance groups who operate in that jurisdiction, similar to 4L(2)(d)?

vi. Provision that gives the lead state the authority to require the GCC for U.S. operations of any non-U.S. based insurance holding company system where after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes, similar to 4L(2)(e)?

Changes to Existing

cc. Provisions for protecting confidential information submitted to the commissioner, including provisions maintaining confidentiality for information shared with state, federal and international regulators similar to Section 8? If sharing confidential information with the NAIC and third-party consultants is permitted, appropriate confidentiality protections should be included.

New

m. Provision prohibiting the making, publishing, disseminating, circulating or placing before the public in any way the group capital calculation and resulting group capital ratio under Section 4L(2) and/or the liquidity stress test along with its results and supporting disclosures required under Section 4L(3), by any insurer, broker, or other person engaged in any manner of the insurance business, except if the sole purpose of the announcement is to rebut a materially false statement, similar to Section 8G of Model #440?
n. Filing requirements for the group capital calculation filing similar to those specified in Section 21 of Model #450?
   
   i. Provision that gives the lead state the authority to exempt the filing of the group capital calculation provided the criteria are similar to those allowed under Section 21A of Model #450?
      
      o Although not required for accreditation, in order to grant an exemption, is the filing required at least once?

   ii. Provision that gives the lead state the authority to accept a limited group capital filing provided the criteria are similar to those allowed under Section 21B of Model #450?
      
      o Although not required for accreditation, in order to grant an exemption, is the filing required at least once?

   iii. Provision that gives the lead state the authority to require the group capital calculation of any group that previously met an exemption or submitted a limited filing if any insurer in the holding company system either triggers an RBC action level event, is deemed in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer, similar to those allowed under Section 21C of Model #450?

   iv. Provision that sets forth the criteria for a jurisdiction to be included on the NAIC listing that “recognize and accept the group capital calculation” similar to that required under Section 21D and Section 21E of Model #450?
INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE

International Insurance Relations (G) Committee Aug. 16, 2021, Minutes...............................................................12-2
International Insurance Relations (G) Committee May 5, 2021, Minutes (Attachment One) ........................................12-5
International Association of Insurance Supervisors (IAIS) Draft Application Paper on Macroprudential Supervision – NAIC Approved Comments (Attachment One-A) ...........................................................................12-7
IAIS Draft Revised Application Paper on Supervisory Colleges – NAIC Approved Comments (Attachment Two) .................................................................................................................................12-10
IAIS Draft Issue Paper on Insurer Culture – APCIA Comment (Attachment Three)..........................................................12-12

© 2021 National Association of Insurance Commissioners
The International Insurance Relations (G) Committee met in Columbus, OH, Aug. 16, 2021. The following Committee members participated: Gary D. Anderson, Chair (MA); Raymond G. Farmer, Vice Chair (SC); Evan G. Daniels (AZ); Andrew N. Mais (CT); Karima M. Woods (DC); David Altmair (FL); Doug Ommen (IA); James J. Donelon (LA); Kathleen A. Birrane (MD); Anita G. Fox (MI); Chlora Lindley-Myers (MO); Eric Dunning (NE); Marlene Caride (NJ); Andrew R. Stolfi (OR); and Jessica K. Altman (PA).

1. **Adopted its May 5 and Spring National Meeting Minutes**

The Committee met May 5 and April 7 and took the following action: 1) approved submission of NAIC comments on the International Association of Insurance Supervisors’ (IAIS’s) draft *Application Paper on Macroprudential Supervision*; 2) heard a presentation on Scalar Methodologies from the American Academy of Actuaries (Academy); 3) heard an update on upcoming IAIS committee meetings and activities; and 4) heard an update on the Sustainable Insurance Forum (SIF), the Organisation for Economic Co-operation and Development (OECD), and other supervisory cooperation activities.

Commissioner Caride made a motion, seconded by Commissioner Mais, to adopt the Committee’s May 5 (Attachment One) and April 7 (see NAIC Proceedings – Spring 2021, International Insurance Relations (G) Committee) minutes. The motion passed unanimously.

2. **Discussed NAIC Comments on the IAIS Draft Issues Paper on Insurer Culture and the Draft Revised Application Paper on Supervisory Colleges**

Commissioner Anderson explained that the IAIS draft *Issues Paper on Insurer Culture* explores the concept of insurer culture as a point of intersection for prudential and conduct risks, with examples to illustrate the broader role of culture in managing these risks. He also explained that the IAIS draft revised *Application Paper on Supervisory Colleges* is a revision of the one published in October 2014, and it aims to foster an understanding of the work of supervisory colleges and explain the role and involvement insurers may have in supervisory colleges.

Ryan Workman (NAIC) gave an overview of the NAIC’s comments on the application paper (Attachment Two), noting that most were editorial or for clarification. He provided more detail on those comments that were more substantial.

David F. Snyder (American Property Casualty Insurance Association—APCIA) noted that the APCIA is coordinating comments on the application paper for industry organizations through the Global Federation of Insurance Associations (GFIA). The GFIA’s comments will focus on the importance of ongoing dialogue with the insurer’s senior management as part of groupwide supervision; the purpose of proportionality, which helps to support competitive markets; and the importance of confidentiality in protecting trade secret information.

Mr. Workman noted that there were no NAIC comments on the issues paper. Mr. Snyder discussed a comment submitted to the Committee (Attachment Three), noting that the subjectivity of the culture discussion should not become an additional layer of regulation beyond current regulations. He remarked on an example in the issues paper of the culture of a U.S.-based bank, which was a federally regulated financial institution and not state regulated. Commissioner Anderson said the introduction of the issues paper makes it clear that the topic of culture is a subjective matter, and the issues paper does not suggest that culture be treated as an additional layer, but rather another consideration as part of prudential and market conduct supervision.

Commissioner Altmair made a motion, seconded by Director Farmer, to approve submission of the NAIC comments. The motion passed unanimously.

3. **Heard an Update on Key 2021 Projects and Priorities of the IAIS**

Commissioner Anderson reported on recent IAIS activities, starting with an update on the insurance capital standard (ICS) monitoring period, noting that work continues on developing criteria to assess whether the aggregation method (AM) provides comparable outcomes to the ICS. Development of the criteria will take place throughout 2021, with a consultation expected by year-end.
Commissioner Anderson said another important area of work underway is the targeted jurisdictional assessment (TJA), which is the second phase of the current implementation assessment of the Holistic Framework for Systemic Risk. He added that the U.S. is taking part in the TJA, which includes a series of in-depth written questionnaires followed by onsite meetings planned for early next year and builds off information provided in the first phase—the baseline assessment—which was completed last summer. He also noted that the global monitoring exercise (GME) is underway, and the IAIS has reviewed data received as part of the individual insurer monitoring and sector wide monitoring to determine the scope of collective discussions on potential systemic risks, which will take place towards the end of September.

Commissioner Anderson reported that the IAIS has launched its peer review process among members on insurance core principle (ICP) 9 (Supervisory Review and Reporting) and 10 (Preventative Measures, Corrective Measures and Sanctions), with an objective of a better understanding of the observance of, and implementation challenges related to, IAIS standards.

Commissioner Anderson noted that strategic planning initiatives at the IAIS for 2022 and 2023 were underway, saying that commitments on projects related to group capital and systemic risk will continue, while also focusing on and addressing emerging topics such as climate risk, diversity and inclusion, innovation and technology, and cyber.

3. **Heard an Update on International Activities**

   a. **Regional Supervisory Cooperation**

   Director Farmer reported that the Latin American Association of Insurance Supervisors (ASSAL), the Financial Stability Institute (FSI), and the IAIS jointly held a webinar to exchange views on the main insurance risks that currently concern supervisors in the Latin American region. Nina Chen (NY) from the New York Department of Financial Services (DFS) participated on a panel on the insurance supervisor’s role in climate change. The next ASSAL meeting is scheduled for later this fall, which may be held in person in Costa Rica.

   Director Farmer said the NAIC met virtually in April with the Bermuda Monetary Authority (BMA) to discuss issues of mutual importance, including climate risk and resilience, COVID-19, the NAIC reciprocal jurisdiction framework, and ICS comparability. The NAIC met with the Financial Services Agency (FSA) of Japan for a biannual bilateral dialogue on June 3. The NAIC and the FSA discussed various topics and developments, including climate risk and resilience, liquidity stress testing, results of the recent Financial Sector Assessment Program (FSAP) of the U.S., and market developments in response to COVID-19.

   Director Farmer said the work of the European Union (EU)-U.S. Insurance Dialogue Project (Project) continues with the working groups and the Project’s Steering Committee meeting in the last few months to wrap up the work of the workstreams on cybersecurity, cyberinsurance, and big data/artificial intelligence (AI). He reported that the Project will host a public virtual webinar on Oct. 19 on its continued progress and future priorities, with representatives of the NAIC, including Commissioner Birrane and Commissioner Ommen; the Federal Insurance Office (FIO) of the U.S. Department of the Treasury (Treasury Department); and the European Insurance and Occupational Pensions Authority (EIOPA) leading the webinar.

   Director Farmer highlighted other upcoming activities, including remarks to be given by Commissioner Altmaier as part of the Asian Forum of Insurance Regulators (AFIR) annual meeting, and the creation of recurring bilateral discussions with the United Kingdom (UK) on areas of mutual interest.

   Director Farmer reported that the Fall 2021 NAIC International Fellows Program will be held in a virtual format Oct. 22–28. Applications are due Oct. 1, and a diverse group of participants from most major regions are expected to participate, including from Western and Eastern Europe, Latin America, the Caribbean, Asia, Africa, and the Middle East. He noted that following the success of the last few virtual Fellows Programs, it has been decided to take a hybrid approach to the program going forward, with all Spring sessions being held virtually and the Fall sessions to continue to be offered in person.

   b. **OECD**

   Director Farmer reported that the OECD’s Insurance and Private Pensions Committee (IPPC) met virtually in June and covered updates on various initiatives underway at the IPPC, which included: 1) International Financial Reporting Standard (IFRS) 17 implementation challenges and benefits; 2) a draft of “Insurance Market in Figures 2021” and a review of the OECD Global Insurance Statistics exercise; 3) an online survey on risk management for health and long-term care insurance (LTCI); 4) issues related to risks that are difficult to insure, including pandemics and catastrophes; and 5) leveraging digitalization for risk prevention and mitigation in the insurance sector in Asia. He noted that Commissioner Mais participated virtually in the OECD-
Asian Development Bank (ADB) Institute Roundtable on Insurance and Retirement Savings in Asia on June 29, sharing the U.S. state insurance regulatory experience regarding AI and concerns around inappropriate uses of big data, including those that may disadvantage people of color and/or historically underrepresented groups.

c. SIF

Director Farmer said the NAIC, alongside individual state SIF members—California, New York, and Washington—will participate in the next virtual call in October. The group will discuss progress relative to the three workstreams agreed to in its workplan: 1) impacts of climate-related risks on insurability of assets; 2) broader sustainability issues beyond climate change; and 3) climate risks in the actuarial processes.

4. Discussed Other Matters

Commissioner Anderson reminded attendees about the EU-U.S. Project webinar on Oct. 19. He noted that registration for the event will open in mid-September, and additional details will follow.

Having no further business, the International Insurance Relations (G) Committee adjourned.
The International Insurance Relations (G) Committee met May 5, 2021. The following Committee members participated: Gary D. Anderson, Chair (MA); Raymond G. Farmer, Vice Chair (SC); Evan G. Daniels (AZ); Andrew N. Mais (CT); Karima M. Woods (DC); David Altmaier (FL); Doug Ommen (IA); James J. Donelon (LA); Kathleen A. Birrane (MD); Anitu G. Fox represented by Steve Mayhew (MI); Chlora Lindley-Myers (MO); Eric Dunning (NE); Marlene Caride represented by Dave Wolf (NJ); Andrew R. Stolfi (OR); and Jessica K. Altman (PA).

1. Discussed NAIC Comments on the IAIS Draft Application Paper on Macroprudential Supervision

Commissioner Anderson explained that the International Association of Insurance Supervisors (IAIS) draft Application Paper on Macroprudential Supervision aims to assist supervisors with the practical application of supervisory material related to macroprudential supervision under Insurance Core Principle (ICP) 24, Macroprudential Surveillance and Insurance Supervision. He noted that as part of developing the holistic framework for systemic risk, ICP 24 was revised to better articulate the elements of macroprudential supervision and to address more explicitly the build-up and transmission of systemic risk at the individual insurer and sector-wide levels.

Ryan Workman (NAIC) gave an overview of the NAIC’s comments on the draft application paper, noting that most were editorial or for clarification. He provided more detail on those comments that were more substantial.

Steve Broadie (American Property Casualty Insurance Association—APCIA) noted APCIA’s general concerns on the draft paper, including an overemphasis on looking at whether individual insurers are systemically important, rather than focusing on an activities-based approach (ABA) to looking at systemic risk in the insurance sector. He suggested that the current recommendation of horizontal reviews of individual insurers’ Own Risk and Solvency Assessment (ORSA) reports should be taken out of the paper given that ORSA reports are not intended for such a purpose, as well as for confidentiality issues. Mr. Workman suggested that the focus on individual insurers may be a result of the IAIS having drawn from material related to the global systemically important insurer (G-SII) that took an entities-based approach (EBA), whereas the ABA is still being articulated.

David Leifer (American Council of Life Insurers—ACLI) spoke about similar concerns to the APCIA, noting that its comments to the IAIS will highlight the paper’s emphasis on an EBA instead of an ABA. He said the ACLI has concerns with Section 4.1.3, which describes a reduced form approach for identifying systemically important insurers. He noted the paper gives too much attention to the approach, which has not been properly vetted elsewhere and may not be appropriate for insurers. He said that the use of risk dashboards gets a lot of attention throughout the paper, but while it is a useful tool, it should not be overly relied upon. The ACLI’s comments will also focus on reigning in what it believes to be overly prescriptive language throughout the paper.

Commissioner Altmaier made a motion, seconded by Director Farmer, to approve submission of the NAIC comments on the draft Application Paper on Macroprudential Supervision (Attachment One-A).

2. Discussed Other Matters

Commissioner Anderson provided an update on planning currently underway for the 2021 NAIC International Insurance Forum scheduled for May 25–26. He encouraged everyone to join the virtual event for the robust panel discussions and featured speaker presentations that are scheduled to take place over the course of the two days.

Mr. Broadie noted that the IAIS has recently sent out an invitation to a June 8 virtual stakeholder session on the insurance capital standard (ICS) and that the APCIA plans to participate and welcomes the opportunity to work with “Team USA” to prepare for the event. Mr. Workman said the stakeholder session is most likely to be an update on results from the 2020 monitoring period data collection and upcoming work.
Robert Neill (ACLI) noted that the IAIS put forth results of the comparability assessment public consultation, leaving in place the high-level principles that will be used to develop the assessment criteria later this year. He said the ACLI submitted comments and suggested having a conversation to better understand where regulators stand on the topic. Commissioner Anderson said he would be open to having a dialogue with interested parties along with federal colleagues involved at the IAIS, noting the Committee has had similar meetings in the past, which have been helpful as this work progresses.

Having no further business, the International Insurance Relations (G) Committee adjourned.
<table>
<thead>
<tr>
<th>Section/Paragraph</th>
<th>Comment</th>
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<tbody>
<tr>
<td>General</td>
<td>Overall the paper reads well and is quite comprehensive. However, the Application paper continues to be overly granular in detail and/or come across as prescriptive in places.</td>
</tr>
<tr>
<td>4 Editorial:</td>
<td>It should not, however, be considered as an exhaustive guide to macroprudential supervision.</td>
</tr>
<tr>
<td>18 Editorial:</td>
<td>Suggest moving this statement to be the first in the paragraph with edits below: A risk dashboard is seen to be a descriptive data tool aimed at regularly assessing relevant risks and trends.</td>
</tr>
<tr>
<td>19 Editorial:</td>
<td>The frequency of updating of indicators may depend on the availability of data, the stage of the financial cycle and other market developments or impending disruptions.</td>
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<tr>
<td>21 Editorial:</td>
<td>The remainder of this section provides general guidance and examples on the construction and use of a risk dashboard. As concrete examples, risk dashboards are included in Annex 2 provides the risk dashboards used by South Africa and EIOPA for the following members: South Africa, EIOPA.</td>
</tr>
<tr>
<td>27 Editorial:</td>
<td>Trends typically reflect the behaviour of the risk by indicating how a certain exposure or indicator has developed over time.</td>
</tr>
<tr>
<td>52, Table 2</td>
<td>Noting both approaches as resource-intensive for supervisors is not phrased in a way that belongs in a table of reasons one approach might be preferred to the other. Therefore, suggest rewording the bottom-up disadvantage both to distinguish the two options and to better reflect the differences of the two approaches: Somewhat less resource-intensive for supervisors, but more intensive for participants and supervisors.</td>
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<tr>
<td>59 Editorial:</td>
<td>Sensitivity analysis is an evaluation of the effects of degree by which a model’s results (i.e. by the function that describes analytically) vary in response to changes induced by changes in the values of input variables.</td>
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<td>60 Editorial:</td>
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<td>Page</td>
<td>Editorial</td>
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<tr>
<td>62</td>
<td>Supervisors could also consider qualitative analysis methods (e.g., review of questionnaires, or surveys, or published material) to monitor and assess specific risks that might not necessarily be identified by quantitative analysis methods.</td>
</tr>
<tr>
<td>79</td>
<td>It becomes a macroprudential concern if a shock (the trigger event) leads to reactions causing liquidity shortages in a particular across an entire sector or across several sectors.</td>
</tr>
<tr>
<td>84</td>
<td>The failure of a large insurer in a critical niche market may become a systemic concern if it leads to financial problems for its counterparties, particularly if these counterparties are critical financial market participants themselves. Hence, Limited substitutability refers to the difficulty for other components in the financial system to ensure the continuation of supply of insurance coverage after a failure or distress of an individual insurer. However, the exposure can also apply to groups of insurers that performs a specialised function.</td>
</tr>
<tr>
<td>96, Table 5</td>
<td>We are not sure that it is appropriate to rely on the “exposure-balance sheet” indicator to assist in the identification of off-balance sheet financing. It may be better to refer to Financial Statement Disclosures or perhaps to say that there is no individual type of indicator.</td>
</tr>
<tr>
<td>105</td>
<td>Insurers’ overall score above thresholds as determined from the sample could be deemed systemically important, while those scoring below the thresholds would not be considered as systemically important financial institutions.</td>
</tr>
<tr>
<td>110</td>
<td>It is tautological that markets correctly price the market value; suggest: Behind this methodology, is the assumption is that markets are efficient and correctly price the market value of assets and liabilities.</td>
</tr>
<tr>
<td>112</td>
<td>Reduced form models require an abundance of data to do appropriate time series econometric analysis with publicly available data for publicly traded entities.</td>
</tr>
<tr>
<td>124, Table 9</td>
<td>Based on publicly available information and real time data Not all companies may be publicly traded, thus many of the measures may not be calculated.</td>
</tr>
<tr>
<td>136</td>
<td>However, as noted above, the aggregate impact of it would be important to take note that non-systemically risky insurers that have not been identified as systemically risky should also be considered when evaluating the identified from prior assessments are isolated from the perimeter of supervisory responses to systemic risk of the sector as a whole.</td>
</tr>
<tr>
<td>160</td>
<td>Typo:</td>
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The concepts for both recovery and resolution planning are described in ICP 12 (Exit from the Market and Resolution) and ICP 16 and further guidance is provided in the Application Paper on Recovery Planning and the draft Application Paper on Resolution Powers and Planning.

175 Footnote 37 – editorial:
An example can be found in 2020 when EIOPA issued a statement on dividends distribution and variable remuneration policies in the context of Covid-19 issued by EIOPA in 2020:

176 Footnote 38 – editorial:
An example can be found in the Macroprudential database, Statistical data warehouse of the European Central bank. https://sdw.ecb.europa.eu/browse.do?node=9689335
<table>
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<tr>
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<tr>
<td>15</td>
<td>The IAIS Glossary defines insurance legal entity as “A legal entity, including its branches, that is licensed to conduct insurance, regulated and subject to supervision” so if branches are mentioned in the first sentence, it should be with emphasis; suggest: ...the supervision of insurance legal entities, including branches, and branches most material... Otherwise including “branches” is redundant and should be deleted – see comments on paragraphs 35 and 37.</td>
</tr>
<tr>
<td>16</td>
<td>Suggest for clarification: The broader supervisory college should be informed of the topics and discussions within the tiers of the supervisory college.</td>
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<td>18</td>
<td>The last sentence reads a bit awkward; suggest: In this regard, coordination agreements are used to establish a framework for supervisory college operations, and the procedures for information exchange, and confidentiality protection and use of as well as IT tools are utilised to that support the functioning of supervisory colleges.</td>
</tr>
<tr>
<td>22, footnote 20</td>
<td>As there is no one set of “professional secrecy requirements”, suggest for clarification: In general, a jurisdiction’s professional secrecy requirements apply to any person currently or previously employed by or acting on behalf of a regulatory authority.</td>
</tr>
<tr>
<td>23</td>
<td>The IAIS typically refers to observance of, rather than compliance with, standards; suggest: The process includes an assessment of the present jurisdictional regime and practices and its compliance with observance of relevant international standards.</td>
</tr>
<tr>
<td>27</td>
<td>Given lessons learned from the pandemic, suggest adding to the end of this paragraph: The group-wide supervisor may also want to consider how to leverage IT tools to facilitate in-person as well as virtual meetings.</td>
</tr>
<tr>
<td>35</td>
<td>The IAIS Glossary defines insurance legal entity as “A legal entity, including its branches, that is licensed to conduct insurance, regulated and subject to supervision” so “branch” in the first sentence is redundant and should be deleted.</td>
</tr>
<tr>
<td>36</td>
<td>It seems “a list of ratios” is more of an example in this context; suggest: In this respect the group-wide supervisor and other members of a supervisory college may agree on selected data, such as a list of ratios, and other selected data to be exchanged within the supervisory college on a regular basis.</td>
</tr>
<tr>
<td>37</td>
<td>The IAIS Glossary defines insurance legal entity as “A legal entity, including its branches, that is licensed to conduct insurance, regulated and subject to supervision” so the first sentence should be revised: the group, and its legal entities and branches are exposed.</td>
</tr>
<tr>
<td>40</td>
<td>Last sentence, suggest being more specific:</td>
</tr>
</tbody>
</table>
In this regard, ICP 25 also recognises the role...

Footnote 29, there is a typo – should be ICP 25.7.8 rather than 27.7.8

Editorial: Supervisory colleges college meetings should be well organised to support the effectiveness of the supervisory colleges...

The latter part of the sentence seems like an example of what group-wide Senior Management may be asked to do; suggest for clarification:

For example, group-wide Senior Management can be asked to provide...
Distinguished Chair and Members of the NAIC International Insurance Relations (G) Committee:

Thank you for your engagement in international standard setting bodies and in holding public discussions on comments to IAIS papers, including the Draft Issues Paper on Insurer Culture. We plan to submit comments on that paper and are coordinating the comments of the Global Federation of Insurance Associations, as well.

There is one key point which we ask the NAIC to consider raising in general comments and/or as otherwise appropriate in comments on the insurer culture paper. It is to note that due to the subjectivity of the concept of culture, it should not be considered a regulatory or supervisory mandate above and beyond the particular standards for conduct and outcomes otherwise mandated by law and regulation.

Language such as this might be considered:

“NAIC agrees that the culture of insurers is important. However, due to the subjective nature of the concept of culture, it should be clear that culture is not intended to be an additional regulatory or supervisory layer beyond the legally established standards of conduct and outcomes.”

Thank you for your consideration.

Sincerely,

David F. Snyder,
Vice President
APCIA
NAIC/CONSUMER LIAISON COMMITTEE

The NAIC/Consumer Liaison Committee met Aug. 14, 2021. The following Committee members participated: Michael Conway, Chair (CO); Andrew R. Stolfi, Vice Chair (OR); Lori K. Wing-Heier represented by Sarah Bailey (AK); Alan McClain (AR); Peni Itula Sapini Teo (AS); Ricardo Lara represented by Lucy Jabourian (CA); Andrew N. Mais (CT); Trinidad Navarro represented by Susan Jennette and Frank Pyle (DE); David Altmairer (FL); John F. King (GA); Dean L. Cameron (ID); Vicki Schmidt (KS); Sharon P. Clark represented by Rob Roberts (KY); Kathleen A. Birrane (MD); Chlora Lindley-Myers (MO); Mike Causey represented by Tracy Bieln (NC); Eric Dunning (NE); Barbara D. Richardson represented by David Cassetty (NV); Judith L. French represented by Jana Jarrett (OH); Glen Mulready (OK); Jessica K. Altman (PA); Doug Slape represented by Nancy Clark and Chris Herrick (TX); Jonathan T. Pike (UT); and Scott A. White represented by Don Beatty and Katie Johnson (VA). Also participating were: Elizabeth Kelleher Dwyer (RI); Raymond G. Farmer (SC); James A. Dodrill (WV); and Jeff Rude (WY).

1. **Announced the Continuation of an E-Vote of its Spring National Meeting Minutes**

Commissioner Conway said the Committee met April 8. During this meeting, the Committee received presentations on health and non-health-related insurance issues from a consumer perspective. To save time for presentations by NAIC consumer representatives today, Commissioner Conway said an e-vote was distributed to Committee members prior to this meeting. He asked that members respond to roll call with their e-vote to Lois E. Alexander (NAIC). He also said as the chair of the Consumer Board of Trustees, he postponed the Aug. 13 Board meeting until after the Summer National Meeting, when the Board will discuss revisions to the Plan of Operation for the Consumer Participation Program suggested by NAIC consumer representatives.

2. **Heard a Presentation on Helping Consumers Avoid Getting Burned or Blown Away by Post-Disaster Fraud**

Matthew J. Smith (Coalition Against Insurance Fraud—CAIF) said there are wildfires raging across the nation, a tropical storm off the coast of Florida, and a depression forming in the Atlantic. He said the scariest part is that the official hurricane season has not yet begun. He said along with Amy Bach (United Policyholders—UP), he wants to present practical tips and solutions to state insurance regulators on how to protect their consumers from post-disaster fraud. Because disasters occur in every state, he said these are tips that every state can use to help their constituents. He said the Insurance Information Institute (III) estimated the cost of natural disaster fraud to be over $551 billion in insured losses only from 2011 through 2020. He said statistical data produced by the Battelle Seattle Research Center indicates that conservative estimates put property/casualty (P/C) insurance fraud at 10% of all claims paid or $55 billion every 10 years. He also said the percentage for natural disaster fraud is generally considered to be much higher at 18% or just under $100 billion each decade.

Mr. Smith said what is being seen following natural disasters is contractor and repair scams requiring upfront advances, then not showing up to do the work. He said fraudsters promise to absorb insurance deductibles; however, such practices have been rendered invalid by state insurance departments in recent years, which results in contractors and repair shops cutting corners and using subpar materials to recoup those expenses. He said incomplete work, shoddy work, and work never started are also the types of fraud that tend to follow natural disasters. He said the CAIF had video evidence of contractors damaging undamaged roofing by using hammers and tearing off shingles while consumers were displaced to increase the scope and cost of the work that needed to be done. He said on the opposite side of the spectrum, fraudsters claim to be Federal Emergency Management Agency (FEMA) housing inspectors when they are not; fake offers of local or federal assistance; seek your FEMA number or other personal or financial information; pose as adjusters, contractors, or attorneys to take assignment of insurance benefits then do no work; and charge to clean items that should be discarded or cannot be cleaned. He said storm chaser claims are another problem, and the first thing fake contractors do after a natural disaster is cross state lines to steal a license plate to put on their repair trucks to convince consumers they are dealing with a trustworthy local contractor. He said the next step is to buy a cheap burner cell phone with a local area code and go to Kinko’s for a magnetic sign with local naming conventions on it, such as Columbus Roofing, for the side of the truck, as well as to have business cards and billing statements printed with a local address. He said consumers are told the companies heard the storm was coming so they were waiting in a staging area for the storm to end so they could be the first on scene to help. After acquiring a down payment, he said fake contractors may show up the next day with a few materials and do a little work; however, within 72 hours following the disaster, they are long gone with a wad of consumer cash having left the license plate, magnetic sign, and fake paperwork in a dumpster. He said this happens in states that do not have a storm chaser law or storm chaser regulations in place. He said insurer actions can also lead
to insurance fraud when insurance companies employ inexperienced adjusters without adequate training; stand firm on an Xactimate estimate when it does not match up with local pricing on materials and labor; apply excessive depreciation when calculating actual cash value (ACV); discourage policyholders from hiring professional help; pressure policyholders to use an insurer preferred contractor that does not have a good track record or references; or bulk contracts with engineering firms that are not adequate to cover thorough inspections, resulting in “cookie cutter” reports. He said unintended or claim-motivated consumer fraud is the padding of a contents inventory, dwelling repair costs, or replacement estimates in anticipation of low-ball claim offers from insurers. He said intentional consumer fraud that is spreading across the country is the creation or cause of damage, such as claiming actual living expenses (ALEs) that were not incurred by faking receipts or claiming replacement cost values (RCVs) payable at 100% by purchasing new items, submitting the receipts for claim payment, and returning the items to stores for cash. He said it is important to educate consumers to avoid such practices that can lead to cancellation of insurance coverage because of the way the fraud language is written in the insurance contract. He said it is also important to talk about the disparate impact of natural disaster fraud as persons of color, persons of age, and those with language barriers are being targeted because they are likely to be more vulnerable, not aware of what the scams are, or not aware of what their rights are. He said insurer responses also exhibit disparate impact because the big, mobile disaster vehicles tend to be parked in high income, predominantly white neighborhoods rather than in low income neighborhoods predominantly with persons of color. He said insurers said they park such vehicles in locations where the most policyholders are; however, he said such vehicles and services should be available to all policyholders.

Mr. Smith said steps departments of insurance (DOIs) can take to better protect consumers include advance planning like having disaster plans in place to address fraud, emergency approval plans for adjusters and contractors, and Contractor State Licensing Board (CSLB) coordination. He said states could also provide consumer warnings about fraudsters in advance of and post-disaster and require insurers to utilize response plans and anti-fraud plans. He said actively prosecuting disaster fraudsters is also an important action to take. He said legislative advocacy for storm chaser laws and regulations as deterrents to those contemplating fraudulent insurance activities is also very important.

3. Heard a Presentation on the Impact of the COVID-19 Pandemic on Consumer Credit Scores and Insurance Underwriting

Birny Birnbaum (Center for Economic Justice—CEJ) said he is speaking for the nearly 300 consumers represented by the Consumer Federation of America (CFA) in showing that the use of consumer credit scores for insurance underwriting became completely unfair and discriminatory, especially during the pandemic. He said this is important to state insurance regulators and consumers, as it highlights the use of average credit scoring by industry for historical purposes. He said average credit scoring experienced a shift due to the pandemic. He also said after hearing his presentation, state insurance regulators would agree that state laws and regulations on rating and unfair trade practices require implementation of a moratorium to pause this practice until the credit scoring environment has a chance to catch up and normalize following the pandemic. He said statutory provisions regarding fair and unfair discrimination are generally found in two parts of insurance statutes: rating and unfair trade practices. He said there are two types of unfair discrimination—i.e., actuarial and protected classes—which means distinctions among groups defined by certain characteristics (e.g., race, religion, national origin, etc.) are prohibited regardless of actuarial basis. He said it is unfair discrimination to treat consumers who are similarly situated differently. He said for rates and trade practices to be considered fair and adequate and to be part of the not excessive, not inadequate, and not unfairly discriminatory rate standard, there must be an actuarial basis for distinction among groups of consumers. He said credit-based insurance scores—CBISs are algorithms derived from individual consumer credit reports matched to the insurance outcomes of those insureds. He said a credit scoring model vendor can generate hundreds of possible data points from consumer credit reports to use as predictive factors in a scoring algorithm. He also said the vendor selects those factors that best predict the outcome and produce the greatest difference between consumers. He said outcome variables might be average claim costs per exposure (pure premium), loss ratio, likelihood of fraud, consumer lifetime value, or others. He said insurers argue that CBISs are predictive of claims and support this with data showing higher claim costs for insureds with poor scores and lower claim costs for insureds with good scores. He said CBISs are intended to help insurers group insureds by their relative claim costs (or some other outcome metric). Unlike some rating factors used for discounts, which reflect an actual reduction in claims, like an anti-theft device in the vehicle or home, he said CBISs redistribute premium from one group of consumers to another. He said stated differently, if lots of drivers suddenly installed anti-theft devices in their cars, the discounts would be paid for by a reduction in theft claims and not by an increase in premium for other drivers. He said this is not so with CBISs, where one insured’s discount is another’s surcharge.

As a result of the pandemic and starting in March 2020, Mr. Birnbaum said many businesses were forced to close and unemployment skyrocketed. He said the federal government instituted a series of actions to help individuals and businesses devastated by the pandemic, including: 1) a moratorium on foreclosures; 2) a moratorium on rental evictions; 3) a moratorium on student debt repayment; and 4) a requirement for lenders to offer “forbearance” for other than non-student loans with such forbearance being any kind of assistance to borrowers that would typically be deferring loan payments. He said these provisions
affected millions of consumers and the information in their credit reports. He said the Coronavirus Aid, Relief, and Economic Security (CARES) Act set out specific provisions directly related to credit reporting to help consumers, and one CARES Act provision was to require credit reporting agencies to report any loan in forbearance as current. He said two similarly situated consumers took out loans in 2018 and were current until February 2020; then, the first consumer had a late payment in 2020, which showed up in their credit report because it was not eligible for forbearance. He said the second consumer also had a late payment, but it was in March, so the second consumer was eligible for and obtained forbearance. He said pre-pandemic, both consumers would have received the same credit score through 2020, but because of the CARES Act provisions, these two similarly situated consumers are now treated differently, which resulted in unfair discrimination in insurance rating. He said CBISs used from March 2020 to the present were developed with data from 2016 to 2019 or earlier, when there were stable economic conditions and a stable relationship between consumer credit information and consumer insurance outcomes. He said that actuarial relationship changed significantly as economic conditions, consumer behavior, and insurance claims changed massively from March 2020 forward. He said it is therefore logical and reasonable to conclude that the segmentation produced by the 2016 to 2019 experience no longer remains actuarially valid for the period starting in March 2020. He also said absent new evidence, which will take time for claims to develop, it is unreasonable to believe CBISs based on pre-pandemic experience remain actuarially sound in the pandemic era.

Mr. Birnbaum said the expiration of pandemic protections will unfairly affect CBISs, as millions of consumers will see loans in forbearance become delinquent, a resumption of foreclosures and evictions, and a resumption in student loan payments becoming due. He said the pandemic has also disproportionately affected communities of color, as they have experienced higher rates of COVID-19 infections and deaths; higher rates of unemployment; and less savings or wealth to withstand the financial stress. He said before the pandemic, numerous studies documented the racial bias in credit scores, generally as well as CBISs, specifically. He said the pandemic has exacerbated that racial bias. He said state insurance regulators have the statutory responsibility and authority to place a moratorium on insurers’ use of consumer credit information. He said a temporary moratorium was needed to enforce unfair discrimination laws for three years following the end of pandemic protections because credit report information and CBISs will be affected for several years following the end of pandemic protections. He suggested that state insurance regulators use an approach that prohibits insurers from raising rates on policyholders due to deteriorating credit score.

4. Heard a Presentation on Regulatory Possibilities for Promoting Equity Through Telehealth

Rachel Klein (The AIDS Institute) said the COVID-19 pandemic led states to rapidly increase the scope of telehealth services through public and private payers. She said initial reports suggested that telehealth services during COVID-19 did more to preserve access for existing patients than to alleviate access disparities and may even have exacerbated these disparities. She said the rapid scaling up of telehealth capabilities among providers across the country offers lessons about what more needs to be done to ensure that telehealth realizes its promise as a tool for advancing equity. She said telehealth promises include increased access to care for people: 1) in a variety of underserved communities; 2) in areas with geographic or transportation challenges; 3) in areas that lacked providers; 4) of racial and ethnic minorities; 5) that were unstably housed or homeless; and 6) with stigma-related barriers. She said flexibility is the key to promoting equity through telehealth with: 1) more flexible scheduling to accommodate people with jobs that do not offer paid leave; 2) more flexible opportunities to literally “meet people where they are”; 3) more flexible access to providers who are not nearby; 4) more flexible access to specialists; 5) more flexible means to overcome stigma-related barriers; and 6) faster connection to care. She said access has expanded rapidly during the pandemic, largely due to state insurance regulators relaxing the restrictions related to: 1) cost-sharing through parity or free services; 2) provider reimbursement; 3) coverage of audio-only telehealth; 4) origination and distant sites; and 5) pre-authorization requirements. She said the good news is telehealth capacity has increased dramatically and quickly. She said patients and providers have more experience and are more comfortable with the system. She also said evidence of lessons learned and the data to support them are still emerging, but state insurance regulators should support payors to build on these systems to help telehealth fulfill its promise.

Karen Siegel (Health Equity Solutions—HES) discussed evaluating utilization data, assessing barriers to telehealth, preserving consumer choice, and safeguarding against unnecessary requirements or cost barriers for in-person care. She said telehealth services have the potential to reduce avoidable emergency department utilization (EDU) and create access for people who lack transportation or dependent care or who face stigma in their communities. She said these benefits will be limited if telehealth services only reach populations who already had access to in-person care. She said what is still needed is access to affordable broadband, unlimited data and minutes, access to the necessary devices, and on the ground training for tech literacy. She said other barriers to consumer access include insurance illiteracy and the inability to connect to providers. She said one issue still to be addressed is cultural or situational appropriateness and the consumer’s right to opt out. She said this right is necessary due to cultural concerns over privacy, safety, language barriers, and personal comfort.

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5. **Heard a Presentation on the Implementation of the NSA and Implications for Consumer Protections**

Natasha Kumar (Families USA) provided an overview of the long-standing abusive practice of surprise medical billing and the protections passed into law through the federal No Surprises Act (NSA) in December 2020. As the release of the first of three interim final rules (IFRs) came out in July, she said consumer representatives wanted to present ways in which insurance commissioners could be sure consumers have the tools they need to ensure comprehensive protections when this law takes effect in January 2022. She said surprise billing occurs when a consumer is unknowingly, and through no fault of their own, charged an out-of-network fee for medical services obtained, such as emergency services, non-emergency services, ambulatory care, or air ambulance. She said almost 20% of emergency department (ED) visits result in a surprise bill; an average surprise bill is $600, but bills can exceed $100,000; and 10% of health plan spending can be attributed to surprise medical bills. She said 17 states have no balance billing protection; 16 states have partial balance billing protection; and 18 states have comprehensive balance billing protection. She said under the NSA, consumers are held harmless in surprise billing situations by cost-sharing at in-network rates; they are protected in emergency situations for ancillary services; and in certain non-emergency situations are required to be given notice and consent for certain out-of-network care. She said the initial payment is negotiated by the insurer and provider or facility. Otherwise, the insurer pays the qualifying payment amount (QPA). She said if the provider and payer do not agree on payment, they can initiate Independent Dispute Resolution (IDR), whereby the arbiter assesses each case based on certain criteria and awards a “win” to either the insurer and the plan or the provider and the facility. She said under IFR 1, the definition of facilities includes hospital, hospital outpatient department, critical access hospital, or an ambulatory surgical center; and consumers are seeking comment on urgent care facilities and retail clinics to be included and procedural considerations as to when the notice and consent are being provided to consumers. She said the payment mechanism indicates that the initial payment to the provider is the “recognized amount,” which gives deference to state payment rates. She said if state rates are not applicable, payment is the greater of billed charges or QPA, which is determined by the median of in-network contracted rates for the service in the geographical area. However, she said there are concerns that this may result in inflation associated with highly concentrated markets. She said geographic region, as defined by the NAIC, is taken to mean a metropolitan statistical area (MSA), but the air ambulance “geographic region” is considered to be all MSAs in a state.

Ms. Kumar said recommendations for insurance commissioners would include consumer education through an “About” section on websites and ensuring this is available to all linguistic groups; helping consumers obtain and understand advance notices of their potential liability; proactively reaching out to consumers, especially those in Black, Indigenous, and People of Color (BIPOC) communities, on new consumer protections. She said recommendations would also include a complaints process that would provide phone assistance, including referrals to other agencies that are enforcing this law; helping uninsured consumers open an arbitration case for a medical bill; helping consumers challenge and take enforcement action to address bills that consumers did not consent to and that should have been covered under the NSA. She also said recommendations would ensure that notice and consent forms reflect the correct set of protections that apply to the specific case of the patient, as state preemption applies in most cases, and in conjunction with other agencies, monitor the provision of consumer notices and consent forms.

6. **Heard Survey Results from the Consumer Representatives Survey**

In Spring 2021, consumer representatives commissioned a survey of state and local grassroots consumer organizations to broaden their perspective on insurance issues represented at the NAIC. This presentation described the survey’s goal, methodology, and preliminary results with the aim to bring the expertise, perspectives, and stories from these organizations to state insurance regulators and other NAIC stakeholders. Brenda J. Cude (University of Georgia—UGA) said the Disparities in Insurance Access online survey fielded May 17 to June 16 was funded by the Robert Wood Johnson Foundation (RWJF). She said the objective of the survey was to: 1) inform the work of state insurance regulators and the NAIC, especially the Special (EX) Committee on Race and Insurance; 2) focus on disparities and inequities in intersectional and overlapping systems of oppression; 3) assess common themes and patterns across demographic groups; and 4) assess the familiarity of community organizations with state DOIs.

Yosha Dotson (Georgians for a Healthy Future—GHF) said the survey sample consisted of 72 unique respondents who are leaders or senior employees of consumer organizations, primarily at the state, local, and regional level who were identified via grassroots sampling, seeking leaders or senior employees of nonprofit and community consumer organizations. She said collectively, the sample represented a mix of focus areas across different lines of insurance, geographic diversity, population focus diversity, as well as robust state and local contact lists. She said the organizational profile was primarily statewide health Black or African American and Latino or Hispanic in low income racial or ethnic groups. She said the challenges that were most commonly identified were around insurance affordability and literacy. She said the source of discrimination and bias was income, race, and ethnicity, as demonstrated by discriminatory or biased algorithms in rating. She said recommendations to
state insurance regulators were to develop more expansive partnership networks with community organizations in areas that represent diverse populations and embrace active, ongoing engagement with community partners. She said recommendations to the NAIC were to: 1) identify, promote, and replicate best practices across states; 2) create minimum community engagement standards; 3) collect more data to better assess and address systemic inequities; 4) examine current industry practices and public policies that disproportionately and negatively affect certain groups; 5) prioritize enhanced data collection and reporting of demographic data; and 6) conduct a deeper review of the algorithms used to set rates.

Having no further business, the NAIC/Consumer Liaison Committee adjourned.